



East, Central and Southern Africa  
Health Community



# The Prevention and Management of Obstetric Fistula: *A Curriculum for Nurses and Midwives*





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# The Prevention and Management of Obstetric Fistula: *A Curriculum for Nurses and Midwives*

A collaborative publication of  
The East, Central, and Southern African Health Community  
and  
USAID  
Fistula Care  
EngenderHealth  
ECSACON



East, Central and Southern Africa  
Health Community



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# FOREWORD

Obstetric fistula is a significant and often neglected problem in East, Central, and Southern Africa. More than 2 million women around the world are living with obstetric fistula, most of them in Sub-Saharan Africa.<sup>1</sup> This number may be an underestimate, because data about the condition are often limited. One study has estimated that at least 33,450 new cases of obstetric fistula occur every year in rural Sub-Saharan Africa.<sup>2</sup>

Obstetric fistula takes a heavy toll on women and society. The affected woman experiences constant leaking of urine and/or faeces; she may also face other complications, such as dermatitis of the vulva and thighs, urinary tract infections, sexual dysfunction, and infertility. She loses her sense of dignity and is often stigmatized, even in her own family. Most of the time, her spouse abandons her. Society suffers because women are unable to attend school, contribute economically, or effectively care for their children.

Yet obstetric fistula can be prevented and treated. Access to safe obstetric care and family planning services can reduce the occurrence of obstetric fistula. Improved nutrition and education for girls and women can play a big role. Changes in traditional practices (such as early marriage, female genital cutting, and the environment in which such practices occur) can also reduce the magnitude of obstetric fistula. If a woman does have obstetric fistula, surgical repair can often cure the condition or lessen its consequences.

Nurses and midwives play an essential role in the prevention and treatment of obstetric fistula. They can educate women and their communities about the risks of prolonged and obstructed labor. They can provide antenatal care. They can take actions during labour and delivery that help to prevent obstetric fistula. They also serve as caring, skilled providers for women who need treatment. They can help women who have had surgical repair reintegrate into their communities and resume productive lives.

This curriculum for nurses and midwives, developed by the East, Central and Southern Africa Health Community, in collaboration with the Fistula Care project at EngenderHealth, is an important tool for countries working to address the serious problem of obstetric fistula. The curriculum represents the expertise and knowledge of dozens of dedicated health care providers, all committed to ending obstetric fistula in Africa.

Dr. Josephine Kibaru-Mbae, MB.CHB U.O.N —1984; MMED-U.O.N—1992  
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<sup>1</sup> Ruminjo, J. 2007. Obstetric fistula and the challenge to maternal health care systems. *IPPF Medical Bulletin* 41(4):3–4.

<sup>2</sup> Vangeenderhuysen, D., Prual, A., and Ould el Joud, D. 2001. Obstetric fistula: Incidence estimates for sub-Saharan Africa. *International Journal of Gynaecology and Obstetrics* 73(1):65–66.



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# PREFACE

Nurses and midwives are on the front line of health care in East, Central, and Southern Africa, especially in the care of women and infants. They play an essential role in reducing both maternal and infant mortality and morbidity. In the case of obstetric fistula, they can take critical steps to prevent the condition, and they are essential team members in the treatment of fistula and the subsequent reintegration of women into their communities.

This nursing curriculum for obstetric fistula represents a unique and strong collaboration between the East, Central and Southern Africa Health Community (ECSA-HC) and the Fistula Care project at EngenderHealth, a global health organisation. A wide range of regional and global experts, including physicians, nursing educators and administrators, midwives, and nurses, contributed to the development of this document. They identified essential nursing and midwifery skills, drafted material, reviewed manuscripts, suggested sources and illustrations, and informed the curriculum with their experience caring for women living with obstetric fistula.

This comprehensive curriculum addresses several critical areas: preventive care, surgical treatment and postoperative recovery, information, education, family and community involvement, counselling, and data collection and use. It also presents learning activities and competency-based skills checklists that help nurses and midwives develop real-world skills for the clinical environment.

ECSA-HC is committed to ending obstetric fistula. This curriculum is one step toward achieving that goal.

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# INTRODUCTION FOR TRAINERS

## Course Overview

### Goal and Objectives

Nursing and midwifery are both integral to comprehensive obstetric fistula care services. The goal of this curriculum is to train nurses and midwives so that they have the knowledge, skills, and attitudes that will enable them to prevent obstetric fistula and care for clients who are living with obstetric fistula. The curriculum will help the participants meet the needs of fistula clients and their communities.

As a result of this training, nurses and midwives will be able to perform the following tasks:

1. Inform and educate women and their communities about obstetric fistula, how it can be prevented, and how it can be treated
2. Use the partograph to prevent prolonged and obstructed labour
3. Provide nursing care to women living with obstetric fistula and undergoing repair surgery
4. Involve communities in fistula prevention and management and in the reintegration of women living with obstetric fistula into their communities
5. Advocate for women living with obstetric fistula, for women who have undergone fistula repair, and for fistula care services
6. Use relevant data to inform decision making in fistula care services

### Course Participants

This curriculum is designed for nurses and midwives serving women of reproductive age in East, Central, and Southern Africa. The primary target audiences are:

- Nurses and midwives providing services to women living with fistula, especially those who have recently been employed. Examples of such services include:
  - Counselling women living with fistula about treatment options
  - Caring for women before, during, and after repair surgery
  - Providing discharge information to women who have undergone repair surgery
- Nurses and midwives working in aspects of health care relevant to fistula prevention, such as:
  - Providing antenatal care
  - Providing health education in the community
  - Assisting with labour and delivery
- Nursing and midwifery students in preservice or postgraduate programmes

Not all components of the curriculum will be relevant to all audiences. The curriculum is designed to allow you to select the modules and training sessions that best fit the specific needs of the participants.

**It is assumed that training participants already possess some of the appropriate knowledge, skills, and attitudes before taking this course. Each module in the curriculum describes the necessary prerequisites.**

## **Number of Participants**

The number of participants should not exceed 25. Depending upon the size of the group, the trainers may need to modify certain activities, such as simulation practises, small-group work, and practica.

## **Trainers for the Course**

This curriculum is designed to be conducted by skilled, experienced trainers. Although the curriculum contains information to guide the training process and to assist you in making decisions that will enhance the learning experience, it is assumed that you understand adult learning concepts, can employ a variety of training methods and techniques, and know how to adapt materials to meet participants' needs.

The trainers also must be aware of standards and guidelines regarding certification, training follow-up, and ongoing supervision of the site or institution sponsoring the training event. Keep these issues in mind when preparing to teach the curriculum.

Trainers must have a solid grounding in nursing and midwifery care for the prevention and management of obstetric fistula. A team of two trainers (either two co-trainers or a lead trainer and an assistant) can be used. As one trainer facilitates a session, the other can record information on flipcharts, monitor time, help keep the discussion on track with the session objectives, moderate small-group work, and act in sample role-plays.

## **Duration of Training**

If all classroom sessions are taught, the training sessions would total about 48 hours in length; the training itself could be spaced out over a period of 7–10 days. However, the training may take more or less time, depending upon (a) the participants' knowledge and skills and (b) whether the trainer chooses to omit certain learning objectives and activities.

The suggested duration for clinical practica varies depending upon (a) the participants' knowledge and skills, (b) whether the trainer chooses to omit certain practica, and (c) the availability of clients and supervisory staff. The developers of this curriculum highly recommend that participants engage in clinical practica if they will soon be using the skills addressed in the practica.

If you change the length of training, you may also need to change the order of sessions, in order to adapt the course to time constraints.

## **The Training Curriculum**

### **Note on Language**

Throughout this curriculum, women are often referred to as *clients*. In many health settings, people receiving health care are referred to as *patients*, a word that often connotes passivity and ill health. This curriculum uses the word *clients* to reinforce the concept of empowerment and to suggest an active role for people seeking health services. (See EngenderHealth. 2003. *COPE Handbook: A Process for Improving Quality in Health Services*. New York. [www.engenderhealth.org/pubs/quality/cope-handbook.php](http://www.engenderhealth.org/pubs/quality/cope-handbook.php).)

This curriculum comprises the three core approaches to addressing obstetric fistula: prevention, treatment, and reintegration. In some literature, the term *rehabilitation* is used instead of *reintegration*. We use *reintegration* to refer to a more holistic approach to helping women after

fistula repair, including assisting with their physical rehabilitation, providing counselling and emotional support, and supporting their social reintegration, which may include efforts to reduce stigma and discrimination and to support vocational and educational training and support.

### **Training Curriculum Components**

The training curriculum has four main components: training modules with training sessions, participant handouts, trainer's resources, and appendices.

### **Training Modules with Training Sessions**

The methodology and instructions for conducting the training are included within six training modules:

1. Overview of Obstetric Fistula
2. Preventing Obstetric Fistula during Pregnancy, Labour, and Delivery
3. Management of Obstetric Fistula
4. Clients' Rights, Information, Education, and Community Involvement
5. Counselling Clients with Obstetric Fistula
6. Using Data to Inform Decision Making within Fistula Care Services

Each module covers a specific aspect of care. Within each module are a series of training sessions. Each session includes:

- The objectives of the session
- Points to remember
- Suggested training methods
- Materials and equipment needed
- Advance preparation
- Training tips
- An estimate of the amount of time needed for the training
- A description of the training activities

Before beginning each session, the trainer should review the session's objectives and list them on flipchart paper, a computer slide, or an overhead transparency. The trainer should review the objectives with the participants again at the end of each module, providing a summary of what has been covered.

The Training Steps section gives detailed instructions for conducting the session, with a suggested time for each activity. Training Tips, which appear in highlighted boxes, provide the trainer with background information and suggestions on content or training approaches.

### **Participant Handouts**

Participant handouts help the trainer conduct training activities and provide information and exercises for the participants. When reviewing the training steps for each session, read the handouts carefully and identify the key points to be covered during the group discussions. This advance preparation will facilitate the process of reviewing and summarising handouts.

The handouts for each session appear after the session activities. The trainer must make copies for the participants of the handouts used in each session.

## **Trainer’s Resources**

Trainer’s resources provide additional information used only by the trainer. They include items such as evaluation tools, information about role-plays, and answer keys. The trainer’s resources for each session appear after the participant handouts.

## **Appendices**

Appendix A provides checklists for conducting clinical practica. Appendix B provides a sample course evaluation form to be given to the participants at the end of the course.

## **Training Materials and Equipment**

Before beginning each module, the trainer should gather all the specified materials and equipment. For every module, the trainer will need flipchart paper, masking tape or temporary adhesive (“blue tack”), and colour markers.

This training relies heavily on the use of flipcharts to guide or summarise discussions. Many of these can be prepared in advance. However, there are dangers in overusing flipcharts:

- Paper is expensive and sometimes scarce.
- Participants can become bored with “training by flipchart,” even though it is intended to make training interactive.
- Participants need to be able to record and refer to some of the information presented, and handouts may work better in such cases.

Specific instructions are given for when to write on the flipchart; try not to do more than is suggested.

If a laptop computer, LCD projector, overhead projector, transparencies, transparency markers, and electricity are available, these aids can be used in addition to or instead of flipcharts.

## **How to Use These Materials**

### **Training Design**

This curriculum has been designed to be flexible, so that it may accommodate:

- Different types of nurses and midwives (nursing students, nurses and midwives serving women living with fistula, nurses and midwives providing general reproductive health care to women, etc.)
- Different levels of participant experience, knowledge, and skills
- Different social and cultural settings

The course design will be determined in part by the participants’ prior experience and training. **In most settings, you can probably choose to omit some of the learning objectives and activities, to best meet the needs of the participants. The goal should be to provide training that will be put to practical use in the near future.** When training is done at a health facility, service providers’ time may be limited; nevertheless, it is preferable that all participants be present for all sessions.

The activities in this curriculum have been designed to achieve specific objectives. Although you will need to adapt the curriculum based on participants’ needs—as well as the setting, culture, and other local factors—you should follow the instructions as closely as possible.

## **Use of Training Methods**

The curriculum relies on a combination of training methods, including presentations and interactive exercises. The steps of the training sessions provide instructions to the trainer. Although you will need to present some of the material through lectures, you should also use participatory methods, such as large-group and small-group exercises, role-plays, simulation practise, and discussion. Never lecture for more than 15 to 20 minutes at a time. While lecturing, use visual aids when possible to illustrate the content. Encourage the participants to ask questions during or after each lecture.

Participatory methods, such as simulation practise, role-plays, and clinical practica, have been shown to be a critical feature of successful adult learning. Although the methods used for this training should be as interactive as possible, both to reduce the amount of lecture time and to engage the participants more fully, the content of the course does not always lend itself to such activities. You can also employ principles of adult learning by encouraging the participants to discuss issues and generate solutions based on their own experiences.

## **Clinical Practica**

Appendix A provides checklists for clinical practica in the following areas:

- Use of the partograph
- Urinary catheterisation
- Physical assessment of women living with obstetric fistula
- Preoperative and postoperative care
- Counselling (seven practica, each for a different phase of care)

Clinical practica are critical to the impact of the overall training experience. After completing the classroom portion of the training, the participants apply what they have learned with actual clients. The clinical setting elevates skills practise to a level of seriousness difficult to approximate in the classroom. Each participant should take part in practica that best fit his or her present or potential work assignments. Exposure to multiple clients in a range of different circumstances helps the participants gain a better understanding of obstetric fistula, its prevention, and its management.

*Note:* When this curriculum is used in in-service settings, classroom training must be carefully planned to ensure that:

- Essential services can still be provided at sites where the participants are working.
- There is a good client mix and an adequate number of clients at the facility when clinical practica are under way.

In in-service settings, trainers will need to be especially flexible with the training schedule.

## **Evaluation**

Evaluation is an important component of training. It gives both the trainers and the participants an indication of what the participants have learned and helps you determine whether the training strategies adopted have been effective.

The true measure of the successful implementation of this curriculum lies in ascertaining whether quality practises, services, and protocols have been instituted or improved upon. This can only be determined through follow-up of training events. However, more immediate evaluation of the course itself is also needed.

Evaluation opportunities within the curriculum include the following:

- Assessing the participants' progress during the training by asking questions of individuals and groups to test their knowledge and comprehension
- Using the quizzes and other exercises from the curriculum to test the participants' knowledge and comprehension
- Creating a pretest and posttest for the entire course and for each module (You may use evaluation questions presented in the first Trainer's Resource provided for each module or create your own questions based on the participants' learning needs.)
- Observing the clinical practica and using the corresponding checklists to assess how the participants' skills have developed

During the clinical practica, trainers and/or supervisors should use the checklists provided (see Appendix A) to observe the participants. The goal of this assessment is to identify strengths and weaknesses in the participants' skills. Using the checklists, discuss with the participants on an individual basis how to improve their skills. For service sites, the participants' performance during the practica should serve as the baseline. Practica results can also be used to identify participants who have exemplary skills and who might be candidates to become trainers in the future.

After training, the trainer or another qualified professional should follow up with the participants to learn how they have applied their new knowledge and skills. If a supervisor is responsible for follow-up, the trainer should contact the supervisor to learn how services have improved in the participant's setting as a result of his or her training.

An end-of-training course evaluation allows the participants to provide feedback on the overall training process and results. The Training Evaluation Form (Appendix B) should be used for this purpose, and the participants should be encouraged to be truthful in their responses. (This may be easier for them if they complete the form anonymously.)

### ***Adjusting the Curriculum***

As the course progresses and you become familiar with the participants' learning styles, knowledge, and skills, you may need to make minor adjustments in the course content or agenda. Time requirements for training sessions will vary, depending on the participants' experience and interests and on your respective levels of experience.

Trainers should cover all important content—in the order prescribed by the agenda and training sessions—and allow sufficient time for discussion.

## **Advance Preparation**

### ***Selection of Training Participants***

Careful selection of participants is integral to the success of the training programme. Before the training begins, the trainer should find out as much as possible about the professional backgrounds of course participants, including their level of knowledge, skills, and attitudes regarding the prerequisites specified at the beginning of each module.

To assess the participants' needs and abilities before training, the trainer may interview the participants, observe them during service provision, or give them a pretest using questions from the first Trainers' Resource provided for each module.

If the participants are in nursing school or graduate training, the trainer will want to know what course work and clinical rotations the participants have completed.

If the participants are already working, the trainer will want to find out:

- Their job responsibilities
- The experience they have had providing antenatal care
- The experience they have had attending women in labour
- The experience they have had providing preoperative, intraoperative, and postoperative care
- The experience they have had providing care to women with obstetric fistula
- The management hierarchy at their work sites
- What plans, if any, are in place at the participant's work site to provide comprehensive fistula services

To obtain this information, ECSA-HC and EngenderHealth recommend that trainers interview the administrators who are most involved with training at the the participants' respective work sites.

### ***Guidelines for Training Preparation***

The following steps will help you become familiar with the curriculum and prepare to conduct the training:

- First, read the entire curriculum and the handouts once quickly for an overall sense of the purpose, content, and approach of the training.
- Next, confer with programme administrators at the service site or faculty at the educational institution where the course will be conducted. Work together to clarify the purpose of the training, ensure that appropriate participants have been chosen, and determine the time available/allotted for training.
- Then read the curriculum again, this time more slowly. Select the training sessions that you will conduct. Think about each session in terms of the needs of the participants and their clients. Carefully review each handout that will be used. The handouts are the permanent record of the training that the participants will take with them; others who have not attended the training may also see them. Revise the handouts as needed to reflect the local situation, issues, and attitudes.
- After reviewing the handouts and revising them (if necessary), make enough copies of them for all participants. If you wish, give out some handouts at the beginning of the course for the participants to read as background. Other handouts are specifically designed to be distributed as part of a training activity. In some cases, you will distribute handouts before a training session as part of a homework exercise. Each participant must be notified in advance of the need to bring a notebook or folder to keep all of his or her materials organised as they are distributed.
- Before each session begins, write the list of objectives for the session on a piece of flipchart paper. You may use computer slides or overhead transparencies if projection equipment is available. At the beginning of each session, briefly state the objectives to be covered. In addition, review the session's objectives during a "wrap-up" to provide a framework for assessing how well objectives were achieved and where participants might have gaps in understanding. These gaps can be addressed in subsequent sessions.

## Creating a Positive Learning Environment

Many factors contribute to the success of a training course. One key factor is the learning environment. Trainers can create a positive learning environment by:

- *Respecting each participant.* Recognise the knowledge and skills that the participants bring to the course. Show respect by learning and using the participants' names, encouraging them to contribute to discussions, and requesting their feedback on the course agenda.
- *Giving frequent constructive feedback.* Constructive feedback—particularly during simulation practises and clinical practica—increases people's motivation and ability to learn. Whenever possible, recognise the participants' correct responses and actions by acknowledging them publicly and making such comments as “Excellent answer!”, “Great question!”, and “Good work!” You can also validate the participants' responses by making such comments as “I can understand why you would feel that way.” You should also help the participants recognise incorrect practises and develop a plan for improving performance.
- *Keeping the participants involved.* Use a variety of training methods that increase participant involvement, such as questioning, case studies, discussions, and small-group work.
- *Making sure that the participants are comfortable.* The training room(s) should be well lit, well ventilated, and quiet, and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.

## Participant Feedback

Trainers should set aside segments of time during the training to allow the participants to raise issues that can interfere with learning, such as those related to personal situations, accommodations, or content. Similarly, set aside time at the end of training sessions to allow the participants to share their insights into the learning process and their assessments of the sessions' effectiveness. Such assessments enable you to make any needed adjustments in the training plans and give the participants the opportunity to comment on how the training is progressing. One effective way to do this is to conduct a “plus/delta” exercise, which is described below.

Towards the end of the training, ask the participants if they require clarification of any points or if they would like anything else to be included in the final sessions.

### Conducting a Plus/Delta Exercise

Plus/delta exercises can be used to solicit feedback about the training. Through these exercises, participants are able to evaluate the training experience together, discussing aspects of the training that have gone well and recommending ways to improve it in the future. This exercise can be conducted at the end of each day or at the end of the course.

Conducting a plus/delta exercise typically takes between 15 and 30 minutes. You can start by asking the participants to call out aspects of the training that they liked. Record their comments in the left-hand column of a flipchart, entitled “Plus” (or “What I Liked about This Training”). Next, ask the participants to call out ways in which to improve the training, and record these responses in the right-hand column of the flipchart, entitled “Delta” (or “What Could Be Done to Improve This Training”).

For each item listed in the “Delta” column, facilitate a discussion by asking whether many people agree or if only one participant feels this way and by encouraging the participants to recommend ways in which to make the suggested changes. Continue asking for ways to

improve the training until the participants have no more suggestions. (*Note:* If the participants seem reluctant to point out negative aspects of the training, you might mention one thing that you have thought of to improve future trainings.)

If the participants' suggestions for improvement involve changes to the training room or environment, communicate the suggestions to someone who can facilitate the changes.

## **At the End of the Training Course**

It is important to summarise the content and activities of the course for the participants. Highlight key points and review any specific concerns or difficulties that were raised during the course.

When the training has concluded, you may choose to administer a posttest made up of evaluation questions presented in the first Trainer's Resource provided for each module or of other questions they consider important. The posttest will help you to assess changes in the participants' knowledge regarding obstetric fistula. It is also important for the participants to complete the end-of-training evaluation (Appendix B), so you can examine overall processes and results.

## **Posttraining Functions**

Participants who complete this curriculum will be able to perform the following functions:

- Create awareness about obstetric fistula and its causes in the community, so as to prevent its occurrence and reduce suffering among girls and women.
- Identify and correct myths about obstetric fistula in the community, so as to create awareness of the need for timely medical intervention to prevent unnecessary suffering among girls and women.
- Advocate for fistula care services to local civic and health leadership.
- Provide information to clients on factors that may contribute to formation of obstetric fistula among girls and women during pregnancy, labour, and delivery and after delivery.
- Counsel individuals, families, and communities about obstetric fistula, including causes, repair procedures, self-care, outcomes, and postrepair, to empower them to make informed decisions.
- Identify girls and women with obstetric fistula in the community and give them information on the referral system and on where they can get help.
- Provide quality care in order to prevent the occurrence of obstetric fistula:
  - During pregnancy (antenatal care, birth planning, screening)
  - During labour and delivery (use of the partograph, catheterisation, assistance with caesarean section)
  - After delivery (identification of leaking, catheterisation)
- Provide nursing care before, during, and after fistula repair surgery.
- Identify clients with obstetric fistula in the health care facility, carry out preliminary assessment and management, and refer clients to the next level for indicated management.
- Apply principles of infection prevention, focusing on care areas specific to fistula services (client assessment, preoperative preparation, postrepair nursing, catheterisation).
- Order, inventory, and maintain instruments, equipment, and supplies at health facilities, so as to treat obstetric fistula clients promptly.
- Integrate clients with obstetric fistula repair back into the community through individual and family counselling and networking with social organisations, so as to support women's health and dignity.

- Network with support groups, social welfare organisations, legal organisations, health partners, and government agencies to empower women living with obstetric fistula psychologically, socially, and economically.
- Record and keep accurate and correct information on clients with obstetric fistula.
- Monitor and evaluate fistula care services for improvement.
- Conduct or participate in surveys, analyse data, and disseminate findings related to fistula for use in decision making to improve fistula care services.

## After the Training Course

### Follow-Up

Learning about obstetric fistula does not end when the course is completed. At the end of the training, most participants will have gained new knowledge and skills and will have a better understanding of how to prevent and manage obstetric fistula. At the end of the course, work with the participants to develop an action plan with goals and objectives; such plans outline ways to implement new knowledge and skills gained during the course. When reviewing action plans with the participants, you may wish to discuss the need for and the possibility of carrying out whole-site training on fistula-related issues at the trainees' work site(s). (See EngenderHealth's web site, [www.engenderhealth.org](http://www.engenderhealth.org), for more information on whole-site training.)

After the course, follow up with supervisors and/or administrators to determine whether the participants are using their new knowledge and skills when providing reproductive health services to women of childbearing age. When possible, observe the provision of care to pregnant women, women in labour, and fistula clients.

If the participants do not have the cooperation of colleagues and the support of their supervisors, they may have difficulty integrating what they have learned into their work sites. For these and other reasons, discuss follow-up with work-site supervisors before the training and with the participants during the training. Where possible, supervisors and facility administrators should be oriented to fistula care and should explore the implications for changes in existing services in order to provide fistula care services. This orientation will help supervisors to be more effective in supporting providers to practise their newly acquired skills.

Before beginning the training, you need to understand your role in follow-up. This can be provided in several different ways, depending on the participants' needs, your own availability, and financial considerations. Follow-up mechanisms include the following:

- *Visiting the participants at their work sites.* This is the most effective way to follow up on the course, particularly if the participants have developed an action plan with goals and objectives. If possible, facilitate a discussion with the participants to talk about the challenges and successes of integrating what they have learned into existing services. Administrative issues and any problems the participants might encounter can be discussed at this time.
- *Inviting the participants to visit other sites or meet other providers who are offering quality care for the prevention and management of obstetric fistula.* During such visits and meetings, participants can observe quality services and obtain helpful advice from providers who are successfully delivering preventive and management services.

Follow-up is a crucial part of training and is integral to the success of any course. The training participants should know who will conduct follow-up, how it will be conducted, and when and how often it will occur.

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# MODULE I: OVERVIEW OF OBSTETRIC FISTULA

## Introduction

This module introduces the obstetric fistula curriculum for nurses and midwives and provides participants with basic information about obstetric fistula, including the anatomy and physiology affected by it, the types and manifestations of the condition, and its incidence and prevalence in Africa. The participants will identify the organs affected by obstetric fistula, learn its causes and consequences, and gain an understanding of the impact fistula has on girls and women living with the condition. The content covered in this introductory module serves as a foundation for the rest of the obstetric fistula curriculum, preparing participants to acquire knowledge and skills for preventing and managing obstetric fistula, educating and counselling fistula clients, and using data to inform decision making within fistula services.

## Prerequisites

- Basic knowledge of the anatomy and physiology of the female reproductive, urinary, and gastrointestinal systems

## Module Objectives

Upon completion of this module, the participants will be able to:

- Describe the contents of the six modules in the obstetric fistula curriculum for nurses and midwives
- Define obstetric fistula
- Describe the anatomy of the following structures affected by obstetric fistula: the vagina, uterus, bladder, urethra, ureters, rectum, and external female genitalia
- Describe the anatomy of the female bony pelvis
- Describe the physiology of the structures affected by obstetric fistula
- Identify and differentiate the different types of obstetric fistula
- Outline the physical causes of obstetric fistula and contributing societal factors
- Identify traditional/cultural factors that affect the reproductive health of women and girls and can contribute to causing obstetric fistula
- Explain the clinical manifestations of obstetric fistula
- Describe the medical and social consequences of fistula
- Describe the incidence and prevalence of obstetric fistula in Africa
- Identify the age-groups typically affected by obstetric fistula in Africa

## Overview of Module Content

Sessions/Parts	Total time
1. Introduction to the Obstetric Fistula Curriculum	30 minutes
A. Workshop Introduction	20 minutes
B. Curriculum Overview	10 minutes
2. Anatomy and Physiology of Obstetric Fistula	1 hour, 15 minutes
A. Anatomy of Structures Affected by Obstetric Fistula	45 minutes
B. Physiology of Structures Affected by Obstetric Fistula	30 minutes
3. Types and Manifestations of Obstetric Fistula	2 hours, 15 minutes
A. Types of Obstetric Fistula	15 minutes
B. Causes of Obstetric Fistula	1 hour
C. Clinical Manifestations and Medical Consequences of Obstetric Fistula	30 minutes
D. Social Consequences of Obstetric Fistula	30 minutes
4. Incidence and Prevalence of Obstetric Fistula in Africa	1 hour, 10 minutes
A. Magnitude of the Problem of Obstetric Fistula in Africa	30 minutes
B. Module 1 Evaluation	40 minutes
<b>Total time</b>	<b>5 hours, 10 minutes</b>

## Evaluation

- Trainer's Resource 1-1: Module 1 Evaluation and Answer Key

## SESSION I

### Introduction to the Obstetric Fistula Curriculum

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Describe the six modules in the obstetric fistula curriculum for nurses and midwives

#### POINTS TO REMEMBER

- Women living with obstetric fistula suffer devastating physical, psychological, and social consequences.
- Nurses and midwives play an important role in the prevention of obstetric fistula and the management and rehabilitation of clients living with obstetric fistula.
- This training will provide nurses and midwives with the knowledge and skills they need to fulfill that role.
- This curriculum is organised into six modules:
  1. Overview of Obstetric Fistula
  2. Preventing Obstetric Fistula during Pregnancy, Labour, and Delivery
  3. Management of Obstetric Fistula
  4. Clients' Rights, Information, Education, and Community Involvement
  5. Counselling Clients with Obstetric Fistula
  6. Using Data to Inform Decision Making within Fistula Care Services

#### Training Methods

- Welcome and introduction
- Story/discussion
- Presentation

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 1-A: Curriculum Overview
- Trainer's Resource 1-1: Module 1 Evaluation and Answer Key
- [Optional] Trainer's Resource 1-2: Terefa's Story
- [Optional] *Obstetric Fistula Digital Stories* video

#### TRAINING TIPS

- ☉ A personal story helps to convey the devastating physical and social consequences of obstetric fistula. For Part A, Activity 2, use one of the following:
  - One of the *Obstetric Fistula Digital Stories* videos of women dealing with fistula in rural Uganda, available online at <http://www.engenderhealth.org/our-work/maternal/digital-stories-uganda-fistula.php>
  - The story of a particularly compelling fistula client you have seen, nursed, or met
  - Trainer's Resource 1-2: Terefa's Story
- ☉ This session is designed for participants who will be going through all or most of the obstetric fistula curriculum in sequence. It introduces those participants to the topics that will be covered and explains the organisation and rationale for this course work. If you will only be delivering a few selected modules from the obstetric fistula curriculum, skip Part B of this session (Curriculum Overview).

### **Advance Preparation**

1. Review the Training Steps.
2. Part A, Activity 2: Determine whether you will show a video or tell a story. If you choose a personal recollection, outline the key elements of the client's story.
3. Prepare a flipchart, a computer slide, or an overhead transparency listing the objective for this session.
4. Part B, Activity 1: Review Participant Handout 1-A.
5. Duplicate Participant Handout 1-A for the participants.

#### **TRAINING TIP**

If you wish to do a pretest for Module 1, select approximately 20 relevant questions from Trainer's Resource 1-1 (based on the sessions and content that you will be covering) to create the test. The pretest will add about 20 minutes to the length of Session 1. The correct answers are shown in **boldface**.

**Session Time (total):** 30 minutes

## SESSION I

### Training Steps

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#### **PART A: WORKSHOP INTRODUCTION**

**Time:** 20 minutes

##### **Activity 1: Welcome and Introductions (10 minutes)**

1. Welcome the participants.
2. Introduce yourself (if the participants do not know you).
3. Ask each participant to briefly introduce himself/herself (if you do not know all of the participants or if they do not all know each other).

#### **TRAINING TIPS**

- ⦿ Adjust the introduction time and process as needed to fit your specific delivery situation (e.g., if the module is being delivered as in-service training at a relatively small facility, introductions might not be necessary).
- ⦿ [Optional] As part of the introductions, ask each participant to indicate whether he/she has ever encountered a client with obstetric fistula. This will help you to assess the level of the participants' familiarity with the condition. If some or all of the participants have encountered obstetric fistula, you can make the training more interactive by building upon their experiences. If most participants are unfamiliar with obstetric fistula, you will need to rely more upon lecture and presentation.  
*Note:* This option is more relevant for participants with nursing or midwifery experience rather than for preservice student nurses and midwives.

##### **Activity 2: Story/Discussion (10 minutes)**

1. Tell the story of a woman living with obstetric fistula (either a personal recollection or Terefa's story from Trainer's Resource 1-2) or show one of the *Obstetric Fistula Digital Stories* videos.
2. Ask the participants to describe their reactions to the story; how did it make them feel?
3. Summarise the participants' comments, emphasising the devastating medical and social consequences of obstetric fistula.

#### **PART B: CURRICULUM OVERVIEW**

**Time:** 10 minutes

##### **Activity 1: Presentation (10 minutes)**

1. Review the session objective, using the prepared flipchart, computer slide, or overhead transparency.
2. Explain that nurses and midwives play an important role in the prevention of obstetric fistula and in the management and rehabilitation of clients living with obstetric fistula.
3. Indicate that this training will provide nurses and midwives with the knowledge and skills they need to fulfill that role.
4. Distribute Participant Handout 1-A and briefly describe the content of each module.
5. Ask the participants what questions they have about the training.

## **SESSION 2**

### **Anatomy and Physiology of Obstetric Fistula**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Define obstetric fistula
- Describe the anatomy of the following structures affected by obstetric fistula: the vagina, uterus, bladder, urethra, ureters, rectum, and external female genitalia
- Describe the anatomy of the female bony pelvis
- Describe the physiology of the structures affected by obstetric fistula

#### **POINTS TO REMEMBER**

- Obstetric fistula is an abnormal opening between the reproductive tract (usually the vagina) and the urinary tract (frequently the bladder) or alimentary tract (usually the rectum) or both. Obstetric fistula typically develops after several days of prolonged or obstructed labour.
- The bladder and urethra lie directly anterior to the vagina.
- The rectum lies directly posterior to the upper third of the vagina.
- The ureters run laterally adjacent to the upper anterior wall of the cervix.
- Knowledge of the shape and dimensions of the normal female pelvis is essential for a proper understanding of labour and its abnormalities.
- When labour is prolonged or obstructed, the constant pressure of the baby's head against the mother's pelvis restricts the flow of blood to the soft tissues of the vagina, bladder, urethra, and/or rectum. This leads to *necrosis* (tissue death), which causes a fistula to develop.
- Understanding the functions of the structures affected by obstetric fistula is essential to understanding the different types of obstetric fistula and their clinical manifestations.

#### **Training Methods**

- Presentation
- Grab bag game
- Question and answer session

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 1-B: Anatomy of Obstetric Fistula
- Participant Handout 1-C: Physiology of Structures Affected by Obstetric Fistula
- Trainer's Resource 1-3: Anatomy Grab Bag Game Answer Key
- Grab bag game materials (bag, pieces of paper numbered 1 through 18)

#### **Advance Preparation**

1. Review the Training Steps.
2. Review Participant Handouts 1-B and 1-C.
3. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - External female anatomy

- Internal female anatomy
  - Anatomy of the female bony pelvis
4. Prepare the grab bag game materials (as described in Part A, Activity 2).
  5. Duplicate Participant Handouts 1-B and 1-C for the participants.

**Session Time (total):** 1 hour, 15 minutes

## SESSION 2

### Training Steps

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#### **PART A: ANATOMY OF STRUCTURES AFFECTED BY OBSTETRIC FISTULA**

**Time:** 45 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Distribute Participant Handout 1-B.
3. Read aloud the definition of obstetric fistula on the handout.
4. Indicate that the different types of obstetric fistula, and their causes, will be described in detail in the next session.

##### **Activity 2: Grab Bag Game (20 minutes)**

1. Display the first diagram on Participant Handout 1-B, using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.
2. Explain that you are going to use a “grab bag game” to review the female pelvic anatomy, starting with the external structures.
3. Facilitate the grab bag game as follows:
  - Put the pieces of paper with numbers 1 through 6 on them in a bag.
  - Have the participants draw numbers out of a bag.
  - Ask the participant who drew “1” to identify the corresponding anatomical structure. (*Note:* Trainer’s Resource 1-3 provides an answer key.)
  - If the participant gives the correct answer (clitoris), acknowledge it and write “1 = Clitoris” on the flipchart.
  - If the participant gives the wrong answer, indicate that he/she is incorrect and ask if anyone else knows what the structure is. When the correct answer is given, acknowledge it and write it on the flipchart.
  - Repeat the process for all of the remaining external structures.
4. Display the second diagram on Participant Handout 1-B, using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.
5. Facilitate a second grab bag game as described above, using the pieces of paper with numbers 7 through 18, to review the internal structures of the female pelvic anatomy.

#### **TRAINING TIP**

Because of their nursing/midwifery training, the participants are expected to know basic female anatomy and to be able to identify the structures on the diagrams. If you do not do a pretest, the grab bag game will allow you to assess their knowledge. If the participants show that they are knowledgeable, proceed to the next activity; if not, you will need to review the diagrams with them before proceeding.

##### **Activity 3: Presentation (20 minutes)**

1. Remind the participants of the definition of obstetric fistula on Participant Handout 1-B.
2. Display the second diagram on Participant Handout 1-B (Female Pelvic Anatomy – Internal Structures), using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.

3. Emphasise the proximity of the vagina to the bladder, urethra, ureters, and rectum.
  - The bladder and urethra lie directly anterior to the vagina.
  - The rectum lies directly posterior to the upper third of the vagina.
  - The ureters run laterally adjacent to the upper anterior wall of the cervix.

#### **TRAINING TIP**

The anatomical diagram in Participant Handout 1-B does not show the ureters. If possible, use an anatomical model or a diagram from a basic anatomy book to point out the location of the ureters and emphasise their proximity to the cervix.

4. Display the third diagram on Participant Handout 1-B (Anatomy of the Female Bony Pelvis), using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.
5. State that knowing the shape and dimensions of the normal female pelvis is essential for a proper understanding of labour and its abnormalities.
6. Describe the anatomy of the female bony pelvis, as described in Participant Handout 1-B, including:
  - Ilium
  - Ischium
  - Pubis
  - Sacrum
  - Coccyx
7. Discuss the passage of the foetal head through the pelvic inlet and outlet, based on Participant Handout 1-B.
8. Explain that, when labour is prolonged or obstructed, the constant pressure of the baby's head against the mother's pelvis restricts the flow of blood to the soft tissues of the vagina, bladder, urethra, and/or rectum. This leads to *necrosis* (tissue death), which causes a fistula to develop.
9. Ask what questions the participants have about the anatomy of structures affected by obstetric fistula.

## **PART B: PHYSIOLOGY OF STRUCTURES AFFECTED BY OBSTETRIC FISTULA**

**Time:** 30 minutes

### **Activity 1: Question-and-Answer Session (30 minutes)**

1. Display the external anatomical diagram on Participant Handout 1-B, using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.
2. Facilitate a question-and-answer session to review the functions of the external structures affected by obstetric fistula, based on Participant Handout 1-C.
  - Ask a participant to describe the function of the clitoris.
  - If the participant gives the correct answer, acknowledge it.
  - If the participant gives a wrong or incomplete answer, indicate that he/she is incorrect (or incomplete) and ask if anyone else knows what the function is. Provide supplemental information (from Participant Handout 1-C) as needed.
  - Repeat the process for the other external structures listed on Participant Handout 1-C.

**TRAINING TIP**

Because of their training, the participants are expected to know basic physiology and to be able to describe the functions of the affected structures. If they show that they are knowledgeable, proceed to the next session; if not, you will need to spend additional time reviewing this information with them before proceeding.

3. Display the internal anatomical diagram on Participant Handout 1-B, using a computer slide, an overhead transparency, or a drawing on a piece of flipchart paper.
4. Facilitate a question-and-answer session to review the functions of the internal structures affected by obstetric fistula, based on Participant Handout 1-C.
  - Ask a participant to describe the function of the vagina.
  - If the participant gives the correct answer, acknowledge it.
  - If the participant gives a wrong or incomplete answer, indicate that he/she is incorrect (or incomplete) and ask if anyone else knows what the function is. Provide supplemental information (from Participant Handout 1-C) as needed.
  - Repeat the process for the other external structures listed on Participant Handout 1-C.
5. Distribute Participant Handout 1-C.
6. Emphasise that understanding the functions of the structures affected by obstetric fistula is essential to understanding the different types of obstetric fistula and their clinical manifestations, because obstetric fistula alters the normal functioning of the affected organs.
7. Ask what questions the participants have about the physiology of the structures affected by obstetric fistula.

## SESSION 3

### Types and Manifestations of Obstetric Fistula

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Identify and differentiate the different types of obstetric fistula
- Outline the physical causes of obstetric fistula and contributing societal factors
- Identify traditional/cultural factors that affect the reproductive health of women/girls and can contribute to causing obstetric fistula
- Explain the clinical manifestations of obstetric fistula
- Describe the medical and social consequences of fistula

#### POINTS TO REMEMBER

- The five types of obstetric fistula are:
  - Vesicovaginal (VVF) fistula: Between the bladder and vagina
  - Rectovaginal fistula (RVF): Between the rectum and vagina
  - Urethrovaginal fistula: Between the urethra and the vagina
  - Ureterovaginal fistula: Between the distal ureter and vagina
  - Vesicouterine fistula: Between the uterus and the bladder
- Vesicovaginal (VVF) is the most common type of obstetric fistula
- A client may have both vesicovaginal and rectovaginal fistula at the same time—the combination of VVF and RVF is the second most commonly encountered type of obstetric fistula.
- The most common cause of obstetric fistula in developing countries is prolonged or obstructed labour.
- Other physical causes of fistula include:
  - Trauma caused by sexual violence
  - Accidental surgical injury
  - Unsafe abortions
  - Harmful traditional practises
  - Diseases or radiotherapy treatments
- Most women who develop obstetric fistula during childbirth do so because they did not receive the health care they needed.
- The problems in accessing timely obstetric care, which can lead to maternal death or complications (including fistula), are commonly referred to as the “Three Delays”:
  1. Delay in deciding to seek care
  2. Delay in reaching a health care facility
  3. Delay in receiving adequate care/attention at the facility
- Other societal factors that contribute to obstetric fistula include:
  - Poverty
  - Early marriage and childbirth
  - Gender discrimination
  - Poor nutrition and compromised development
  - Inadequate family planning information

**POINTS TO REMEMBER (continued)**

- Cultural beliefs can contribute to the problem of obstetric fistula, including rumours or myths related to:
  - The causes of fistula
  - The reasons why certain women develop fistula
  - The reasons why some women who develop fistula do not seek care
- Leaking urine and/or faeces is the primary clinical manifestation of obstetric fistula.
- The type of fistula determines the kind of leaking that the woman experiences.
- The leaking urine and/or faeces typically cause an unpleasant odour and/or a foul-smelling vaginal discharge.
- Obstetric fistula, in conjunction with prolonged or obstructed labour, can lead to a range of physical and mental health complications, including:
  - Gynecologic sequelae
  - Nerve damage
  - Dermatologic injuries
  - Bone abnormalities
  - Anxiety and depression
  - Ancillary medical conditions (such as dehydration, bladder stones, malnutrition, anemia, urinary tract infections, and kidney disease)
- The social consequences for women living with obstetric fistula include:
  - Stigma related to stillbirth
  - Subjection to myths and misconceptions about fistula
  - Social isolation (Because of the unpleasant odour, women with fistula may be perceived as unclean and are often excluded, or exclude themselves, from participating in community activities.)
  - Marital breakdown/divorce
  - Shame, self-esteem issues, and other psychological problems
  - Inability to make a living (Many women with fistula live for years without any financial or social support and fall into extreme poverty.)
  - Suicide
- “The understanding that one must treat the ‘whole person’ with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care” (Lewis Wall, 1998).

**Training Methods**

- Lecture/discussion
- Group discussion
- Story
- Individual exercise/group debrief
- Story/discussion

**Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 1-D: Types of Obstetric Fistula
- Participant Handout 1-E: Physical Causes of Obstetric Fistula
- Participant Handout 1-F: Contributory Factors Affecting Obstetric Fistula

- Participant Handout 1-G: Myths and Misconceptions about Fistula
- Participant Handout 1-H: Clinical Manifestations and Medical Consequences of Obstetric Fistula
- Participant Handout 1-I: Social Consequences of Obstetric Fistula
- [Optional] Trainer’s Resource 1-2: Terefa’s Story
- [Optional] *Obstetric Fistula Digital Stories* video
- [Optional] *UNFPA Fistula Advocacy* video
- Paper and a pencil/pen for each participant

### Advance Preparation

1. Review the Training Steps.
2. Review Participant Handouts 1-D through 1-I.
3. Determine whether you will show a video or tell a story during Part D, Activity 2. If you choose a personal recollection, outline the key elements of the client’s story.
4. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Diagram of four most common types of obstetric fistula (from Participant Handout 1-D)
  - Diagram showing how prolonged or obstructed labour causes obstetric fistula (from Participant Handout 1-E)
  - The “Three Delays” (from Participant Handout 1-F)
  - Quote from Lewis Wall (from Participant Handout 1-I)
5. Duplicate Participant Handouts 1-D through 1-I for the participants.

#### TRAINING TIP

Because Session 3 is 2 hours, 15 minutes in length, it may not be practical to conduct the entire session on a single day. If you need to split the session, we suggest conducting Part A (Types of Obstetric Fistula) and Part B (Causes of Obstetric Fistula) on one day and Part C (Clinical Manifestations and Medical Consequences of Obstetric Fistula) and Part D (Social Consequences of Obstetric Fistula) on another day. If you do conduct all the sessions on a single day, be sure to schedule a break between Parts B and C.

**Session Time (total):** 2 hours, 15 minutes

## SESSION 3

### Training Steps

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#### **PART A: TYPES OF OBSTETRIC FISTULA**

**Time:** 15 minutes

##### **Activity 1: Lecture/Discussion (15 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Ask the participants to name the internal anatomical structures affected by obstetric fistula:
  - Vagina
  - Bladder
  - Urethra
  - Ureter
  - Rectum
3. Distribute Participant Handout 1-D.
4. Describe the most common types of obstetric fistula, using a computer slide, an overhead transparency, or a diagram drawn on a prepared flipchart to show the location of each type:
  - Vesicovaginal (VVF) fistula: Between the bladder and vagina
  - Rectovaginal fistula (RVF): Between the rectum and vagina
  - Urethrovaginal fistula: Between the urethra and the vagina
  - Ureterovaginal fistula: Between the distal ureter and vagina
  - Vesicouterine fistula: Between the uterus and the bladder
5. Explain the following information about the types of obstetric fistula:
  - The names of the types of obstetric fistula reflect the anatomical structures affected.
  - A client can sometimes develop both a VVF and an RVF.
  - The most common type of obstetric fistula is VVF.
  - The second most common type is the combined VVF and RVF.
  - Urethrovaginal fistula is relatively uncommon, compared with the VVF and RVF types.
  - Ureterovaginal fistula, which is also relatively uncommon, is typically the result of injuries sustained during gynaecologic procedures.
  - Vesicouterine fistula is a relatively rare complication of a caesarean section.
6. Ask the participants what questions they have about the types of obstetric fistula.

#### **PART B: CAUSES OF OBSTETRIC FISTULA**

**Time:** 1 hour

##### **Activity 1: Lecture/Discussion (15 minutes)**

1. Ask the participants to name one cause of obstetric fistula that we have previously discussed:
  - Prolonged or obstructed labour
2. Explain how prolonged or obstructed labour causes obstetric fistula, using a computer slide, an overhead transparency, or a diagram drawn on a prepared flipchart to show the diagram of the bladder, rectum, and foetal head (from Participant Handout 1-E):
  - When labour is prolonged or obstructed, the foetal head exerts continuous pressure against the mother's pelvis, greatly reducing the flow of blood to the soft tissues surrounding the vagina, bladder, urethra, and/or rectum.

- If the mother survives, this kind of labour often ends when the foetus dies and gradually decomposes enough to slide out of the vagina.
  - If the mother survives, the injured tissue within her pelvis soon sloughs away as a consequence of necrosis (tissue death), causing a fistula to develop between adjacent organs.
3. Indicate that, while prolonged or obstructed labour is the main cause of obstetric fistula, there are other direct physical causes as well as contributing societal factors.
  4. Ask the participants if they can think of any other physical causes (situations or conditions that could result in fistula).
  5. Write the participants' responses on a piece of flipchart paper.
  6. Distribute Participant Handout 1-E.
  7. Describe the following physical causes of fistula, based on the information in Participant Handout 1-E:
    - Trauma caused by sexual violence
    - Accidental surgical injury
    - Unsafe abortions
    - Harmful traditional practises
    - Diseases or radiotherapy treatments
  8. Ask the participants what questions they have about the direct physical causes of obstetric fistula.

### **Activity 2: Lecture/Discussion (30 minutes)**

1. Explain that lack of access to health care services is a leading contributory factor in obstetric fistula—most women who develop obstetric fistula during childbirth do so because they did not receive the health care they needed.
2. Describe how the lack of access to health care contributes to the prevalence of obstetric fistula, based on the information in Participant Handout 1-F, including:
  - Lack of skilled birth attendants
  - Lack of suitably equipped facilities
  - Inadequate/incomplete antenatal care
  - High costs for clients
  - Inadequate monitoring during labour
  - Lack of prompt access to emergency obstetrical care
3. Discuss the “Three Delays” (described on Participant Handout 1-F), using a computer slide, an overhead transparency, or a prepared flipchart listing the “Three Delays,” as follows:
  - List the “Three Delays.”
  - Ask the participants for reasons for/causes of the first delay (delay in deciding to seek care).
  - Write the participants' responses on a piece of flipchart paper. If they are not mentioned, add cultural beliefs and practises (such as delivering a firstborn child at home), being unaware of the need for care, and being unaware of the warning signs of problems.
  - Ask the participants for reasons for/causes of the second delay (delay in reaching a health care facility).
  - Write their responses on a piece of flipchart paper. If they are not mentioned, add transportation-related issues (transportation that is unavailable, too expensive, too slow, etc.).

- Ask the participants for reasons for/causes of the third delay (delay in receiving adequate care/attention at the facility).
  - Write their responses on a piece of flipchart paper. If they are not mentioned, add unavailability of resources (human, equipment, etc.) and inadequate or harmful care (such as incorrect diagnosis).
4. Ask the participants if they can think of any other underlying societal factors (situations/ social conditions that indirectly contribute to causing fistula).
  5. Write the participants' responses on a piece of flipchart paper.
  6. Distribute Participant Handout 1-F.
  7. Describe the following contributory societal factors affecting obstetric fistula, based on the information in Participant Handout 1-F:
    - Poverty
    - Early marriage and childbirth
    - Gender discrimination
    - Poor nutrition and compromised development
    - Inadequate family planning information
  8. Facilitate a group discussion about the interrelationship of all the contributory factors listed on Participant Handout 1-F.

#### **TRAINING TIP**

Ask open-ended questions (such as “What connections do you see between these contributory factors?”) to help start the discussion. If need be, ask more specific questions (such as “How does poverty relate to the lack of access to health care?”) to keep the discussion going. Be prepared to suggest some causal relationships (for example: “Poverty is a cause of poor nutrition and early marriage.” “Early marriages are often arranged or forced marriages, and thus a consequence of gender discrimination.”)

9. Thank the group for their participation.
10. Ask the participants what questions they have about contributory factors affecting obstetric fistula.

#### **Activity 3: Group Discussion (15 minutes)**

1. Explain that—related to these contributory societal factors—cultural beliefs can contribute to the problem of obstetric fistula.
2. Facilitate a discussion by asking the participants to describe rumours or myths that they have heard about fistula. These rumours or myths can relate to:
  - The causes of fistula
  - The reasons why certain women develop fistula
  - The reasons why some women who develop fistula do not seek care
3. Record the rumours or myths on a piece of flipchart paper.

#### **TRAINING TIP**

If the participants find it difficult to identify any myths or rumours, prompt them with some examples from Participant Handout 1-G.

4. Point out that many of these rumours and myths are linked to a woman's alleged personal and/or social characteristics or behaviours.
5. Ask the participants, "Why are rumours and myths like these invented?" Possible responses include:
  - Ignorance
  - Fear
  - Discrimination against women
  - Shame
6. Ask the participants, "Which of the 'Three Delays' do these rumours and myths contribute to?"
  - The first delay, delay in deciding to seek care
7. Distribute Participant Handout 1-G and ask the participants to read it.
8. Ask the participants whether they have questions about myths and misconceptions about fistula.

## **PART C: CLINICAL MANIFESTATIONS AND MEDICAL CONSEQUENCES OF OBSTETRIC FISTULA**

**Time:** 30 minutes

### **TRAINING TIP**

If you already determined (during the participant introduction in Session I of this module) that the participants have never encountered a client with obstetric fistula, skip Activity 1 and go directly to Activity 2.

### **Activity 1: Story (5 minutes)**

1. Ask the participants if they have ever had a client who presented with obstetric fistula.
2. If any of the participants have encountered clients with obstetric fistula, ask them to briefly describe:
  - The primary clinical manifestation of obstetric fistula
  - Any other medical conditions the client had that were related to or the consequence of the obstetric fistula

### **Activity 2: Lecture/Discussion (10 minutes)**

1. Explain that leaking urine and/or faeces is the primary clinical manifestation of obstetric fistula.
2. Display the computer slide, overhead transparency, or diagram drawn on a prepared flipchart that you used in Part A of this session; point out the location of the four most common types of obstetric fistula.
3. Explain that the type of fistula determines the kind of leaking that a woman experiences, as follows:
  - *Vesicovaginal fistula (VVF)*: Urine from the bladder flows into the vagina, leading to total or continuous leaking of urine.
  - *Rectovaginal fistula (RVF)*: Stool flows into the vagina, leading to total or continuous leaking of faeces.
  - *Both VVF and RVF*: Urine from the bladder flows into the vagina and stool flows into the vagina, leading to leaking of urine and faeces.

- *Urethrovaginal fistula*: Urine from the bladder flows into the urethra and then into the vagina, leading to total or continuous leaking of urine.
  - *Ureterovaginal fistula*: Urine from the ureter bypasses the bladder and flows into the vagina, leading to total or continuous leaking of urine.
  - *Vesicouterine fistula*: Urine from the bladder flows into the uterus and then into the vagina, leading to total or continuous leaking of urine.
4. Indicate that the leaking urine and/or faeces often lead to an unpleasant odour and/or a foul-smelling vaginal discharge.
  5. Distribute Participant Handout 1-H.
  6. Ask the participants what questions they have about the clinical manifestations of obstetric fistula.

### **Activity 3: Lecture/Discussion (15 minutes)**

1. Describe the medical consequences of obstetric fistula (based on the information in Participant Handout 1-H), including:
  - Gynecologic sequelae
  - Nerve damage
  - Dermatologic injuries
  - Bone abnormalities
  - Anxiety and depression
  - Ancillary medical conditions (such as dehydration, bladder stones, malnutrition, anemia, urinary tract infections, and kidney disease)

#### **TRAINING TIP**

If the participants have nursing or midwifery experience, ask them to describe cases of the medical conditions listed on Participant Handout 1-H that they have seen.

2. Ask the participants what questions they have about the medical consequences of obstetric fistula.

## **PART D: SOCIAL CONSEQUENCES OF OBSTETRIC FISTULA**

**Time:** 30 minutes

### **Activity 1: Individual Exercise/Group Debrief (15 minutes)**

1. Explain that, besides clinical manifestations and medical consequences, there often are devastating social consequences for women with fistula.
2. Ask each participant to take three or four minutes to:
  - Think of ways that women with fistula might be stigmatised or discriminated against
  - Write them down on a sheet of paper
3. Ask the participants to share what they have written (without repeating examples that have already been mentioned).
4. Write their responses on a sheet of flipchart paper.
5. Review and summarise the social consequences of fistula.
6. Distribute Participant Handout 1-I and point out any examples that were not already mentioned.

**Activity 2: Story/Discussion (15 minutes)****TRAINING TIP**

As in Session 1, a story will help the participants to understand more deeply the devastating social consequences of obstetric fistula. For this activity, use one of the following:

- One of the *Obstetric Fistula Digital Stories* videos of women dealing with fistula in rural Uganda, available online at <http://www.engenderhealth.org/our-work/maternal/digital-stories-uganda-fistula.php>
- The United Nations Population Fund's fistula advocacy video, which is available online at [http://www.endfistula.com/video/unfpa\\_advocacy10.html](http://www.endfistula.com/video/unfpa_advocacy10.html)
- The story of a particularly compelling fistula client you have seen, nursed, or met
- Terefa's story (Trainer's Resource 1-2)

*Note:* Choose a different story from the one that you used in Session 1.

1. Show one of the videos or tell the story of a woman living with obstetric fistula (either a personal recollection or Terefa's story from Trainer's Resource 1-2).
2. Ask the participants to describe their reactions to the story; how did it make them feel?
3. Summarise the participants' comments, emphasising the devastating social consequences of obstetric fistula.
4. Ask the participants what questions they have about the social consequences of obstetric fistula.
5. Display the quote from Lewis Wall (from Participant Handout 1-I), using a computer slide, an overhead transparency, or a prepared flipchart.
6. Conclude the session by reading aloud the quote from Lewis Wall: "The understanding that one must treat the 'whole person' with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care."

**TRAINING TIP**

[Optional] Show (or assign viewing as homework) one of the following feature-length videos about the impact of obstetric fistula:

- *A Walk to Beautiful*  
Viewable at: <http://www.youtube.com/watch?v=3w-fOmovijc>  
DVD available at: <http://www.walktobeautiful.com/>
- *Love, Labor, Loss*  
DVD available at: <http://governessfilms.com/fistula/index2.html>

## **SESSION 4**

### **Incidence and Prevalence of Obstetric Fistula in Africa**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Describe the incidence and prevalence of obstetric fistula in Africa
- Identify the age-groups typically affected by obstetric fistula in Africa

#### **POINTS TO REMEMBER**

- The United Nations Population Fund estimates that, worldwide, fistulas occur in one or two of every 1,000 deliveries. The actual prevalence of fistula, however, is not known.
- If only 2% of prolonged or obstructed labours in the developing world result in a subsequent fistula, 130,000 new cases would be added each year.
- Based on the number of women seeking treatment, the World Health Organization has estimated that more than 2 million women have untreated obstetric fistula. However, this figure is thought to be an underestimate, because many women with fistula do not seek treatment.
- The overall rate of obstetric fistula in Africa is three to five cases per 1,000 deliveries; in rural Africa, however, the rate is five to 10 cases per 1,000 deliveries.
- One study estimated that at least 33,450 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa.
- Fistula from prolonged or obstructed labour can strike any pregnant woman, regardless of her age or gravidity.
- However, adolescents who marry early have unique characteristics that put them at increased risk for obstetric fistula. Most of these adolescents become pregnant before the pelvis is fully developed for childbearing.
- In East Africa, the average age of fistula clients ranges from 20 to 24 years.
- Obstetric fistula clients are most frequently in their first pregnancy (primigravid).

#### **Training Methods**

- Lecture/discussion posttest
- Review/debrief

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 1-J: Magnitude of the Problem of Obstetric Fistula
- Trainer's Resource 1-1: Module 1 Evaluation and Answer Key

#### **Advance Preparation**

1. Review the Training Steps.
2. Review Participant Handouts 1-J.
3. Research the rates of obstetric fistula in your country.

**TRAINING TIP**

In general, data on fistula incidence and prevalence are very limited. Several countries have started to include questions about fistula in the Demographic and Health Surveys. Trainers in those countries should look for that information. As an alternative, you can contact a surgeon or other expert at the facility and collect anecdotal data about the number of fistula clients.

4. Complete the last section of Participant Handout 1-J, if possible, based on your research (see previous item).
5. Review Trainer's Resource 1-1.

**TRAINING TIP**

Based on the sessions and content covered, select approximately 20 relevant questions from Trainer's Resource 1-1 for the Module 1 Posttest. The correct answers are shown in **boldface** and the source of the correct answer is shown in [brackets].

6. Prepare a flipchart, a computer slide, or an overhead transparency of the objectives for this session.
7. Duplicate the Module 1 Posttest for the participants.

**TRAINING TIP**

Keep the session interactive, asking questions and soliciting input from the participants, as much as feasible—depending upon the level of the participants' experience with fistula.

**Session Time (total):** 1 hour, 10 minutes

## SESSION 4

### Training Steps

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#### **PART A: MAGNITUDE OF THE PROBLEM OF OBSTETRIC FISTULA IN AFRICA**

**Time:** 30 minutes

##### **Activity 1: Lecture/Discussion (30 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Explain the following information about the global rates of obstetric fistula:
  - The United Nations Population Fund estimates that, worldwide, fistulas occur in one or two of every 1,000 deliveries (UNFPA, 2003). The actual prevalence of fistula, however, is not known.
  - An estimate from the World Health Organization Global Burden of Disease Study suggested that prolonged or obstructed labour affects at least 7 million women every year, 6.5 million of whom live in the least-developed regions of the world, where access to competent obstetric care is poorest and the likelihood of serious complications is greatest (AbouZahr, 1998).
  - If only 2% of prolonged or obstructed labours in the developing world result in a subsequent fistula, 130,000 new cases would be added each year.
  - Based on the number of women seeking treatment, the World Health Organization has estimated that more than 2 million women have untreated obstetric fistula (UNFPA, 2003). However, this figure is thought to be an underestimate, because many women with fistula do not seek treatment.
3. Ask the participants what they think the prevalence of obstetric fistula is in Africa.
4. Write their responses on a piece of flipchart paper.
5. Distribute Participant Handout 1-J to the participants
6. Point out the rates of obstetric fistula in Africa, as shown in the second section of the handout:
  - The overall rate in Africa is three to five cases per 1,000 deliveries.
  - In rural Africa, however, the rate is five to 10 cases per 1,000 deliveries. The rate is higher in mountainous regions and on islands.
  - One study estimated that at least 33,450 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa (Vangeenderhuysen, 2001). This estimate is much higher than estimates based on hospital reports.
7. Ask the participants why rates of obstetric fistula are higher in rural Africa.
8. Write their responses on a piece of flipchart paper. If they are not mentioned, add:
  - Lack of emergency obstetric facilities
  - Lack of transportation/remote location
  - Poverty
  - Cultural beliefs
9. Ask the participants if obstetric fistula only affects adolescents.
10. Facilitate a brief discussion. If not mentioned, add:
  - Fistula from prolonged or obstructed labour can strike any pregnant woman, regardless of her age or pregnancy history, including those who previously have had deliveries without complications.

- Adolescents who marry when young have unique characteristics that put them at increased risk for prolonged or obstructed labour and thus fistula.
  - Most of these adolescents become pregnant before the pelvis is fully developed for childbearing; as a result, they are likely to present with prolonged or obstructed labour.
11. Describe the age-groups typically affected by obstetric fistula in Africa, as shown in the third section of Participant Handout 1-J:
    - The age range of the women affected varies by country and by region within the country.
    - In Nigeria, about 30% of fistula cases occur among girls younger than 16 years of age.
    - In East Africa, the average age of fistula clients ranges from 20 to 24 years.
    - A study in Uganda found that the median age of women at the time they sustained fistula was 19 years; the youngest was 13 and the oldest was 41 (Women’s Dignity Project/EngenderHealth, 2007).
  12. [Optional] Discuss the rates of obstetric fistula in your country (if data are available).
  13. Ask the participants what they think is the most important step that could be taken to reduce the prevalence of obstetric fistula in Africa.
  14. Facilitate a brief discussion and write the participants’ responses on a piece of flipchart paper. Potential responses include:
    - Provide education programs on nutrition and family planning
    - Improve access to skilled care during pregnancy and childbirth
    - Increase the number of facilities offering comprehensive emergency obstetric services
    - Improve the skills and motivation of providers in giving antenatal care, offering feedback and advice to clients, and using partographs to monitor women delivering in health facilities
    - Increase the number of facilities providing fistula repair and postoperative rehabilitation
  15. Ask the participants what questions they have regarding the incidence and prevalence of obstetric fistula in Africa.

## **PART B: MODULE I EVALUATION**

**Time:** 40 minutes

### **Activity 1: Posttest (20 minutes)**

1. Distribute the Module 1 Evaluation (based on the questions provided in Trainer’s Resource 1-1) to the participants and tell them they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

### **Activity 2: Review/Debrief (20 minutes)**

1. Review the answers to the Module 1 Evaluation (using the Answer Key in Trainer’s Resource 1-1).
2. Ask the participants whether they have any questions.

#### **TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.



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# **MODULE I RESOURCES**



# PARTICIPANT HANDOUT I-A

## Curriculum Overview

### Purpose

Nurses and midwives play an important role in the prevention of obstetric fistula and the management and rehabilitation of clients living with obstetric fistula. This training will provide nurses and midwives with the knowledge and skills they need to fulfill that role.

### Contents

*The Prevention and Management of Obstetric Fistula: A Curriculum for Nurses and Midwives* is organised into six modules, as follows:

1. Overview of Obstetric Fistula
  - Introduction to the Obstetric Fistula Curriculum
  - Anatomy and Physiology of Obstetric Fistula
  - Types and Manifestations of Obstetric Fistula
  - Incidence and Prevalence of Obstetric Fistula in Africa
2. Preventing Obstetric Fistula during Pregnancy, Labour, and Delivery
  - Monitoring and Managing Pregnancy to Prevent Obstetric Fistula
  - Using the Partograph
  - Referral of Clients with Prolonged or Obstructed Labour
  - Preventive Management of Clients Who Have Experienced Prolonged or Obstructed Labour
3. Management of Obstetric Fistula
  - Infection Prevention
  - Assessing Clients Living with Obstetric Fistula
  - Managing Clients Who Present with Fistula Immediately after Delivery
  - Preoperative Care of Clients Undergoing Fistula Repair
  - Management of Clients with Obstetric Fistula during Repair Surgery
  - Postoperative Management of Clients after Surgical Repair of Obstetric Fistula
4. Clients' Rights, Information, Education, and Community Involvement
  - Clients' Rights in Fistula Care
  - Community Factors Contributing to Fistula
  - Information, Education, and Communication for Behaviour Change
  - Community Involvement and Mobilisation
  - Advocacy
  - Male Involvement
  - Networking with Partners and Stakeholders
5. Counselling Clients with Obstetric Fistula
  - Introduction to Counselling
  - Introduction to the REDI Counselling Framework
  - Overview of Fistula-Related Counselling

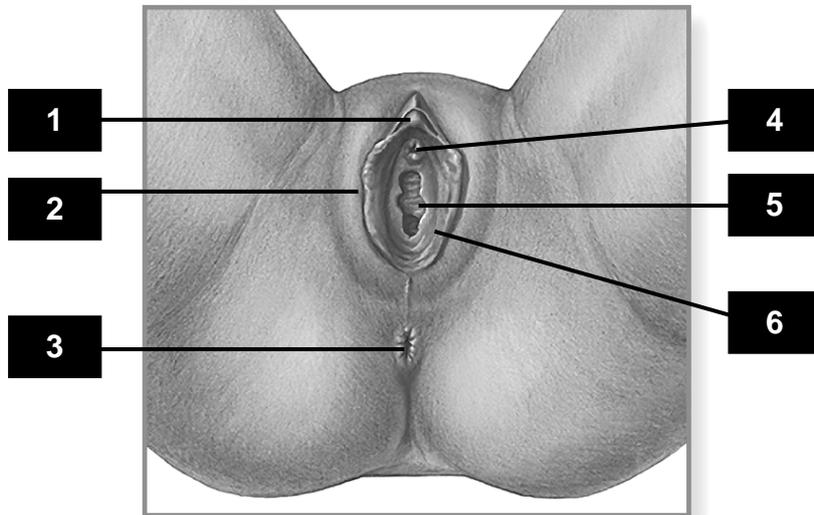
6. Using Data to Inform Decision Making within Fistula Care Services
  - Introduction to Data for Decision Making
  - Collection and Management of Routine Fistula Care Data
  - Assuring the Quality of Routinely Collected Fistula Care Data
  - Using Research to Improve Fistula Care Services
  - Displaying, Presenting, and Disseminating Data to Maximise Their Use to Inform Decision Making

**PARTICIPANT HANDOUT I-B**  
**Anatomy of Obstetric Fistula**

**Definition of Obstetric Fistula**

Obstetric fistula is an abnormal opening between the reproductive tract (usually the vagina) and the urinary tract (frequently the bladder) or alimentary tract (usually the rectum) or both. Obstetric fistula typically develops after several days of prolonged or obstructed labour.

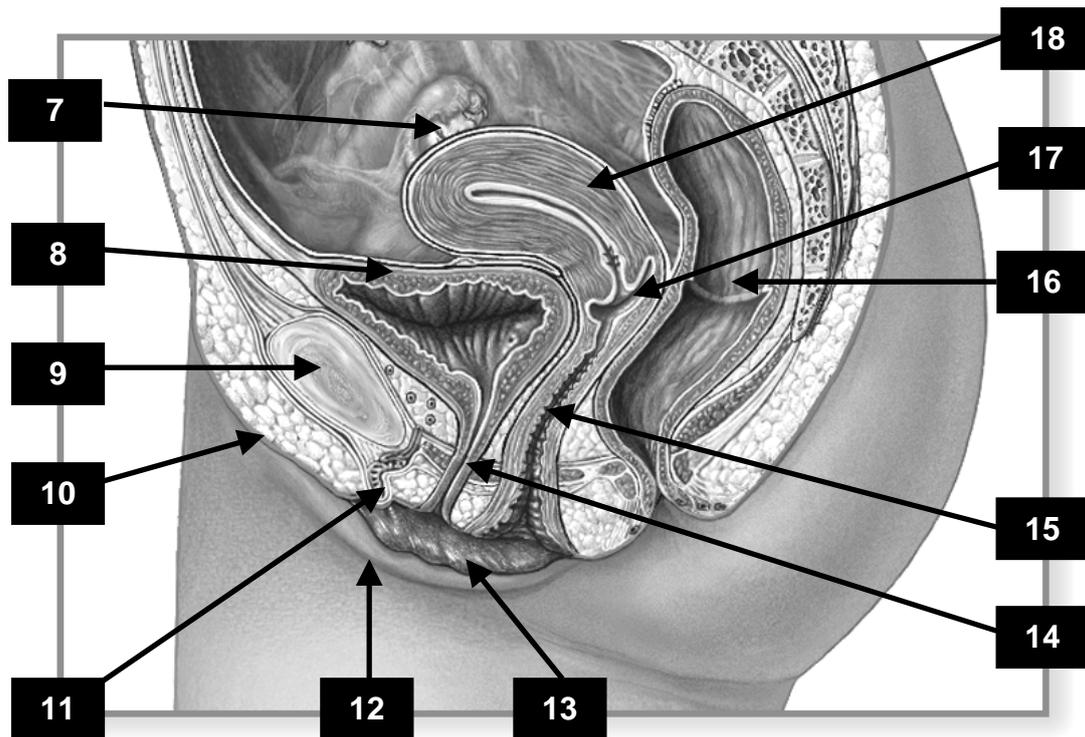
**Female Pelvic Anatomy—External Structures**



*Source:* A.D.A.M. Images. Adamimages.com. Imageld 107\_72EWJ. Retrieved from <http://www.adamimages.com/Female-reproductive-anatomy-Illustration/PI366/F4>, June 29, 2011.

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### Female Pelvic Anatomy—Internal Structures

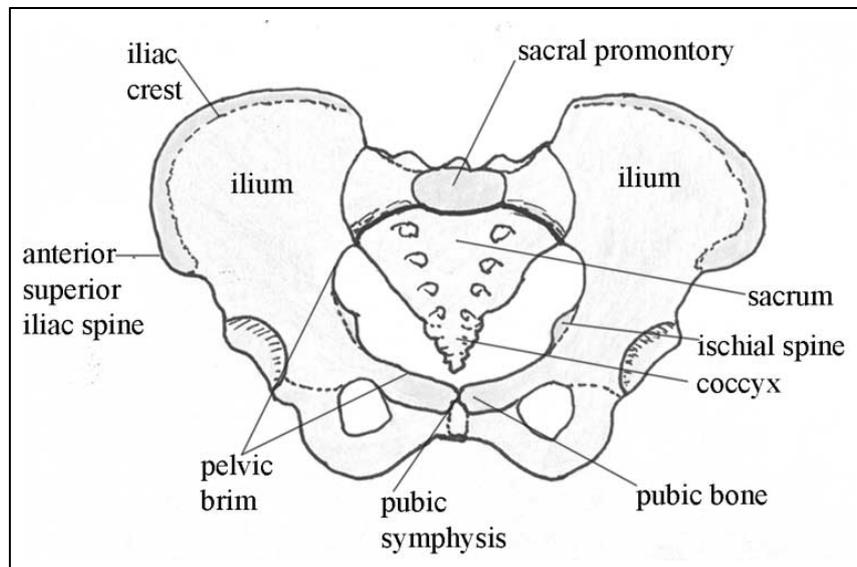


**Source:** U.S. National Cancer Institute (NCI) Surveillance, Epidemiology, and End Results (SEER) Program. [no date given] Female reproductive system. Atlanta: NCI SEER Cancer Registry. Accessed at [www.training.seer.cancer.gov/module\\_anatomy/unit12\\_3\\_repd\\_t\\_female.html/](http://www.training.seer.cancer.gov/module_anatomy/unit12_3_repd_t_female.html/), March 12, 2008.

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## Anatomy of the Female Bony Pelvis

The female pelvis, with a wider and flatter shape than the male pelvis, is adapted for childbearing. Knowledge of the shape and dimensions of the normal female pelvis is essential for a proper understanding of labour and its abnormalities.



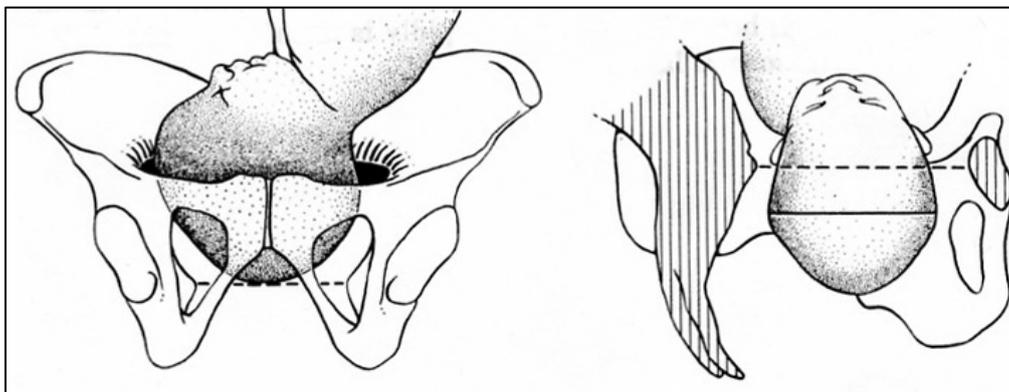
**Source:** Ethiopian Federal Ministry of Health (FMOH) Health Education and Training (HEAT) Programme, Antenatal Care Module. Accessed at [http://labspace.open.ac.uk/mod/oucontent/view.php?id=452208&extra=thumbnail\\_id392363172318](http://labspace.open.ac.uk/mod/oucontent/view.php?id=452208&extra=thumbnail_id392363172318). December 9, 2011.

The pelvis is a hard ring of bone that supports and protects the pelvic organs and the contents of the abdominal cavity. It consists of three pairs of hip bones: the *ilium*, *ischium*, and *pubis*, as well as the *sacrum* and the *coccyx*.

- The major portion of the pelvis is composed of two bones, each called the ilium—one on either side of the backbone (or spinal column) and curving towards the front of the body.
- The ischium is the thick lower part of the pelvis, formed from two fused bones—one on either side. When a woman is in labour, the descent of the foetal head as it moves down the birth canal is estimated in relation to the *ischial spines*, which are inward projections of the ischium on each side.
- The pubic bones on either side form the front part of the pelvis. The two pubic bones meet in the middle at the *pubic symphysis*.
- The sacrum is a tapered, wedge-shaped bone at the back of the pelvis, consisting of five fused vertebrae. The upper border of the first vertebra in the sacrum sticks out and points towards the front of the body; this protuberance is the *sacral promontory*.
- The coccyx is a tail-like bony projection at the bottom of the sacrum.

The *pelvic inlet* is formed by the pelvic brim. The pelvic brim is rounded, except where the sacral promontory and the ischial spines project into it.

The *pelvic outlet* is formed by the lower border of the pubic bones at the front and the lower border of the sacrum at the back. The ischial spines point into this space on both sides.



**Source:** *Oxorn-Foote Human Labor & Birth*, 5<sup>th</sup> edition by Harry Oxorn, McGraw Hill, 1986. Page 67. This illustration is copyright by The McGraw-Hill Companies, Inc., and is used by permission. McGraw-Hill makes no representations or warranties as to the accuracy of the information included here, and in no event shall McGraw-Hill be held liable to any party for any damages arising from use of this illustration.

The pelvic inlet is the space where the foetal head enters the pelvis; it is larger than the pelvic outlet, where the foetal head emerges from the pelvis. In order to get through the widest diameter of the inlet and the outlet, the foetus has to rotate as it passes through the pelvic canal.

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## PARTICIPANT HANDOUT I-C

### Physiology of Structures Affected by Obstetric Fistula

#### Female Pelvic Anatomy—External Structures

The external female genitals are the mons pubis, clitoris, labia majora, and labia minora. Together, along with the opening of the vagina, they are known as the vulva.

- **Clitoris**—This is an erectile, hooded organ at the upper joining of the labia that contains a high concentration of nerve endings and is very sensitive to stimulation. When female genital cutting (FGC) is performed, the clitoris is the organ that may be partially or totally removed.
- **Labia majora**—These are two spongy folds of skin (one on either side of the vaginal opening) that cover and protect the genital structures.
- **Labia minora**—These are two erectile folds of skin between the labia majora that extend from the clitoris on both sides of the urethral and vaginal openings. The area covered by the labia minora (including the vaginal and urethral openings) is called the vestibule.

#### Female Pelvic Anatomy—Internal Structures

The internal structures that are affected by obstetric fistula include the vagina, uterus, bladder, urethra, ureters, and rectum.

- **Vagina**—This is a muscular, highly expandable tubular cavity leading up from the vestibule to the cervix. It is penetrated by the penis during vaginal intercourse and serves as the exit channel for menstrual flow and for the foetus during normal spontaneous vertex delivery (SVD).
- **Uterus**—This is a hollow, thick-walled, pear-shaped, muscular organ located between the bladder and rectum; the lower part (the cervix) protrudes into the vagina. It sheds its lining monthly during menstruation and is the site of implantation of the fertilised ovum (egg) where the foetus develops during pregnancy.
- **Bladder**—This is a membranous sac that serves as a reservoir for urine until it is ready to be voided. Contraction of the bladder results in urination. It is a pelvic organ, but may rise to the abdomen when full; it also becomes an abdominal organ during labour.
- **Urethra**—This is a narrow tube that conveys urine from the bladder. In the female, it runs from the neck of the bladder and opens into the vestibule of the vulva at the urethral opening.
- **Ureters**—These are tubes that carry urine down from the kidneys to the bladder. People typically have two kidneys (a left one and a right one), so there usually are two corresponding ureters.
- **Rectum**—This is the last portion of the large intestine (colon); it links the sigmoid colon (above) and the anus (below). It acts as a temporary storage for stool prior to defecation; muscles in the rectum move the stool out of the body through the anus.
- **Perineum**—This is a network of muscles, located between and surrounding the vagina and anus, that supports the pelvic cavity and helps keep pelvic organs in place. Tearing of the perineum can occur during childbirth, particularly during first-time deliveries.

*Note:* When obstetric fistula occurs, it alters the normal functioning of the affected organs.

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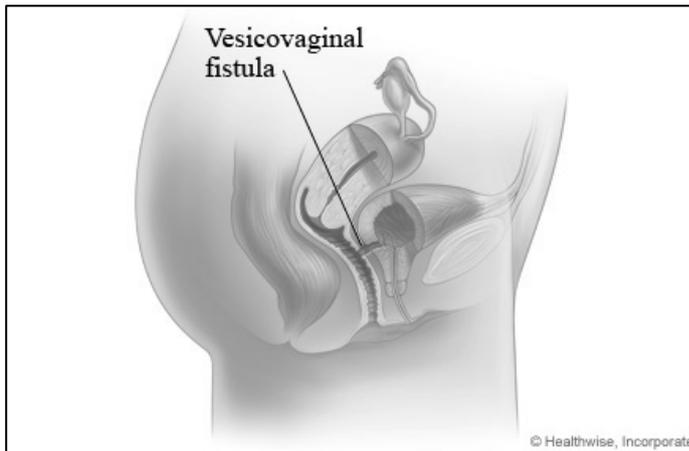
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## PARTICIPANT HANDOUT I-D

### Types of Obstetric Fistula

The names of the types of obstetric fistula reflect the anatomical structures affected.

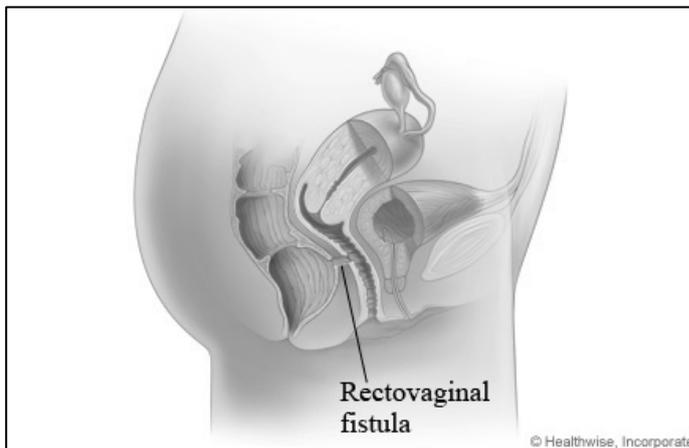
#### Vesicovaginal Fistula (VVF)



*Source:* © Healthwise Incorporated. Used with permission.

Vesicovaginal fistula is an opening between the bladder and the vagina. This is the most common type of obstetric fistula.

#### Rectovaginal Fistula (RVF)



*Source:* © Healthwise Incorporated. Used with permission.

Rectovaginal fistula (RVF) is an opening between the rectum and the vagina. A client may have both vesicovaginal and rectovaginal fistula at the same time—the combination of VVF and RVF is the second most commonly encountered type of obstetric fistula.

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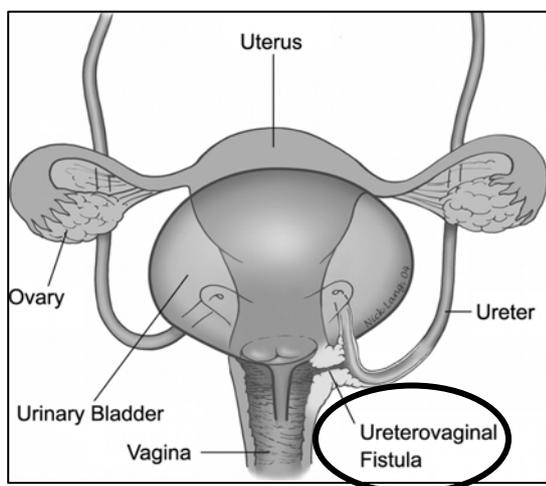
### Urethrovaginal Fistula



**Source:** Copyright © 2001–2011 Mayo Foundation for Medical Education and Research. Retrieved from <http://www.mayoclinic.org/images/vaginal-fistulas-275-bdy.jpg>, March 6, 2011.

Urethrovaginal fistula is an opening between the urethra and the vagina. Urethrovaginal fistula is relatively uncommon compared to the VVF and RVF types.

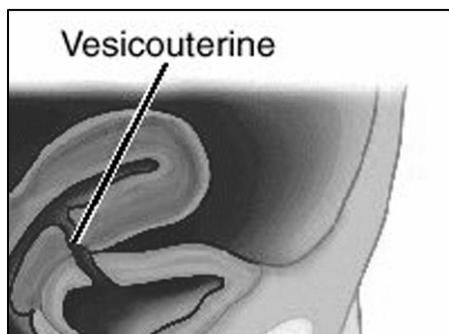
### Ureterovaginal Fistula



**Source:** Geneva Foundation for Medical Education and Research. Retrieved from [http://radiographics.rsna.org/content/vol24/suppl\\_1/images/large/g04oc14c02x.jpeg](http://radiographics.rsna.org/content/vol24/suppl_1/images/large/g04oc14c02x.jpeg), March 6, 2011.

Ureterovaginal fistula is an opening between the distal ureter and the vagina. The condition, which is also relatively uncommon, is typically the result of injuries sustained during gynaecologic procedures.

### Vesicouterine Fistula



**Source:** Merck & Co., Inc. 2006. *Dorland's illustrated medical dictionary*. Whitehouse Station, NJ.

Vesicouterine fistula is an opening between the uterus and the bladder. It is a relatively rare complication of caesarean section.

## PARTICIPANT HANDOUT I-E

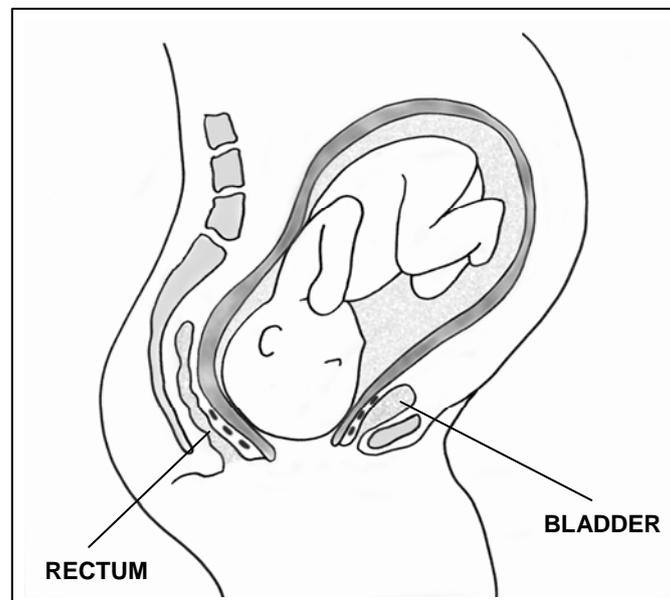
### Physical Causes of Obstetric Fistula

Obstetric fistula has both direct physical causes and indirect, underlying, or contributory social causes.

This handout describes common physical causes of obstetric fistula. Knowledge of these physical causes helps nurses and midwives to provide appropriate care, based on individual client needs. Participant Handout 1-F discusses the contributory societal factors.

#### **Prolonged or Obstructed Labour**

The most common cause of obstetric fistula in developing countries is prolonged or obstructed labour. Prolonged or obstructed labour can last for days or weeks before a woman receives obstetric care or dies.



When labour is prolonged or obstructed, the foetal head exerts continuous pressure against the mother's pelvis, greatly reducing the flow of blood to the soft tissues surrounding the vagina, bladder, urethra, and/or rectum. If the mother survives, this kind of labour often ends when the foetus dies and gradually decomposes enough to slide out of the vagina. If the mother survives, the injured tissue within her pelvis soon sloughs away as a consequence of necrosis (tissue death), causing a fistula to develop between adjacent organs.

If the client had received timely care, the baby would have been delivered by a caesarean section, and both the mother and baby would most probably have survived.

#### **Trauma Caused by Sexual Violence**

Fistula can occur as the result of sexual violence—generally from trauma or tearing caused by rape and/or forced insertion of objects into a woman's vagina—often but not always in conflict and postconflict settings (ACQUIRE Project, 2006). In wartime conditions, sexual violence is

common, often used as tactic to intimidate and control. Aid workers in war-torn areas have estimated that one woman in every three is a rape victim and that the majority of new fistula cases are caused by rape.

### **Accidental Surgical Injury**

During obstetric operations, accidents occasionally occur that may injure the bladder or other soft pelvic tissue. Surgical trauma can occur during caesarean births, difficult forceps deliveries, and destructive vaginal deliveries (e.g., surgical division of the collar bones in cases of shoulder dystocia or cranial perforation for hydrocephalus).

### **Unsafe Abortions**

Abortions induced by poorly trained individuals or performed under unsanitary conditions can lead to dangerous complications, including visceral trauma—most commonly to the uterine wall, but also to the genitalia, rectum, and bladder—that can result in fistula.

### **Harmful Traditional Practises**

Female genital cutting or mutilation (FGC or FGM) also contribute to the risk for fistula. Such cutting is usually carried out under unsanitary conditions, often by removing large amounts of vaginal or vulval tissue, thus causing the vaginal outlet and birth canal to become constricted by thick scar tissue. These practises increase the likelihood of gynaecologic and obstetric complications, including prolonged or obstructed labour (WHO, 2006).

Harmful cutting before or during labour by unskilled birth attendants (“gishiri cutting”) also contributes to fistula formation. In some countries, a traditional midwife or barber uses a sharp instrument, such as a knife, a razor blade, or a piece of broken glass, to make a series of random cuts in the vagina in an attempt to either prepare the vagina for delivery or, during labour, to remove a perceived obstruction and make way for the baby. These practises may explain as many as 15% of fistula cases in some parts of Africa (Wall, 2004).

### **Diseases or Radiotherapy Treatments**

Some diseases can cause fistula, including lymphogranuloma venereum and rectal carcinoma. Radiotherapy treatments for some gynaecologic cancers can also cause fistula. These are rarely the cause in developing countries.

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## PARTICIPANT HANDOUT I-F

### Contributory Factors Affecting Obstetric Fistula

Obstetric fistula has both direct physical causes and indirect, underlying or contributory social causes.

Knowledge of contributory societal factors can help nurses and midwives to design and implement strategies to reduce the incidence of fistula.

#### **Lack of Access to Health Care Services**

Most women who develop obstetric fistula during childbirth do so because they did not receive the health care they needed (WHO, 2006).

Obstetric fistula is rare in the developed world because health care services are widely available: Problems with labour can be anticipated during antenatal care, potentially difficult labour that may become prolonged or obstructed can be identified, and emergency obstetric care (such as a caesarean section) can be provided.

In the developing world, however, these services may be lacking, or women may be unable, for various reasons, to access the health care that is available. Several factors can account for inaccessible health care services, including:

- *Lack of skilled birth attendants:* Only half of the women in developing countries receive assistance from a skilled attendant during delivery (AbouZahr, 2003).
- *Lack of suitably equipped facilities:* Assessments of emergency obstetric care (EmOC) carried out in Uganda, Kenya, Southern Sudan, and Rwanda in 2003 and 2004 found that coverage of comprehensive EmOC services ranged from 0.5 to 4.3 per 500,000, compared with the recommended level of 1 per 500,000. However, there was a huge gap in the coverage of *basic* EmOC services per 500,000 population, ranging between zero and one (Pearson & Shoo, 2005).
- *Inadequate/incomplete antenatal care:* Despite high attendance in most countries, clients frequently are not informed of what to expect, where to deliver, and the risks of possible complications if delivery is not done by a skilled attendant (Women's Dignity Project, 2003).
- *High costs for clients:* Pregnant women are often required to provide their own surgical gloves, dressings, and sanitary pads for a clean delivery and may be required to pay official and, often, unofficial costs. For a poor family living in extreme poverty, the costs of an emergency caesarean section can be crippling; some families cannot afford them, or are left in debt for many years after paying for one (Women's Dignity Project, 2003).
- *Inadequate monitoring during labour:* Providers often fail to use the partograph to monitor labour at their health facility and make timely referral decisions.
- *Lack of prompt access to emergency obstetrical care:* Fistula is more likely to occur in rural, rather than urban, settings. For rural women, health centres offering basic emergency obstetric care may be far away and transportation can be hard to access or unaffordable. Even if health facilities are available, referral services for emergency obstetric care may be limited.

Improving access to timely obstetric care is the most important first step that can be taken to prevent fistula from occurring in the first place. The problems in accessing maternity care that can lead to maternal death or complications are commonly referred to as the “Three Delays” (Thaddeus & Maine, 1994). Fistula can develop because of any one of these:

1. **Delay in deciding to seek care:** Delays in deciding to seek care include either a woman’s or her family’s delay in seeking care from a skilled birth attendant and the attendant’s delay in making the appropriate, timely referral to an emergency obstetric care facility. Common contributors to such delay include cultural taboos, a lack of knowledge and skills (including lack of understanding of the parameters for normal and complicated pregnancy and labour and delivery), little or no preparation for birth or for possible complications, inadequate/incomplete antenatal care, inadequate limited options for transportation, and lack of resources.
2. **Delay in reaching a health care facility:** It has been said that obstetric fistula results from a combination of obstructed labour and obstructed transportation. Even after a decision has been made to seek care, a woman might not reach a facility in time to receive emergency care. Transportation-related issues can include:
  - Lack of a vehicle (leaving only the option of transporting the client on someone’s shoulders, in a wheelbarrow, or by donkey or other pack animal)
  - Lack of funds to hire transport
  - Lack of transport to hire
  - Poor or nonexistent roads
  - Infrequent boat or ferry service to islands
  - Remote location
  - Rugged or steep terrain
3. **Delay in receiving adequate care/attention at the facility:** Many hospitals and clinics do not have enough skilled personnel to offer prompt surgical treatment for emergency obstetric cases. Emergency care might be delayed because equipment is already in use or supplies are lacking, diagnoses are late or wrong, actions are incorrect, or women cannot afford to pay for services or there is no subsidy policy for emergency treatment (Hinrichsen, 2004). Failure to adequately use partographs to monitor labour and make timely referral decisions may result in fistula.

### **Poverty**

Women of low socioeconomic status are at increased risk for fistula and other obstetric complications. This makes it very difficult to save enough funds for transportation and hospitalisation costs. They often live in remote areas, are poorly nourished and underweight, and usually have little schooling. Two epidemiologic studies of fistula have found that over 99% of women undergoing repair were illiterate (Tahzib, 1983; and Emembolu, 1992).

### **Early Marriage and Childbirth**

In some Sub-Saharan African countries, women often marry as adolescents. Sometimes poor parents give away their daughters—as young as 10 years of age—to raise funds. In other cases, parents give young daughters to be raised by their husbands so that the girl’s family can uphold community or religious honor (and possibly to conceal an illegitimate pregnancy). Many become pregnant immediately thereafter, before their pelvises are fully developed for childbearing; thus, they are at increased risk for prolonged or obstructed labour. Fistula formation is also more likely to follow a first labour (Kelly & Kwast, 1993).

## Gender Discrimination

In much of Africa, the socioeconomic status of women is low (e.g., educational opportunities for women are limited). Cultural and social values and belief systems can make it difficult for women to manage their own lives and bodies without fear and interference. Women often lack the power to make decisions about their own health; the responsibility to decide to seek health care during pregnancy, or even after prolonged or obstructed labour, falls to the husband or other family members, including the mother-in-law. Additionally, the women may have been the victims of forced marriages and may not be able to choose when to start having children or where to give birth.

## Poor Nutrition and Compromised Development

The growth and development of many young women in the developing world are compromised due to cultural food selection norms (women and girl-child feeding). Some have a contracted pelvis because of malnutrition during childhood, infection during adolescence, or diseases such as rickets, polio (due to lack of immunisation), and other gait-affecting conditions.

## Inadequate Family Planning Information

In many traditional communities, large families are the norm. Having many children is a source of respect and standing within the community; they are seen as “insurance” for the parents’ old-age security. Few people are aware of the risks of early pregnancy; women (and their husbands) may not know that spacing pregnancies and allowing time for the mother to recuperate after delivery are important (WHO, 2006).

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## **PARTICIPANT HANDOUT I-G**

### **Myths and Misconceptions about Fistula**

In many countries where fistula is prevalent, cultural beliefs shape a woman's ability and desire to seek medical services. Although some community members might correctly recognise prolonged or obstructed labour as the cause of obstetric fistula, they might attribute the length of labour, the fact of its not progressing, and/or ultimately the development of fistula to a variety of other causes, many of which are believed to be linked to a woman's personal and/or social characteristics or behaviours. Myths and misperceptions can play a role in lack of fistula prevention, unwarranted stigma and discrimination, and poor access to treatment.

Myths and misperceptions about the origin of fistula vary depending on cultural context. Below are some examples of beliefs that a woman (or others in her community) might have about why she has developed a fistula:

- She had an affair with a man who is not her husband.
- She came under a “spiritual attack” because she did not give birth under the care of a person who had the ability to protect her spiritually.
- Someone who was jealous of her performed witchcraft against her (perhaps because of her marriage or socioeconomic status, or because she had many children).
- The fingernails of a traditional birth attendant or provider at a health facility pinched her bladder during labour or delivery.
- She had a sexually transmitted infection.
- She or her mother offended the spirits during pregnancy.
- She is a young girl married to an older man.
- She had an illegitimate baby (and perhaps also that her parents put a curse on her for becoming pregnant before marriage).
- She failed to pay her dowry and was punished as a result.
- She tried to abort her baby while she was pregnant.
- She was bewitched by a co-wife.

Other cultural beliefs and practises that might contribute to the incidence and prevalence of fistula include the following:

- Some societies expect a woman to have a natural birth; if she cannot, she is considered a coward or “not woman enough.”
- In some societies, a woman is expected to deliver her firstborn child at home (on the grounds, for example, that “a real woman is able to have first delivery at home”). Such practises might prevent a woman from going to a health care facility, even when labour complications arise.
- In some cultures, a woman is expected to deliver at home so that the placenta can be buried in the homestead.
- Because of her religion, a woman might feel that she must accept the fistula as her destiny and live with it for the rest of her life. She might believe that her suffering will be rewarded in heaven and therefore she should not seek treatment.

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## PARTICIPANT HANDOUT I-H

### Clinical Manifestations and Medical Consequences of Obstetric Fistula

#### Clinical Manifestations of Obstetric Fistula

Leaking urine and/or faeces is the primary clinical manifestation of obstetric fistula. The type of fistula determines the kind of leaking that a woman experiences, as follows:

- *Vesicovaginal fistula (VVF)*: Urine from the bladder flows into the vagina, leading to total or continuous leaking of urine.
- *Rectovaginal fistula (RVF)*: Stool flows into the vagina, leading to total or continuous leaking of faeces.
- *Both VVF and RVF*: Urine from the bladder flows into the vagina and stool flows into the vagina, leading to leaking of urine and faeces
- *Urethrovaginal fistula*: Urine from the bladder flows into the urethra and then into the vagina, leading to total or continuous leaking of urine.
- *Ureterovaginal fistula*: Urine from the ureter bypasses the bladder and flows into the vagina, leading to total or continuous leaking of urine.
- *Vesicouterine fistula*: Urine from the bladder flows into the uterus and then into the vagina, leading to total or continuous leaking of urine.

The leaking urine and/or faeces typically cause an unpleasant odour and/or a foul-smelling vaginal discharge.

#### Medical Consequences of Obstetric Fistula

Obstetric fistula, in conjunction with prolonged or obstructed labour, can lead to a range of physical and mental health complications, including:

- Gynecologic sequelae
  - Pituitary and hypothalamic dysfunction possibly attributable to fistula may lead to amenorrhea.
  - Women who have suffered through prolonged or obstructed labour also have a higher risk for acquiring infections, including pelvic inflammatory disease.
  - The genital tract may be scarred and lead to dyspareunia (pain during sexual intercourse) and complete vaginal atresia.
  - Ashermann's syndrome (scarring of the endometrium) can result from either repeated infections or urine in the endometrial cavity.
  - Genital tract injury can also lead to vaginal stenosis and cervical stenosis.
  - The combination of amenorrhea, pelvic inflammatory disease, and genital tract scarring results in a high rate of secondary infertility in these clients—a significant problem, considering the importance placed on childbearing in most societies in the developing world.
- Nerve damage
  - A certain percentage of women with fistula experience symptoms of perineal nerve injury, including *foot drop*.<sup>\*</sup> Foot drop results from excessive compression of the sacral

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<sup>\*</sup> Foot drop is an extended position of the foot caused by paralysis of the flexor muscles of the leg; in women, it can be caused by prolonged or obstructed labour.

- nerve plexus by the foetal head. Damage to the perineal nerve can also result from labouring for days in a squatting position. The damage may be exacerbated by the application of pressure on the gravid abdomen by traditional labour assistants.
- Damage to the pelvic sacral nerves to the legs leaves some women unable to walk, and they may need extensive physical rehabilitation that begins before surgery and is completed after treatment.
  - Many women suffer nerve damage to the bladder, which results in complex bladder/urinary problems.
  - Dermatologic injuries
    - Women who have vesicovaginal fistulas often experience painful vulvar excoriation.
    - Continuous urine leakage can cause ammoniacal dermatitis. When the client is incontinent, the phosphates and nitrates contained in the urine irritate the skin, causing local hyperkeratosis and secondary ulceration.
  - Bone abnormalities
    - Prolonged or obstructed labour can result in complications such as bone resorption, fractures, bone spurs, and obliteration or separation of the symphysis.
  - Anxiety and depression
  - Ancillary medical conditions
    - Some women experience dehydration because they drink as little as possible, to avoid urine leakage. This self-imposed restricted drinking can also cause bladder stones.
    - Many women with fistulas are socially isolated and may not receive adequate nutrition.
    - Some women experience infection or haemorrhage at the time of birth and may subsequently suffer from anemia.
    - Women may develop frequent ulcerations and urinary tract infections, which can lead to kidney disease.
    - Other fistula-related infections can include hydronephrosis and, in rare instances, renal failure.

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## PARTICIPANT HANDOUT I-I

### Social Consequences of Obstetric Fistula

A fistula can be devastating. Not only does the afflicted woman often lose her baby, but the lasting manifestations—including the constant leakage of urine, faeces, or both, and the resulting odour—make it difficult, if not impossible, for her to lead a normal life. These, coupled with associated social and economic problems, often contribute to a general decline in health and well-being that eventually results in early death.

The wide range of adverse medical and social consequences has crucial implications for care. “The understanding that one must treat the ‘whole person’ with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care,” writes Lewis Wall (1998).

#### **Stigma Related to Stillbirth**

The delivery of a stillborn (which occurs in up to 90% of cases of prolonged or obstructed labour) is particularly distressing in societies that place a great emphasis on childbirth. The birth of a living baby is celebrated by a woman’s family and community, whereas a woman who gives birth to a stillborn typically brings sorrow and shame to her family.

#### **Subjection to Myths and Misconceptions about Fistula**

The causes and consequences of prolonged or obstructed labour are often misunderstood, and some believe that the problem is the work of evil spirits or the result of sexually transmitted infections (see Participant Handout 1-G).

#### **Social Isolation**

- Because of the unpleasant odour, women with fistula may be perceived as unclean, and thus they are often excluded, or they exclude themselves, from participating in community activities, including religious celebrations or public observances.
- The odour, incontinence, and childlessness caused by prolonged or obstructed labour and fistula sometimes lead to marital breakdown and eventually divorce. For example, a study in Nigeria found that 71% of fistula clients were divorced or separated from their husbands (Wall, 2004).
- In some cases, women with fistula are not permitted to live in the same house as their families or husbands, nor are they allowed to handle food, cook, or pray.
- In some cases, women with fistula feel they are a disgrace to their families and deserve to be outcasts. The shame these women feel may cause them to develop low self-esteem and other psychological problems.
- Women hospitalised for fistula repair might not receive as much care and support from their husbands as women receiving treatment for other conditions or illnesses, and the amount of practical support provided by family members usually diminishes over time.
- Facing familial and social rejection and unable to make a living by themselves, many women with fistula live for years without any financial or social support. Many fall into extreme poverty. At the Addis Ababa Fistula Hospital, for example, one woman in every five reported begging for food to survive (Wall, 2001).
- Some women cannot cope with the pain and suffering and resort to suicide.

Despite the stigma and discrimination, many women with fistulas show remarkable resilience and strength. They find ways to be survivors, rather than victims; they support themselves and their children; and some manage to set money aside over many years so that they can seek fistula repair.

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## PARTICIPANT HANDOUT I-J

### Magnitude of the Problem of Obstetric Fistula

#### **Global Rates of Obstetric Fistula**

- In countries where quality obstetric care is available, obstetric fistula due to prolonged or obstructed labour was all but eradicated half a century ago.
- The United Nations Population Fund estimates that, worldwide, fistulas occur in one or two of every 1,000 deliveries (UNFPA, 2003). The actual prevalence of fistula is not known, however.
- An estimate from the World Health Organization Global Burden of Disease Study suggested that prolonged or obstructed labour affects at least 7 million women every year, 6.5 million of whom live in the least-developed regions of the world, where access to competent obstetric care is poorest and the likelihood of serious complications is greatest (AbouZahr, 1998). If only 2% of prolonged or obstructed labours in the developing world result in a subsequent fistula, 130,000 new cases would be added each year.
- Based on the number of women seeking treatment, the World Health Organization has estimated that more than 2 million women have untreated obstetric fistula (UNFPA, 2003). However, this figure is thought to be an underestimate, because many women with fistula do not seek treatment.

#### **Rates of Obstetric Fistula in Africa**

- The overall rate of obstetric fistula in Africa is three to five cases per 1,000 deliveries (Achwal, 2008).
- In rural Africa, however, the rate is five to 10 cases per 1,000 deliveries (Achwal, 2008).
- One study estimated that at least 33,450 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa (Vangeenderhuysen, 2001). This estimate is much higher than estimates based on hospital reports.

#### **Age-Groups of Women Affected By Obstetric Fistula in Africa**

Fistula from prolonged or obstructed labour can strike any pregnant woman, regardless of her age or number of pregnancies, including those who previously have had deliveries without complications. However, adolescents who become pregnant early have unique characteristics that put them at significantly increased risk for prolonged or obstructed labour and thus fistula. Most of these adolescents become pregnant before the pelvis is fully developed for childbearing; as a result, they are likely to present with prolonged or obstructed labour. Consequently, women are most frequently in their first pregnancy (primigravidae) when they sustain fistula.

The age range of the women affected varies by country and by region within the country:

1. In Nigeria, about 30% of fistula cases occur among girls younger than 16 years of age
2. In East Africa, the average age of fistula clients ranges from 20 to 24 years
3. A study in Uganda found that the median age of women at the time they sustained fistula was 19 years; the youngest was 13 and the oldest was 41 (Women's Dignity Project & EngenderHealth, 2007).

## Rates of Obstetric Fistula in [insert country name]

### TRAINING TIP

In general, fistula incidence and prevalence data are very limited. Several countries have started to include questions about fistula in the Demographic and Health Surveys. Trainers in those countries should look for that information and insert (above) the number of cases per 1,000 deliveries, percentage of women of childbearing age with obstetric fistula, and/or number of new cases per year for your country, if such data are available. For example, in Uganda:

- The national prevalence is 142,000 women.
- An estimated 2.6% of women of reproductive age have experienced obstetric fistula (UBOS & Macro International, 2007).

As an alternative, you can contact a surgeon or other expert at your facility and collect anecdotal data about the number of fistula clients.

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## TRAINER'S RESOURCE I-I

### Module I Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select approximately 20 relevant questions for the Module I Pretest and/or Posttest. The correct answers are shown below in **boldface**, and the source of the correct answer is shown in [brackets].

1. Nurses and midwives play an important role in the prevention of obstetric fistula and in the management and rehabilitation of clients living with obstetric fistula.
  - a. **True**
  - b. False

[Participant Handout 1-A]
  
2. Which of the following modules are included in the obstetric fistula curriculum for nurses and midwives?
  - a. Preventing Obstetric Fistula during Pregnancy, Labour, and Delivery
  - b. Management of Obstetric Fistula
  - c. Counselling Clients with Obstetric Fistula
  - d. **All of the above**

[Participant Handout 1-A]
  
3. Obstetric fistula typically develops after \_\_\_\_\_.
  - a. A caesarean section
  - b. **Several days of prolonged or obstructed labour**
  - c. A woman has had one or more deliveries without complications
  - d. All of the above

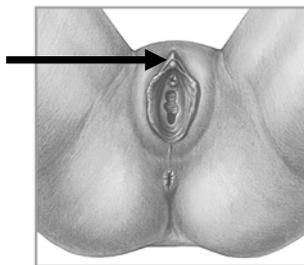
[Participant Handout 1-B]
  
4. Obstetric fistula is an abnormal opening between the reproductive tract and \_\_\_\_\_.
  - a. The urinary tract
  - b. The alimentary tract
  - c. Both the urinary tract and the alimentary tract
  - d. **All of the above**

[Participant Handout 1-B]
  
5. The circled structure is the
  - a. Urethra
  - b. Uterus
  - c. **Bladder**
  - d. None of the above

[Participant Handout 1-B]



6. The bold arrow is pointing to is the
- Anus
  - Clitoris**
  - Vagina
  - None of the above
- [Participant Handout 1-B]



7. The rectum lies directly anterior to the upper third of the vagina.
- True
  - False**
- [Session 2, Part A, Activity 3—The rectum lies directly *posterior* to the upper third of the vagina]

8. The perineum:
- Is a network of muscles located between and surrounding the vagina and anus
  - Supports the pelvic cavity
  - Helps keep pelvic organs in place
  - All of the above**
- [Participant Handout 1-C]

9. Which structure is a muscular, highly expandable, tubular cavity leading from the vestibule to the cervix?
- Vagina**
  - Urethra
  - Rectum
  - None of the above
- [Participant Handout 1-C]

10. When a woman is in labour, the descent of the foetal head as it moves down the birth canal is estimated in relation to the \_\_\_\_\_.
- Pubic symphysis
  - Sacrum
  - Ischial spines**
  - None of the above
- [Participant Handout 1-B]

11. Which type of obstetric fistula is shown in this diagram?
- Vesicovaginal fistula
  - Rectovaginal fistula**
  - Urethrovaginal fistula
  - Ureterovaginal fistula
- [Participant Handout 1-D]



12. A client cannot have both vesicovaginal and rectovaginal fistula at the same time.
- True
  - False**
- [Participant Handout 1-D—A client *can* have both vesicovaginal and rectovaginal fistula at the same time.]

13. Which is the most common type of obstetric fistula?  
**a. Vesicovaginal fistula**  
 b. Rectovaginal fistula  
 c. Urethrovaginal fistula  
 d. Ureterovaginal fistula  
 [Participant Handout 1-D]
14. When labour is prolonged or obstructed, the foetal head exerts continuous pressure against the mother's \_\_\_\_\_, greatly reducing the flow of blood to the soft tissues surrounding the vagina, bladder, urethra, and/or rectum.  
 a. Spine  
 b. Anus  
**c. Pelvis**  
 d. None of the above  
 [Participant Handout 1-E]
15. Besides prolonged or obstructed labour, fistula can be caused by which of the following?  
 a. Trauma caused by sexual violence  
 b. Accidental surgical injury  
 c. Harmful traditional practises  
**d. All of the above**  
 [Participant Handout 1-E]
16. Most women who develop obstetric fistula during childbirth do so because they did not receive the health care they needed.  
**a. True**  
 b. False  
 [Participant Handout 1-F]
17. What are the “Three Delays?”  
 Delay in deciding to seek care  
 Delay in reaching a health care facility  
 Delay in receiving adequate care/attention at the facility  
 [Participant Handout 1-F]
18. Which of the following is *not* considered a contributory societal factor affecting obstetric fistula?  
 a. Poverty  
 b. Gender discrimination  
**c. Premarital sexual relations**  
 d. Poor nutrition and compromised development  
 [Participant Handout 1-F]
19. Some myths and misperceptions about the causes of obstetric fistula include:  
 a. She had an affair with a man who is not her husband.  
 b. Someone who was jealous of her performed witchcraft against her.  
 c. She failed to pay her dowry and was punished as a result.  
**d. All of the above**  
 [Participant Handout 1-G]

20. In some societies, a woman is expected to deliver her firstborn child at home, even if labour complications arise.
- True**
  - False
- [Participant Handout 1-G]
21. The primary clinical manifestation of obstetric fistula is a foul-smelling vaginal discharge.
- True
  - False**
- [Participant Handout 1-H—Leaking urine and/or faeces is the primary clinical manifestation of obstetric fistula.]
22. Vesicovaginal fistula (VVF) leads to total or continuous leaking of \_\_\_\_\_.
- Faeces
  - Urine**
  - Faeces and urine
  - None of the above
- [Participant Handout 1-H]
23. In cases of ureterovaginal fistula, urine from the bladder flows into the vagina.
- True
  - False**
- [Participant Handout 1-H] In cases of ureterovaginal fistula, *urine from the ureter bypasses the bladder and* flows into the vagina.
24. Women with fistula may experience foot drop, which is a symptom of \_\_\_\_\_.
- Perineal nerve injury**
  - Pelvic inflammatory disease
  - Bone resorption
  - None of the above
- [Participant Handout 1-H]
25. Some women experience dehydration due to drinking as little as possible to avoid urine leakage.
- True**
  - False
- [Participant Handout 1-H]
26. The delivery of a stillborn occurs in up to \_\_\_\_\_ of cases of prolonged or obstructed labour.
- 50%
  - 75%
  - 90%**
  - None of the above
- [Participant Handout 1-I]

27. Women with fistula frequently suffer social consequences, including \_\_\_\_\_.
- a. Exclusion from participation in community activities
  - b. Separation from their husbands or divorce
  - c. Falling into extreme poverty
  - d. All of the above**
- [Participant Handout 1-I]
28. One study estimated that at least 130,000 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa.
- a. True
  - b. False**
- [Participant Handout 1-J—One study estimated that at least 33,450 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa]
29. In rural Africa, the incidence and prevalence of obstetric fistula is \_\_\_\_\_.
- a. One or two of every 1,000 deliveries
  - b. Three to five cases per 1,000 deliveries
  - c. Five to 10 cases per 1,000 deliveries**
  - d. None of the above
- [Participant Handout 1-J]
30. Women are most frequently in their first pregnancy (primigravidae) when they sustain fistula.
- a. True**
  - b. False
- [Participant Handout 1-J]
31. In East Africa, the average age of fistula clients is \_\_\_\_\_.
- a. 20 to 24**
  - b. 19
  - c. 16
  - d. None of the above
- [Participant Handout 1-J]

## TRAINER'S RESOURCE 1-2

### Terefa's Story

Terefa is 14 years old. She lives in a small village in Africa, more than 200 km from the country's capital. She is the sixth child in a family of eight children and has never been to school. Her father, a farmer, did not have enough money to send all of his children to the village school. The older children—two boys—benefitted from schooling, while Terefa stayed at home to help the family survive. Her chores were to gather firewood, draw water, and work in the fields.

When Terefa was 13 years old, her father married her to one of his friends who was a little better off than Terefa's family. Terefa had no choice but to accept the marriage; a few months later, she became pregnant. Throughout her pregnancy, she continued working as if nothing in her life had changed. The closest antenatal clinic was a few dozen km from her house; she did not go because she did not have money to pay for transport. Also, everyone in the village said that pregnancy was not an illness and that the other women had always given birth without any problems, so why shouldn't she?

Terefa's husband and mother-in-law let the traditional birth attendant know when labour started. The contractions became more and more violent, and more and more painful, but the baby did not come out. Terefa saw the sun rise and set three times. She was exhausted by the long ordeal. The village birth attendant tried to speed up events. She first gave Terefa herbal portions. Then she inserted various substances into the vagina. Finally, the attendant made incisions with a rusty knife in Terefa's vagina. But nothing worked.

The village elders then met to make a decision: Terefa had to go to the health centre. It took several hours to collect the necessary money, to transport Terefa in a cart to the road, and to find a driver to take her to town. Terefa was afraid, for she knew no one at the health centre and wondered how she, a simple peasant, would be received.

Once Terefa reached the health centre, a midwife examined her. The midwife was not happy that Terefa had come so late. She told Terefa that her baby was dead and that she needed an operation. The doctor who performed caesarean sections was away for several days for a training course, so Terefa had to go to another hospital.

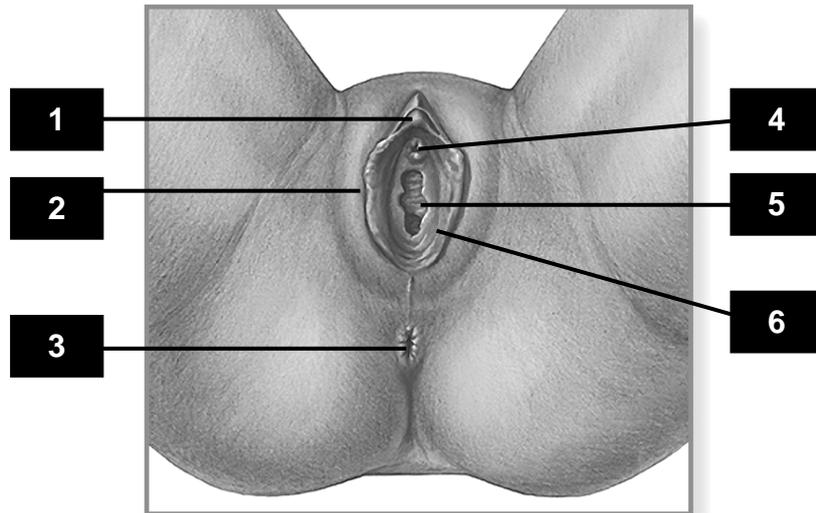
After the operation, Terefa realised that she could not retain her urine. Back at the village, she was ashamed because she had lost her child, was constantly wet, and was continually giving off the smell of urine. Seeing that the situation was not improving, her husband rejected her and chose another wife. Little by little, the entire village turned its back on Terefa. Today Terefa and her mother live in a tent at the edge of the village. The two women subsist on charity, and Terefa's health becomes a little more precarious every day. No one knows how much longer she will survive.

*Adapted from:* World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## TRAINER'S RESOURCE I-3

### Anatomy Grab Bag Game Answer Key

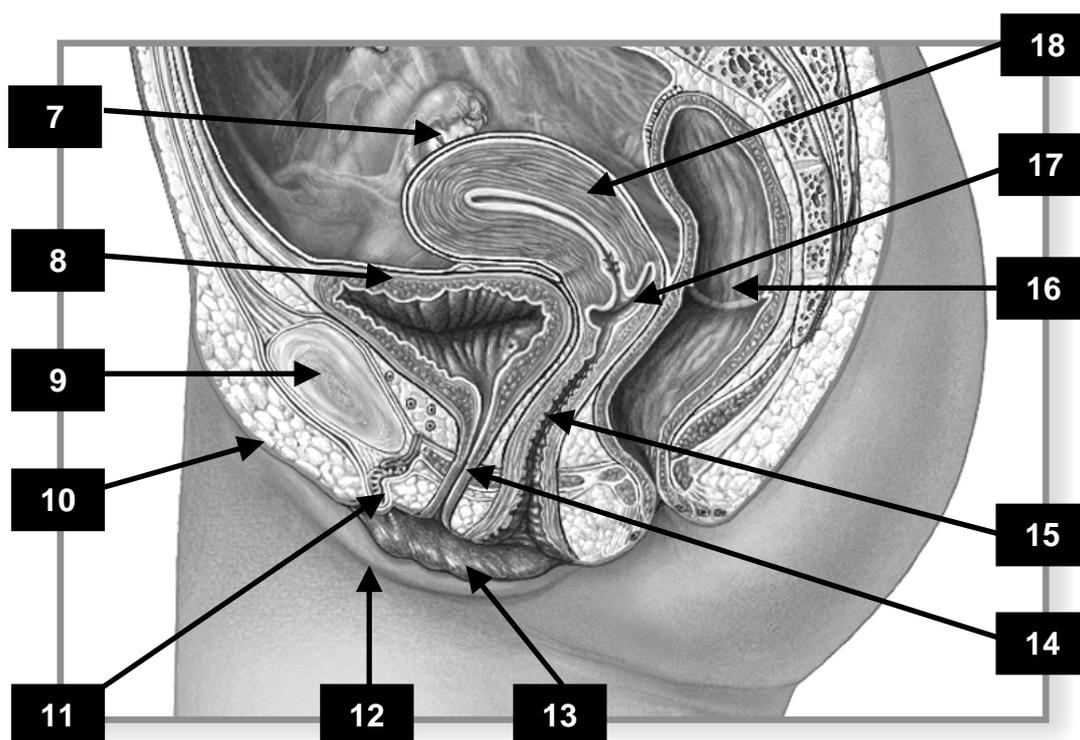
#### Female Pelvic Anatomy—External Structures



*Source:* A.D.A.M. Images. Adamimages.com. Imageld 107\_72EWJ. Retrieved from <http://www.adamimages.com/Female-reproductive-anatomy-Illustration/PI366/F4>, June 29, 2011.

<b>1</b>	Clitoris	<b>4</b>	Urethral Orifice
<b>2</b>	Labia Majora	<b>5</b>	Vagina
<b>3</b>	Anus	<b>6</b>	Labia Minora

### Female Pelvic Anatomy—Internal Structures



*Source:* U.S. National Cancer Institute (NCI) Surveillance, Epidemiology, and End Results (SEER) Program. [no date given] Female reproductive system. Atlanta: NCI SEER Cancer Registry. Accessed at; [www.training.seer.cancer.gov/module\\_anatomy/unit12\\_3\\_repd\\_t\\_female.html/](http://www.training.seer.cancer.gov/module_anatomy/unit12_3_repd_t_female.html/), March 12, 2008.

<b>7</b>	Ovary	<b>13</b>	Labia Minora
<b>8</b>	Urinary Bladder	<b>14</b>	Urethra
<b>9</b>	Symphysis Pubis	<b>15</b>	Vagina
<b>10</b>	Mons Pubis	<b>16</b>	Rectum
<b>11</b>	Clitoris	<b>17</b>	Cervix
<b>12</b>	Labia Majora	<b>18</b>	Uterus

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# MODULE 2: PREVENTING OBSTETRIC FISTULA DURING PREGNANCY, LABOUR, AND DELIVERY

## Introduction

The incidence of obstetric fistula can be reduced if pregnant women have access to skilled antenatal care, skilled care during labour and delivery, and emergency obstetric care. A woman's family and her community can play a role in helping her to obtain such care. Use of the partograph in the management of labour can improve pregnancy outcomes and reduce obstetric fistula. Prompt, professional care of women who have recently endured prolonged and obstructed labour can also prevent obstetric fistula. Finally, a functioning referral system ensures that women receive the care they need during pregnancy, delivery, and the postpartum period.

## Prerequisites

- Successful completion of Module 1 of this curriculum (or equivalent knowledge and experience)
- Basic competence in the following subjects acquired either through course work or practical experience:
  - Antenatal care
  - Monitoring and recording of vital signs
  - Physical assessment (antenatal and intrapartum assessment)
  - Management of labour, including performance of vaginal digital examinations during labour
  - Insertion and care of an indwelling catheter
  - Use of the partograph

## Module Objectives

Upon completion of this module, the participants will be able to:

- Explain the role of antenatal care in the prevention of obstetric fistula
- Identify risk factors for obstetric fistula during focused antenatal care
- Develop strategies for overcoming challenges to the delivery of antenatal care
- Demonstrate a willingness to provide focused antenatal care to standard
- Identify the true signs of labour
- Describe the stages and phases of labour
- Explain the purpose of the partograph
- Describe the components of the partograph and how the components can help prevent and manage obstetric fistula
- Describe how the normal progress of labour appears on the partograph
- Describe the responsibilities of nurses and midwives in the use of the partograph
- State the signs and symptoms of prolonged labour and obstructed labour

- Identify signs of prolonged labour and obstructed labour and accurately record them on the partograph
- Identify signs of prolonged labour and obstructed labour
- Accurately record findings about prolonged labour and obstructed labour on the partograph
- Describe when partograph findings indicate that a woman should be referred for emergency care
- Explain the importance of the timely referral of clients with prolonged or obstructed labour when caesarean section or vacuum delivery cannot be performed at the location where a woman is in labour
- Describe the characteristics of a functional referral system
- Describe the different types of referral systems
- Outline the role of the community in the referral system for obstetric fistula
- Interpret data from a referral audit.
- Outline principles for the immediate care of a recent survivor of prolonged or obstructed labour in order to prevent obstetric fistula

### Overview of Module Content

Sessions/Parts	Total time
1. Monitoring and Managing Pregnancy to Prevent Obstetric Fistula	2 hours
A. Antenatal care	2 hours
2. Using the Partograph	2 hours, 25 minutes
A. Labour	30 minutes
B. The Partograph	1 hour, 20 minutes
C. Prolonged Labour and Obstructed Labour	35 minutes (excluding practicum)
3. Referral of Clients with Prolonged or Obstructed Labour	1 hour, 50 minutes
A. Referral of Clients with Prolonged or Obstructed Labour	40 minutes
B. The Role of the Community in Referral Systems for Obstetric Fistula	30 minutes
C. The Referral Audit	40 minutes
4. Preventive Management of Clients Who Have Recently Experienced Prolonged or Obstructed Labour	1 hour, 20 minutes
A. Preventive Management of Clients Who Have Recently Experienced Prolonged or Obstructed Labour	40 minutes
B. Module 2 Evaluation	40 minutes
<b>Total time</b>	<b>7 hours, 35 minutes</b>

### Evaluation

- Trainer’s Resource 2-1: Module 2 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select 10 to 15 relevant questions from Trainer’s Resource 2-1 for the Module 2 Pretest and Posttest.

## **SESSION I**

### **Monitoring and Managing Pregnancy to Prevent Obstetric Fistula**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Explain the role of antenatal care in the prevention of obstetric fistula
- Identify risk factors for obstetric fistula during focused antenatal care
- Develop strategies for overcoming challenges to the delivery of antenatal care
- Demonstrate a willingness to provide focused antenatal care to standard

#### **POINTS TO REMEMBER**

- Antenatal care plays an important role in the prevention of obstetric fistula.
- Certain factors increase the risk for obstetric fistula and can be identified during antenatal care. While these risk factors cannot predict which women will develop obstetric fistula, they alert the provider to counsel women, their partners, and their families to plan for delivery in a health care facility, to help ensure the best possible outcome for mother and baby.

#### **Training Methods**

- Presentation
- Discussion
- Homework
- Case studies
- Pair exercise
- Guest speaker
- Large-group work

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 2-A: Antenatal Care and the Prevention of Obstetric Fistula
- Participant Handout 2-B: Identifying Women at Increased Risk for Obstetric Fistula
- Participant Handout 2-C: Identifying Risk Factors for Obstetric Fistula during Pregnancy: Case Studies
- Participant Handout 2-D: Challenges to the Delivery of Antenatal Care
- Trainer's Resource 2-1: Module 2 Evaluation and Answer Key (if conducting a pretest)
- Trainer's Resource 2-2: Identifying Risk Factors for Obstetric Fistula during Pregnancy: Case Studies: Answer Key
- Trainer's Resource 2-3: Sample Pledge: Providing Focused Antenatal Care

### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 2-A, 2-B, 2-C, and 2-D.
4. Duplicate Participant Handouts 2-A, 2-B, 2-C, and 2-D for the participants
5. Part A, Activity 2: Give the homework assignment before the training activities begin.
6. Part A, Activity 4: Arrange for a highly respected nurse, midwife, or doctor to speak to the group about how important it is to provide focused antenatal care that meets established standards.
7. Part A, Activity 4: Make whatever arrangements are needed to help the volunteer prepare copies of the pledge for the group (e.g., provide access to a computer and copying machine).

#### **TRAINING TIP**

If the participants have completed Module 1, look for ways to link the content in Module 1 to the content in this module. This will reinforce what has already been learned. For instance, link the physical causes and contributory factors from Module 1 to the discussion of risk factors in this module.

**Session Time (total):** 2 hours

## SESSION I

### Training Steps

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**Time:** 2 hours

#### **Activity 1: Presentation and Discussion (20 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explore *how antenatal care can help prevent obstetric fistula*.
3. Ask the participants what questions they have about the session objectives.
4. Ask the participants to define antenatal care.
5. Summarise, recognising the participant's contributions. Add any aspects of the definition that the group has not addressed, using Participant Handout 2-A as a reference.
6. Ask the participants how antenatal care can help prevent obstetric fistula. Note their comments on flipchart paper.
7. Summarise again, recognising the participants' contributions. Add any critical points that the group has not addressed, using Participant Handout 2-A as a reference. Ask the participants if they have any questions or comments.
8. Ask the participants to list the "Three Delays" that contribute to obstetric fistula and that were introduced in Module 1:
  - Delay in deciding to seek care for prolonged or obstructed labour
  - Delay in reaching a health care facility
  - Delay in receiving care at the facilityEmphasise that antenatal care can help prevent the first two of these delays by identifying women at risk and by educating women.
9. Emphasise that when antenatal care is lacking, nurses and midwives can work with communities to lobby their local and national governments for more quality services and for maternity homes or waiting facilities. (For more about advocacy, see Module 4.)
10. At the end of the activity, distribute copies of the handout to the group.

#### **TRAINING TIP**

In 1989, the World Health Organization produced an excellent video titled *Why Did Mrs. X Die?* in VHS and SECAM formats. The video tells the story of a woman on the road to maternal death and presents the main causes of maternal mortality. It also explains the steps that can be taken to prevent so many needless deaths. Although the video is currently out of print, copies were widely distributed. If you can obtain a copy, you may want to show it during Part A, Activity 1.

#### **Activity 2: Homework, Case Studies, and Discussion (30 minutes for case studies and discussion)**

1. As a homework assignment, ask the participants to study Participant Handout 2-B on identifying risk factors for obstetric fistula during pregnancy.
2. Emphasise that nurses and midwives can take actions during antenatal care that can help prevent obstetric fistula.
3. When the group convenes, distribute copies of Participant Handout 2-C, case studies of clients who appear at an antenatal care facility. Ask volunteers to present each case study:
  - The volunteer reads each sentence in the case and then pauses.

- Whenever the group hears a sentence that describes at least one risk factor, they raise their hands.
- The volunteer asks one of the participants who has raised a hand to name the risk factor(s) in the sentence.

Trainer's Resource 2-2 provides an answer key.

4. Ask the participants if they have any questions or comments about the cases. Respond to their comments.

### **Activity 3: Discussion, Presentation, and Pair Exercise (25 minutes)**

1. Ask the participants to list challenges to the delivery of antenatal care.
2. Summarise, recognising the participants' contributions. Add any critical points that the group has not addressed, using Participant Handout 2-D as a reference.
3. Place the participants in pairs. Ask them to identify strategies to overcome the challenges. Give each pair five minutes to work.
4. Convene the large group. Ask volunteers to call out a strategy and to avoid repeating what has already been said.
5. Summarise the activity, recognising the participants' contributions. Add any points that the group has not addressed, using Participant Handout 2-D as a reference. Ask the participants if they have any questions or comments. At the end of the activity, distribute copies of the handout to the group.

### **Activity 4: Guest Speaker, Discussion, and Large-Group Work (45 minutes)**

1. Introduce the guest speaker, who will talk for about 15 minutes to the group about how important it is to provide focused antenatal care according to standard. The speaker may want to tell a story from personal experience about how lack of antenatal care led to the death of a woman and/or her baby. Encourage the participants to ask questions of the speaker.
2. For in-service training:
  - Option 1: Ask the participants to think of instances in which they have demonstrated their commitment to providing focused antenatal care despite obstacles. Ask volunteers to share their experiences with the group.
  - Option 2: Ask the participants to identify at least one thing that they will stop doing, start doing, or continue doing when they provide antenatal care. Have volunteers share their ideas with the group.
3. Facilitate development of a brief pledge demonstrating a commitment to providing quality, focused antenatal care. Have the participants call out the wording of the pledge, which you or a volunteer can transcribe on a piece of flipchart paper. The guest speaker can also facilitate this part of the activity. Trainer's Resource 2-3 provides a sample pledge for reference.
4. Once the pledge has been written on flipchart paper, ask the participants to come to the front of the room and sign their names to the pledge.
5. Ask for a volunteer to make a word-processed version of the pledge with a list of the participants who signed it and to distribute copies to the participants.

#### **TRAINING TIP**

The World Health Organization has issued updated guidelines on antenatal care (see the references cited on Participant Handout 2-D). You or the speaker in Part A, Activity 4, may want to emphasise and review this guidance with participants during this session.

## SESSION 2

### Using the Partograph

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Identify the true signs of labour
- Describe the stages and phases of labour
- Explain the purpose of the partograph
- Describe the components of the partograph and how they can help prevent and manage obstetric fistula
- Describe how the normal progress of labour appears on the partograph
- Describe the responsibilities of nurses and midwives in the use of the partograph
- State the signs and symptoms of prolonged labour and obstructed labour
- Identify signs of prolonged labour and obstructed labour
- Accurately record findings about prolonged labour and obstructed labour on the partograph
- Describe when partograph findings indicate that a woman should be referred for emergency care

#### POINTS TO REMEMBER

- The provider listens to the foetal heart rate immediately after the strongest part of a contraction.
- During the first stage of normal labour, the provider records the foetal heart rate every half hour.
- The normal foetal heart rate is between 120 to 160 beats per minutes.
- Increased moulding with a high head is a sign of disproportion (baby is too big for the mother's pelvis).
- During the latent phase of the first stage of labour, the cervix should reach 4 cm of dilatation within eight hours; the cervix also effaces (softens and thins) during this time.
- During the active phase of the first stage of labour, the cervix dilates from 4 to 10 cm, at a rate of approximately 1 cm per hour.
- When labour progresses well, dilatation of the cervix remains on or to the left of the alert line on the partograph.
- Measuring descent of the foetal head helps the provider to follow the progress of labour. Failure to descend may indicate obstructed labour.
- An abdominal examination is always done before a vaginal examination to identify scarring, evidence of cesarean section or other surgery, and Bandl's ring.
- The provider observes contractions for frequency and duration and records them on the partograph every 30 minutes.
- The provider records the number of contractions within a 10-minute period on the partograph.
- The provider records the duration of contractions in three ways:
  - Less than 20 seconds
  - 20 to 40 seconds
  - More than 40 seconds
- The action line means that immediate intervention is needed (e.g., consultation with a doctor regarding the need for augmentation or operative delivery; referral if the facility is not able to provide the necessary care). If the woman must be transferred, the World Health Organization recommends that a provider accompany the woman during the trip.

## **Training Methods**

- Presentation
- Homework
- Large-group work
- Discussion
- Quiz
- Practicum

## **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Pencil for each participant
- Participant Handout 2-E: Signs and Stages of Labour
- Participant Handout 2-F: Using the Partograph
- Participant Handout 2-G: The Partograph
- Participant Handout 2-H Partograph Case Study 1
- Participant Handout 2-I: The Partograph: Responsibilities of Nurses and Midwives
- Participant Handout 2-J: Prolonged Labour
- Participant Handout 2-K: Obstructed Labour
- Participant Handout 2-L: Partograph Case Study 2
- Participant Handout 2-M: Partograph Case Study 3
- Trainer's Resource 2-4: Signs and Stages of Labour: Exercise
- Trainer's Resource 2-5: Partograph Case Study 1: Answer Key (Normal Labour)
- Trainer's Resource 2-6: Prolonged Labour and Obstructed Labour: Quiz—Answer Key
- Trainer's Resource 2-7: Partograph Case Study 2: Answer Key (Prolonged Labour)
- Trainer's Resource 2-8: Partograph Case Study 3: Answer Key (Obstructed Labour)

## **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 2-E, 2-F, 2-G, 2-H, 2-I, 2-J, 2-K, 2-L, and 2-M.
4. Duplicate Participant Handouts 2-E, 2-F, 2-G, 2-H, 2-I, 2-J, 2-K, 2-L, and 2-M for the participants. Each participant will need at least five copies of Participant Handout 2-G, the blank partograph, to use in the case studies.
5. Part A: If the group is small and the training room is large enough, write the four stages of labour on four separate sheets of flipchart paper. Hang the four sheets in four different areas of the room. The group will move to different sheets, depending upon the correct answers in the exercise.
6. Part B, Activity 1: Write the definition and purpose of the partograph from Participant Handout 2-F on a sheet of flipchart paper.
7. Part C, Activity 3: Make arrangements for the practicum.
8. Give all homework assignments before the training activities begin.

### TRAINING TIPS

While most of the participants may be familiar with the use of the partograph, they may not actively and consistently use it in labour management, or they may not have seen it actively and consistently used in labour management.

*Managing Prolonged and Obstructed Labour: Education Materials for Teachers of Midwifery: Midwifery Education Modules, 2<sup>nd</sup> ed.*, which is available on the web site of the World Health Organization ([www.who.org](http://www.who.org)), is an excellent resource for this module. Encourage the participants to download this booklet. If they do not have access to the Internet, consider duplicating copies of the information for them.

You may choose to provide copies of the answer keys for the partograph case studies (Trainer's Resource 2-5, 2-7, and 2-8). They can check their own work against the answer keys. Or you can have them pair up and check each other's work. The group can then discuss together how they did on the case studies and what they have learned.

*Active management of the third stage of labor: A demonstration* is an online presentation produced by the Access Program; it is available at [www.accesstohealth.org/toolres/amtslweb/amtsl.html](http://www.accesstohealth.org/toolres/amtslweb/amtsl.html). You may wish to use it during this session.

**Session Time (total):** 2 hours, 25 minutes (excluding practicum)

## SESSION 2

### Training Steps

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#### **PART A: LABOUR**

**Time:** 30 minutes

##### **Activity: Presentation, Homework, and Large-Group Work (Review) (30 minutes)**

1. As a homework assignment, ask the participants to study Participant Handout 2-E, on the signs of true labour and the stages of labour.
2. When the group convenes, review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
3. Emphasise that the purpose of this session is to explore *how the partograph can help prevent obstetric fistula*.
4. Ask the participants what questions they have about the session objectives.
5. Ask the group if they have any comments or questions about the handout.
6. Ask a volunteer to describe how he/she would advise clients to recognise the signs of labour. Encourage him/her to use simple language that the client can easily understand.
7. Tell the group that you will lead them in an exercise about labour. Begin by reading one of the signs listed on Trainer's Resource 2-4. Ask the participants if it is a true sign of labour. Have them raise their hands if a sign indicates true labour.
8. For stages and phases of labour, read out each item on Trainer's Resource 2-4.
  - If the group is small and the training room is large enough, ask the participants to go and stand by the flipchart that indicates the correct stage of labour. Once the correct stage is identified, ask the group to name the phase of labour.
  - If the group is large, call out first stage, second stage, third stage, and fourth stage; participants should raise their hands when you name the correct stage. Then ask the participants to identify the phase.
9. Summarise the activity, recognising the participants' contributions and clarifying any issues that were problematic.

#### **PART B: THE PARTOGRAPH**

**Time:** 1 hour, 20 minutes

##### **Activity 1: Homework, Presentation, and Discussion (30 minutes for presentation and discussion)**

1. As a homework assignment, ask the participants to study Participant Handouts 2-F and 2-G on the partograph.
2. Referring to the definition on the flipchart, define the partograph and explain its purpose.
3. Using Participant Handout 2-F as a reference, briefly review the components of the partograph.
4. Present and emphasise the Points to Remember related to the partograph on page 73 of this module.
5. Ask the participants if they have any questions or comments.

##### **Activity 2: Discussion (20 minutes)**

1. Ask the participants how the partograph can help prevent or manage fistula. Sample responses include: identification of prolonged labour, identification of obstructed labour, and a visual tool for decision making to take action.

2. Ask the participants if they have used or do use the partograph. Ask those who routinely use it to describe any challenges they have faced. Ask the group to describe ways to address the challenges. Supplement their suggestions as needed. Sample challenges to the use of the partograph include:
  - Inadequate supply of partograph forms
  - Lack of knowledge and skills in the use of the partograph among nursing or midwifery staff
  - Inconsistent use of the partograph during labour
  - Completion of the partograph after delivery, but no use of the tool during labour
  - Medical personnel not conversant with the partograph
3. Resolving such challenges depends on the degree to which local protocols encourage nurses and midwives to advocate with their supervisors and department heads. Sample responses to challenges include:
  - Building skills in the use of the partograph among all relevant staff
  - Supervising labour staff to ensure use of the partograph during labour management
  - Identifying and reducing barriers to maintaining an adequate supply of partographs

### **Activity 3: Homework and Discussion (15 minutes for discussion)**

#### **TRAINING TIP**

The World Health Organization has developed a laminated, erasable, poster-size version of a partograph that can be used for training. Contact your Ministry of Health or Division of Reproductive Health to see if they have this resource. The participants can use the laminated form to plot partograph findings for the three case studies in this module (Participant Handouts 2-H, 2-L, and 2-M). This can be done as an alternative to the homework assignment in Part B, Activity 3. You may also want to complete the laminated partograph so participants can check their work on the case studies.

1. Distribute copies of Participant Handouts 2-G and 2-H (the partograph form and Case Study 1). The case study depicts normal labour.
2. Ask each participant to use a pencil to plot the findings on the partograph.
3. When the participants turn in their assignments, check each participant's work, referring to Trainer's Resource 2-5 as the answer key. Provide feedback on each participant's work.
4. When the group convenes, speak to the group about what was done correctly and incorrectly. Provide guidance as needed.

### **Activity 4: Discussion (15 minutes)**

1. Ask the participants to describe the responsibilities of nurses and midwives in the use of the partograph. Record their responses on a sheet of flipchart paper.
2. Summarise the discussion, recognising the participants' contributions. Add any critical points that the group has not addressed, using Participant Handout 2-I as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

## **PART C: PROLONGED LABOUR AND OBSTRUCTED LABOUR**

**Time: 35 minutes (excluding practicum)**

### **Activity 1: Homework, Discussion, and Quiz (20 minutes)**

1. As a homework assignment, ask the participants to study Participant Handouts 2-J and 2-K on prolonged labour and obstructed labour.

2. When the group convenes, ask them how prolonged labour and obstructed labour are related to obstetric fistula. Responses might include:
  - When labour is prolonged or obstructed, the foetal head exerts continuous pressure against the mother's pelvis.
  - This pressure greatly reduces the flow of blood to the soft tissues surrounding the vagina, bladder, urethra, and or/rectum.
  - If the woman survives, the injured tissue within her pelvis soon sloughs away (as a consequence of necrosis, or tissue death), causing a fistula to develop between adjacent organs.
3. Read the quiz questions from Trainer's Resource 2-6 and ask the group to respond orally to them.
4. At the end of the quiz, ask the participants if they have any questions or comments.

**Activity 2: Homework, Discussion (15 minutes for discussion)**

1. Distribute copies of Participant Handouts 2-G (two copies per participant), 2-L, and 2-M (the partograph form and Case Studies 2 and 3). The case studies depict prolonged labour and obstructed labour.
2. Ask each participant to use a pencil to plot the findings on the partograph for each case study.
3. When the participants turn in their assignments, check each participant's work, using Trainer's Resources 2-7 and 2-8 as answer keys. Provide feedback on each participant's work.
4. When the group convenes, ask the group to identify the signs on the partographs that indicated labour was either prolonged or obstructed. Talk to the group about what was done correctly and incorrectly on the homework assignments. Provide guidance as needed.

**Activity 3: Practicum**

1. Arrange for the participants to carry out a clinical practicum on use of the partograph, which should be supervised by clinical staff trained and experienced in the partograph's use. Appendix A includes a checklist (page 405) on partograph use that can be utilised in this practicum.
2. After the practicum, ask the participants:
  - What did they find most useful during the practicum?
  - What do they need additional practise on?
  - What questions or comments do they have about the practicum?

## **SESSION 3**

### **Referral of Clients with Prolonged or Obstructed Labour**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Explain the importance of timely referral of clients with prolonged or obstructed labour when caesarean section or vacuum delivery cannot be performed at the location where they are experiencing labour
- Describe the characteristics of a functional referral system
- Describe the different types of referral systems
- Outline the role of the community in the referral system for obstetric fistula
- Interpret data from a referral audit

#### **POINTS TO REMEMBER**

- Timely referral of clients with prolonged or obstructed labour is often necessary to save the lives of both mother and baby. It also can often help prevent obstetric fistula and other complications of pregnancy, labour, and delivery.
- Communities can participate in and strengthen referral systems for obstetric fistula.

#### **Training Methods**

- Presentation
- Discussion
- Homework
- Small-group work

#### **Materials and Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 2-N: Referral Systems
- Participant Handout 2-O: Sample Blank Referral Form
- Participant Handout 2-P: The Referral Audit
- Participant Handout 2-Q: The Referral Audit: Exercise
- Trainer's Resource 2-9: The Referral Audit: Exercise—Answer Key

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 2-N, 2-O, 2-P, and 2-Q.
4. Duplicate Participant Handouts 2-N, 2-O, 2-P, and 2-Q for the participants.
5. Part A, Activity 2: Write the definition of a referral system on a sheet of flipchart paper, using Participant Handout 2-N as a reference. From your own experience, think of parts of a referral system both that have been highly effective and that needed improvement.

6. Part C: Give the homework assignment before the training activities begin.

**TRAINING TIP**

Participants will bring knowledge of referral systems from their professional and personal experience. Encourage them to share that knowledge with the group and to reflect on how referral systems can be improved.

**Session Time (total):** 1 hour, 50 minutes

## SESSION 3

### Training Steps

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#### **PART A: REFERRAL OF CLIENTS WITH PROLONGED OR OBSTRUCTED LABOUR**

**Time:** 40 minutes

##### **Activity 1: Presentation and Discussion (10 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explain *the importance of referral in the management of prolonged and obstructed labour and the prevention of obstetric fistula*.
3. Ask the participants what questions they have about the session objectives.
4. Tell the participants that they may practise in clinical settings that are not able to provide a caesarean section or other services that are needed by women who experience prolonged or obstructed labour.
5. Ask the participants why it is important for such clients to be referred in a timely manner. Possible responses include:
  - “The client’s life is at risk.”
  - “The life of the infant is at risk.”
  - “Timely referral may help prevent obstetric fistula and other complications.”

##### **Activity 2: Presentation and Discussion (30 minutes)**

#### **TRAINING TIP**

For Part A, Activity 2, you may want to ask a guest speaker to talk about local referral systems. This may be especially appropriate for preservice participants who lack professional experience with referral.

1. Referring to the definition on a sheet of flipchart paper, define a referral system.
2. Ask the participants to describe the characteristics of a functional referral system, drawing upon previous training and experience, both professional and personal. Note their comments on a sheet of flipchart paper.
3. Summarise the participants’ contributions. Add any critical points that the group has not addressed, using Participant Handout 2-N as a reference. Ask the participants if they have any questions or comments.
4. Ask two or three participants to describe local referral systems and to identify aspects of the systems that either are very effective or need improvement, drawing on both their professional and personal experiences. Offer examples of your own if necessary. Ask the group to suggest ways to improve the systems that need improvement.
5. Using Participant Handout 2-N as a reference, describe the types of referral. Ask the participants if they have any questions or comments.
6. At the end of the activity, distribute Participant Handouts 2-N and 2-O to the group. Tell the participants that Participant Handout 2-O is a sample referral form; they can adapt it for use in their practises.

## **PART B: THE ROLE OF THE COMMUNITY IN REFERRAL SYSTEMS FOR OBSTETRIC FISTULA**

**Time:** 30 minutes

### **Activity: Discussion (30 minutes)**

1. Ask the group to:
  - List ways in which the community can participate in the referral system, without looking at Participant Handout 2-N.
  - Describe community members who are important participants in the referral system. Examples include leaders in the following areas: health care, local government, women's organisations, religious organisations, transportation.
  - Describe how these community members should work with nurses, midwives, and other providers to strengthen the referral system.Note the group's responses on flipchart paper.
2. Summarise the activity, recognising the groups' contributions. Add any critical points that the groups have not addressed, using Participant Handout 2-N as a reference. Ask the participants if they have any questions or comments.

## **PART C: THE REFERRAL AUDIT**

**Time:** 40 minutes

### **Activity: Homework, Small-Group Work and Discussion (40 minutes for small-group work and discussion)**

1. As a homework assignment, ask the participants to study Participant Handout 2-P on referral audits.
2. Divide the group into small groups, with four or five participants per group. Ask the groups to review Participant Handout 2-Q and to answer the following questions:
  - Were the referrals appropriate?
  - What actions would they take based on the findings of the referral audit?
3. Allow 15 minutes for each group to work. Ask each group to appoint a presenter-notetaker.
4. Convene the large group. Review the findings of the referral audit for each facility and ask the presenters/notetakers to report on the conclusions of their groups.
5. Summarise the activity, recognising the groups' contributions. Add any critical points that the small groups have not addressed, using Trainer's Resource 2-9. Ask the participants if they have any questions or comments.
6. Ask the large group how referral audits relate to the three delays introduced in Module 1. Sample responses include:
  - Referral audits can identify transportation problems and help address the second delay (reaching a health care facility).
  - Referral audits can identify issues within a health care system that relate to the third delay (receiving care).

## **SESSION 4**

### **Preventive Management of Clients Who Have Recently Experienced Prolonged or Obstructed Labour**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Outline principles for the immediate care of a recent survivor of prolonged or obstructed labour, to prevent obstetric fistula.

#### **POINTS TO REMEMBER**

- All maternity units should draw up a protocol for the management of women who have survived prolonged or obstructed labour.
- For women who have recently experienced prolonged or obstructed labour:
  - An indwelling catheter is inserted as soon as possible to encourage the drainage of urine.
  - Twice a day, the perineum and vagina are cleansed with salty water (sitz baths) or a solution of mild detergent in water.
  - Staff encourage the women to drink a large volume of fluids, around 4 to 5 L per day.
  - A speculum examination is performed as soon as possible.

#### **Training Methods**

- Presentation
- Discussion

#### **Materials and Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 2-R: Has a Client Recently Experienced Prolonged or Obstructed Labour? Factors to Consider
- Participant Handout 2-S: Preventing Obstetric Fistula: Managing Clients Who Have Recently Experienced Prolonged or Obstructed Labour
- Trainer's Resource 2-1: Module 2 Evaluation and Answer Key

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 2-R and 2-S.
4. Duplicate Participant Handouts 2-R and 2-S for the participants.

#### **TRAINING TIP**

Some participants may have already cared for women who have recently experienced prolonged or obstructed labour. Encourage them to share what they have learned and observed with the rest of the group. How were the women managed? What were the outcomes?

**Session Time (total):** 1 hour, 20 minutes

## SESSION 4

### Training Steps

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#### **PART A: PREVENTIVE MANAGEMENT OF CLIENTS WHO HAVE RECENTLY EXPERIENCED PROLONGED OR OBSTRUCTED LABOUR**

**Time:** 40 minutes

##### **Activity 1: Presentation and Discussion (20 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to describe *how to manage clients who have recently experienced prolonged or obstructed labour*.
3. Ask the participants what questions they have about the session objectives.
4. Tell the participants that they may work in facilities where women who have recently experienced prolonged or obstructed labour arrive to receive care. Ask the group to consider what they have learned about prolonged and obstructed labour (Session 2 of this module) and to name signs that might identify such women. Note their responses on a sheet of flipchart paper.
5. Summarise, recognising the participants' contributions. Add any critical points that the group has not addressed, using Participant Handout 2-R as a reference. Ask the participants if they have any questions or comments.
6. At the end of the activity, distribute copies of the handout to the group.

##### **Activity 2: Presentation and Discussion (20 minutes)**

1. Using Participant Handout 2-S as a reference, describe the principles for immediate management of clients who have recently experienced prolonged or obstructed labour.
2. Emphasise that all maternity units should have a protocol for the management of women who have survived prolonged or obstructed labour.
3. Ask the participants if they have any questions or comments.
4. At the end of the activity, distribute copies of the handout to the group.

#### **PART B: MODULE 2 EVALUATION**

**Time:** 40 minutes

##### **Activity 1: Posttest (20 minutes)**

1. Distribute the Module 2 Evaluation (based on the questions provided in Trainer's Resource 2-1) to the participants and tell them that they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

##### **Activity 2: Review/Debrief (20 minutes)**

1. Review the answers to the Module 2 Evaluation (using the Answer Key in Trainer's Resource 2-1).

#### **TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.

2. Ask the participants what questions they have.

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# **MODULE 2**

# **RESOURCES**



## **PARTICIPANT HANDOUT 2-A**

### **Antenatal Care and the Prevention of Obstetric Fistula**

**Antenatal care** is the care given to women from the time of conception until the onset of labour. Antenatal care uses a goal-oriented, problem-solving, solution-focused, and action-oriented approach. Every woman should receive holistic, individualised care within the context of her family and community.

Poor women, women who live in remote areas, and women with little or no education are the least likely to seek antenatal care. Many of these women are at increased risk for obstetric fistula. Studies show that women who receive antenatal care are more likely to receive skilled assistance during labour and delivery than women who do not receive antenatal care.

#### **How Antenatal Care Can Prevent Obstetric Fistula**

Quality antenatal care:

- Identifies girls and women at increased risk for obstetric fistula (see Participant Handout 2-B)
- Enables the client to plan for an appropriate place of birth
- Enables the client to develop a plan in case an emergency arises
- Informs the client of signs of prolonged labour, obstructed labour, and other pregnancy complications
- Informs the client when it is essential for her to seek care from a skilled attendant without delay
- Helps the client develop a plan to save for any expenses related to pregnancy and delivery
- Helps the client identify support persons from her family and community (e.g., someone who can help with transportation, someone who can care for her home and other children)
- Provides an opportunity to educate the client and her partner about the causes of obstetric fistula and to correct any myths or rumours about the condition

If a woman plans to deliver in a health care facility, quality antenatal care:

- Helps her to arrange for transportation to the facility before it is needed
- Informs her when she should go to the health care facility after labour begins and what she should bring with her

#### **During Pregnancy: When to Go to a Health Facility As Soon As Possible**

If a woman develops any of the following symptoms, she must go to a health care facility immediately:

- Fever > 38.5°C
- Vaginal bleeding
- Convulsions (fits)
- Severe and continued headache with blurred vision
- Severe lower abdominal pain
- Rapid or difficult breathing
- Severe fatigue (too weak to get out of bed)

- Feeling ill
- Swelling of fingers, face, or legs

Both pregnant women and their family members need to know these warning signs, since a woman may not be able to seek help on her own if she is experiencing any of them.

### **During Labour: When to Go to a Health Facility As Soon As Possible**

A pregnant woman must go to a health care facility immediately if:

- Her water breaks and (a) labour does not start within six hours or (b) she and/or her caregiver(s) cannot feel any foetal movement.
- Her labour pains (contractions) continue for 12 hours.

### **References**

Caroli, G., et al. 2001. WHO systematic review of randomised controlled trials of routine antenatal care. *Lancet* 357(9268):1565–1570.

Dowswell, T., et al. 2010. Alternative versus standard packages of antenatal care for low-risk pregnancy. *Cochrane Database of Systematic Reviews*, issue 10, article no. CD000934. DOI: 10.1002/ 14651858.CD000934.pub2. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000934.pub2/abstract>, September 12, 2011.

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WHO. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*, 2nd ed. Geneva.

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## **PARTICIPANT HANDOUT 2-B**

### **Identifying Women at Increased Risk for Obstetric Fistula**

**IMPORTANT: All pregnant women are at risk for birth complications, including obstetric fistula.** All women should receive focused antenatal care, according to international and national standards, including counselling and planning for delivery at a health facility. Referral to a higher-level facility should be based on risk factors, without bias or discrimination.

The risk for obstetric fistula is greater for some women than others. The following risk factors are not predictive. Women who have one or more risk factors may or may not develop obstetric fistula. However, if a woman has a risk factor, the provider counsels her, her partner, and her family to plan for delivery at a health care facility to help ensure the best possible outcome for mother and baby. Identification of risk factors also can help the provider determine which women should be referred to a higher-level facility.

In taking the medical history of a pregnant woman, it is important to note all of the following factors:

#### **History Taking: Physical Factors**

- Small stature, contracted pelvis, and/or malnutrition leading to stunted growth and low weight
- Less than two years between the previous birth and the current pregnancy
- Prolonged or obstructed labour in a previous pregnancy
- Unexplained stillbirth in a previous pregnancy
- The current pregnancy being the woman's fifth or higher (known as grand multiparity), which increases the likelihood of unstable lie and prolonged labour with abnormal presentation
- Primigravida (first pregnancy)
- Unsafe induced abortion (sharp instruments can damage the genital tract and underlying organs)
- Harmful traditional practises, such as female genital cutting
- Trauma caused by sexual abuse or rape
- History of certain diseases or treatments that increase the risk for obstetric fistula (e.g., known diabetes or gestational diabetes with risk for big baby, rectal carcinoma, infection caused by lymphogranuloma venereum, radiotherapy for cervical carcinoma)
- Surgical injury
- Previous obstetric fistula (with or without repair)
- Big baby (which may also lead to diabetes during pregnancy)

#### **History Taking: Social Factors**

- Young age (younger than 18 years)
- Poverty
- Early marriage and childbirth

- Low level of education
- Inadequate family planning
- Gender discrimination
- Residence in a remote area

### **History Taking: Service Delivery Factors**

- Lack of access to skilled antenatal and delivery care
- Lack of access to emergency obstetric care
- Lack of access to health care facilities
- Lack of access to family planning

### **Abdominal Examination**

- After 36 weeks gestation: fundal height greater than gestational age (this may indicate an increased risk for prolonged or obstructed labour)
- Abnormal presentation or lie: an abnormal presentation, especially after 36 weeks of gestation, is likely to result in obstructed labour; all women with abnormal presentation must deliver in health care settings that can provide emergency obstetric care; abnormal presentation may be a sign of hydrocephalus

### **References**

De Cock, J., and Van der Walt, C. 2004. *Maternal and newborn care: A complete guide for midwives and other health professionals*. Landsdowne, South Africa: Juta.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 2-C**

### **Identifying Risk Factors for Obstetric Fistula during Pregnancy: Case Studies**

The clients below come to a health care facility where you are providing antenatal care. Identify the risk factors for obstetric fistula.

#### **Case 1: Tigrest**

1. Tigrest was married at age 12.
2. She lives in a remote village.
3. Tigrest is not literate and has never been to school.
4. Tigrest became pregnant at age 14.

#### **Case 2: Pendo**

1. Pendo is 17.
2. She is poor.
3. She is malnourished.
4. Pendo is married to a much older man.
5. She has had one previous pregnancy, which ended in stillbirth.
6. Pendo has experienced female genital cutting.

#### **Case 3: Aberesh**

1. Aberesh is 25.
2. Aberesh has had two previous pregnancies, both of which resulted in the safe delivery of two healthy babies, despite physical abuse during the pregnancies.
3. During one of her pregnancies, Aberesh had high blood pressure.

#### **Case 4: Naneye**

1. Naneye is 16.
2. She has a contracted pelvis.
3. Naneye has had one previous pregnancy, during which she endured prolonged labour. She delivered a small baby with medical assistance. The baby is alive, appears normal, and is 18 months old.

## **PARTICIPANT HANDOUT 2-D**

### **Challenges to the Delivery of Antenatal Care**

#### **Challenges**

- For a variety of reasons, many girls and women do not seek care. They may not have money or access to transportation. They may need permission to leave home. Domestic demands may prevent them from seeking care, especially when they have to wait many hours before receiving services. They may not be able to travel to the health care facility on their own, and no one may be available to accompany them. They may face discrimination from health care workers, especially if they are poor, very young, or from certain ethnic groups.
- Girls and women may live in localities far from health care services.
- Health facilities may lack enough trained staff to deliver antenatal care.
- Health facilities may lack necessary laboratory and diagnostic services.
- Providers may lack skills in appropriate, effective, nondiscriminatory, and respectful communication with a variety of clients, especially vulnerable populations such as the poor, youth, and women with disabilities.
- Staff may not have enough time to provide recommended antenatal care.
- Urgent health needs may take priority over antenatal care.
- Providers may lack the skills and gender sensitivity needed to counsel women and their families about risk factors and about the danger signs of pregnancy and labour.
- Resources may not be dedicated to reaching those who play decision-making roles during pregnancy, such as partners, in-laws, and community members.
- Health facilities may lack maternity waiting homes or wards for clients who live far away or who have identified risk factors.
- Providers may not be skilled in addressing social issues such as gender discrimination, young age at marriage, abuse, and violence.
- Communities may not have the resources needed to assist women experiencing abuse or violence.

#### **Strategies for Responding to the Challenges**

- Educate girls and women and their communities about the importance of antenatal care, possible maternal complications, and the need for skilled care during labour and delivery.
- Work with communities to help women secure transportation for antenatal care.
- Train community health workers in remote areas to deliver the four focused antenatal care visits recommended by the World Health Organization (WHO) (2002) and to identify girls and women at high risk for pregnancy complications, including obstetric fistula.
- Train health workers in referral procedures.
- Upgrade laboratory and diagnostic services at health care facilities.
- Train providers in social issues related to obstetric fistula.
- Help communities obtain the resources needed to assist women experiencing abuse or violence.
- Consider providing antenatal information in group sessions; then tailor individual clinical and counselling sessions to the needs of individual women or couples.

- Use the antenatal care model developed by WHO (2002). This model identifies women with particular health conditions or risk factors for pregnancy complications; these women receive the most antenatal care services or are referred to a higher-level facility. Women who are not at high risk receive a minimum of four antenatal visits. Numerous visits for most women are no longer recommended because they place a burden on health care systems. Research has shown that reducing the number of visits for most women does not have a negative effect on maternal or infant outcomes.
- Follow WHO guidance about what should be included in each visit. This will increase efficiency and also will focus antenatal care on preventing the most serious pregnancy complications. The publication *WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model*, cited below, outlines each of the four visits recommended for women who are not at high risk.
- To dispel misconceptions about obstetric fistula, give comprehensive information about the medical nature of the condition and its causes to women and their families.
- Inform women, their families, and the community about the availability of fistula repair services.

### References

Carrolli, G., et al. 2001. WHO systematic review of randomised controlled trials of routine antenatal care. *Lancet* 357(9268):1565–1570.

Dowswell, T., et al. 2010. Alternative versus standard packages of antenatal care for low-risk pregnancy. *Cochrane Database of Systematic Reviews*, issue 10, article no. CD000934. DOI: 10.1002/14651858.CD000934.pub2. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000934.pub2/abstract>, September 12, 2011.

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## **PARTICIPANT HANDOUT 2-E**

### **Signs and Stages of Labour**

It is important for all service providers working with pregnant women to be able to distinguish the signs of true labour from those that indicate false labour.

#### **Signs of True Labour: What the Woman Observes**

- *Rupture of membranes:* The amniotic sac leaks or breaks.
- *Contractions:* A contraction is a tightening of the uterus. When a woman is in labour, contractions occur regularly. The interval between contractions gradually shortens over the course of labour, while the severity and duration of contractions increase over time. Mild contractions last less than 20 seconds; moderate, 20 to 40 seconds; strong, more than 40 seconds. True contractions continue regardless of the woman's activity or position. Pain starts in the back and moves to the front over time.
- *Bloody show:* True labour is often accompanied by discharge of blood-tinged mucous through the vagina (known as bloody show); labour usually occurs within 24–48 hours of bloody show (Varney et al., 2004).

#### **Signs of True Labour: What the Provider Observes**

- The cervix effaces (softens and thins).
- The cervix dilates (opens).
- The uterus hardens (the harder the uterus, the more intense the pain).
- The presenting part descends.
- The presenting part/foetal head is fixed between pains.
- Sedation does not stop true labour.

A pregnant woman who experiences signs of true labour should immediately report to a health care facility that provides obstetric care. After 37 weeks of gestation, all women who live far from a health care facility that offers emergency obstetric care should move either (a) to such a facility or (b) to an established maternity waiting home located close to such a facility.

#### **False Labour**

- The woman has no palpable contractions, or the contractions are irregular, vary in length, and can sometimes be stopped by changing activity or position. The interval between contractions does not become shorter over time; the duration and severity of contractions do not increase. Pain is mainly in the front.
- Hardening of the uterus and intensity of the pain are not related.
- There is no bloody show.
- The cervix does not dilate.
- There is no descent of the presenting part.
- The foetal head remains free; it is not already engaged.
- Effective analgesia stops false labour pains.

## Stages and Phases of Labour

Stage	Phase	Symptoms and Signs
First	Latent	Cervix dilated less than 4 cm
First	Active	Cervix dilated 4 to 9 cm Rate of dilatation typically 1 cm per hour or more Foetal descent begins
Second	Early (nonexpulsive)	Cervix fully dilated (10 cm) Foetal descent continues Woman has no urge to push
Second	Late (expulsive)	Cervix fully dilated (10 cm) Presenting part of foetus reaches pelvic floor Woman has a strong urge to push
Third		Delivery of the baby Expulsion of the placenta

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## **PARTICIPANT HANDOUT 2-F**

### **Using the Partograph**

#### **Definition and Purpose**

A *partograph* is a record of all observations made on a woman in labour. The central feature of the partograph is a graphic presentation of the dilatation of the cervix as assessed by vaginal examination. The partograph provides information that helps the service provider assess the condition of the mother and foetus during labour. The purpose of the partograph is to reduce maternal and perinatal mortality and morbidity.

#### **Digital Vaginal Examinations**

Vaginal examinations are done approximately every four hours. Some women, particularly multipara (women who have had two or more pregnancies in which the foetus or foetuses reached the point of viability, that is, 20 weeks gestation or 500 grams; see Varney et al., 2004), may need to be checked more often in advanced labour. An abdominal examination is always done before a vaginal examination to identify scarring, evidence of cesarean section or other surgery, and Bandl's ring.

If her membranes have ruptured and the woman has no contractions, the provider does not perform a digital vaginal exam because it does not help to establish a diagnosis and it risks introducing infection.

#### **Components of the Partograph**

- Identifying information about the woman and her pregnancy
- Foetal heart rate
- Liquor amnii (amniotic fluid)
- Moulding
- Cervical dilatation
- The alert line (starts at 4 cm of cervical dilatation to the point of expected full dilatation at the rate of 1 cm per hour)
- The action line (parallel to the alert line and four hours to the right of the alert line)
- Descent of head
- Hours (refers to the time elapsed since the onset of the active phase of labour)
- Time (the actual time of day)
- Contractions
- Oxytocin, drugs, and I.V. fluids
- Pulse, blood pressure, and temperature
- Urine

#### **Recording and Interpreting Findings**

##### ***Foetal heart rate***

To monitor the condition of the foetus, the provider records the foetal heart rate every half hour in the first stage of labour and more often at the end of the first stage and in the second stage. The normal foetal heart rate is 120 to 160 beats per minute. The provider listens to the foetal heart rate immediately after the strongest part of a contraction.

On the partograph, each square for the foetal heart rate represents 30 minutes. The lines for 100 and 180 beats per minute are darker to remind the provider that a foetal heart rate that is less than 100 or more than 180 indicates nonreassuring foetal status (NRFS).

### ***Liquor amnii***

The provider records the appearance of the liquor amnii at each vaginal examination. If the membranes are intact, the provider records “I.” If the membranes are ruptured, the provider records the appearance of the liquor as follows:

- Clear (the normal colour) (C)
- Blood-stained (B)
- Meconium-stained (M)
- Absent (A)

The provider listens to the foetal heart rate every five minutes if:

- If the liquor contains thick green or black meconium
- If liquor is absent at the time the membranes rupture

### ***Moulding***

This assessment is based on the overlapping of the foetal saggital sutures as the foetal head moves to fit into and pass through the mother’s bony pelvis. The purpose is to describe how well the baby’s head is fitting into the pelvis and to indicate the pressure that the pelvis exerts on the head during labour (e.g., a large pelvis exerts little pressure on a small head, a small pelvis exerts marked pressure on a large head). Recording is as follows:

- Bones are separated and the sutures can be felt easily (0).
- Bones are just touching each other (+).
- Bones are overlapping, but can be separated easily with pressure from the examiner’s finger (++).

These three signs indicate mild to moderate moulding, which is considered within the range of normal; the woman should be watched closely. If moulding increases, action must be taken or the woman should be referred to a higher level of care.

- Bones are overlapping, but cannot be separated easily with pressure from the examiner’s finger (+++).

This sign indicates that action must be taken or the woman referred to a higher level of care.

Increased moulding with a high head is a sign of disproportion (baby is too big for the mother’s pelvis).

### ***Cervical dilatation***

This assessment is the most important observation to monitor progress of labour. The provider assesses dilatation, which should be progressive, at every vaginal examination; it is marked with an X. Plotting begins at 4 cm.

The numbers 0 to 10 appear along the left side of the partograph; each number/square represents 1 cm of dilatation. Running across the partograph are 24 squares, each representing one hour.

During the latent phase of the first stage of labour, the cervix should reach 4 cm of dilatation within eight hours; the cervix also effaces during this time. Findings during the latent phase are not plotted on the partograph.

The active phase of the first stage of labour begins when the cervix is 4 cm dilated and is completed at full dilatation (i.e., 10 cm). During this phase, progress is approximately 1 cm per hour and often quicker in multigravidae (women who have been pregnant two or more times). If progress is satisfactory, documentation of cervical dilatation remains on, or to the left, of the alert line.

### ***Descent of the presenting part***

For labour to progress well, dilatation is accompanied by descent of the presenting part. Descent is assessed by abdominal examination immediately before a vaginal examination. This enables the provider to know (a) the level of descent and (b) where to expect to feel the presenting part during the vaginal exam.

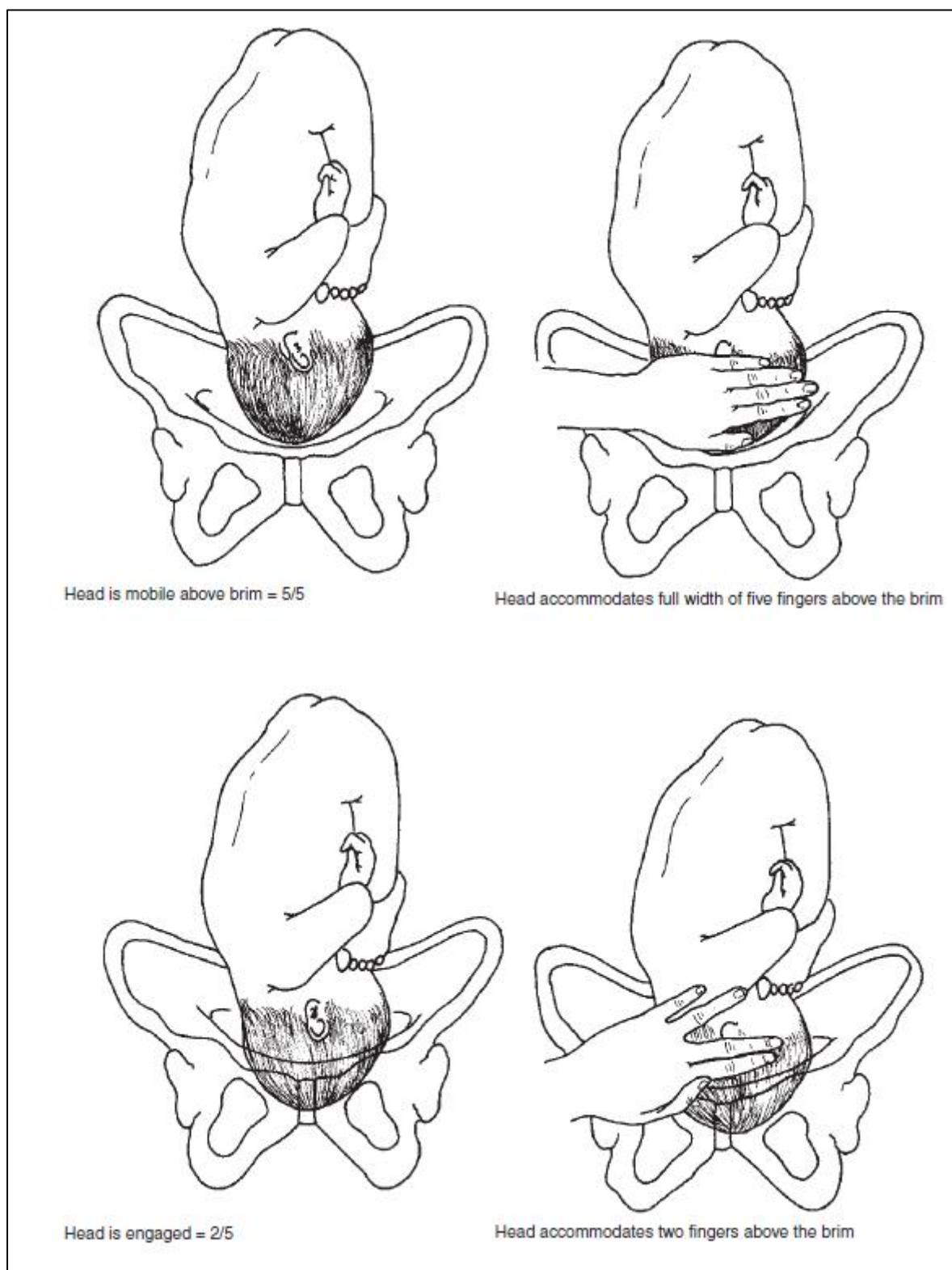
For purposes of assessment, the head, which is palpable above the symphysis pubis, is divided into five parts. The width of four closed fingers and the thumb can be used to estimate fifths of the head above the brim; a head that is mobile above the brim accommodates the full width of four fingers and the thumb when they are closed (see page 99).

As the head descends, the portion remaining above the brim is represented by fewer fingers (4/5, 3/5, etc.). When the portion of the head above the brim is represented by two fingers' width or less, the head is usually engaged. Descent is recorded as a circle (O).

### ***Uterine contractions***

Normally, contractions become more frequent and last longer as labour progresses. The provider records contractions every 30 minutes; he/she palpates the number of contractions within a 10-minute period and records their duration in seconds. Duration is recorded in three ways:

- Less than 20 seconds
- 20 to 40 seconds
- More than 40 seconds



The squares in this section of the partograph are numbered from 1 to 5. Each square represents one contraction (for example, if two contractions are felt within 10 minutes, the provider shades two squares).

<b>KEY TO SHADING</b>		
• Dots: mild contractions that last less than 20 seconds	• Diagonal lines: moderate contractions that least 20 to 40 seconds	• Solid colour: strong contractions that last longer than 40 seconds
		

If contractions are weak, labour may require augmentation. A doctor should be consulted. Augmentation is done only after a thorough risk assessment.

***Oxytocin, drugs, and I.V. fluids***

The provider records the time when drugs and fluids are given.

***Pulse, blood pressure, and temperature***

The provider checks the woman’s pulse every half hour; blood pressure, every four hours; and temperature, every two hours.

<b>Normal limits of vital signs</b>	
Pulse	60 to 90
Blood pressure	90/60 to 130/80
Temperature	37.2 C (98.6 F)

***Urine***

If the woman’s blood pressure is elevated on admission, the provider examines the urine for acetone, albumin, and glucose. The provider encourages the woman to pass urine every two hours during labour. He/she examines the urine for amount and concentration. Dark colour is a sign of dehydration. Each specimen is tested for protein and ketones. The provider records every time the woman passes urine.

***Vomiting***

Occasionally, women vomit during labour. The provider records the vomitus on the partograph, noting colour and consistency.

***The action line***

The action line means that an immediate intervention is needed (e.g., consultation with a doctor regarding the need for augmentation or operative delivery, or referral if the facility is not able to provide the necessary care). If the client must be transferred, the World Health Organization (2006, p. 64) recommends that a provider accompany the client during the trip.

***Reporting deviations from normal***

If any assessment deviates from normal, the provider follows the local protocol for management and referral.

## References

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## PARTICIPANT HANDOUT 2-G

### The Partograph

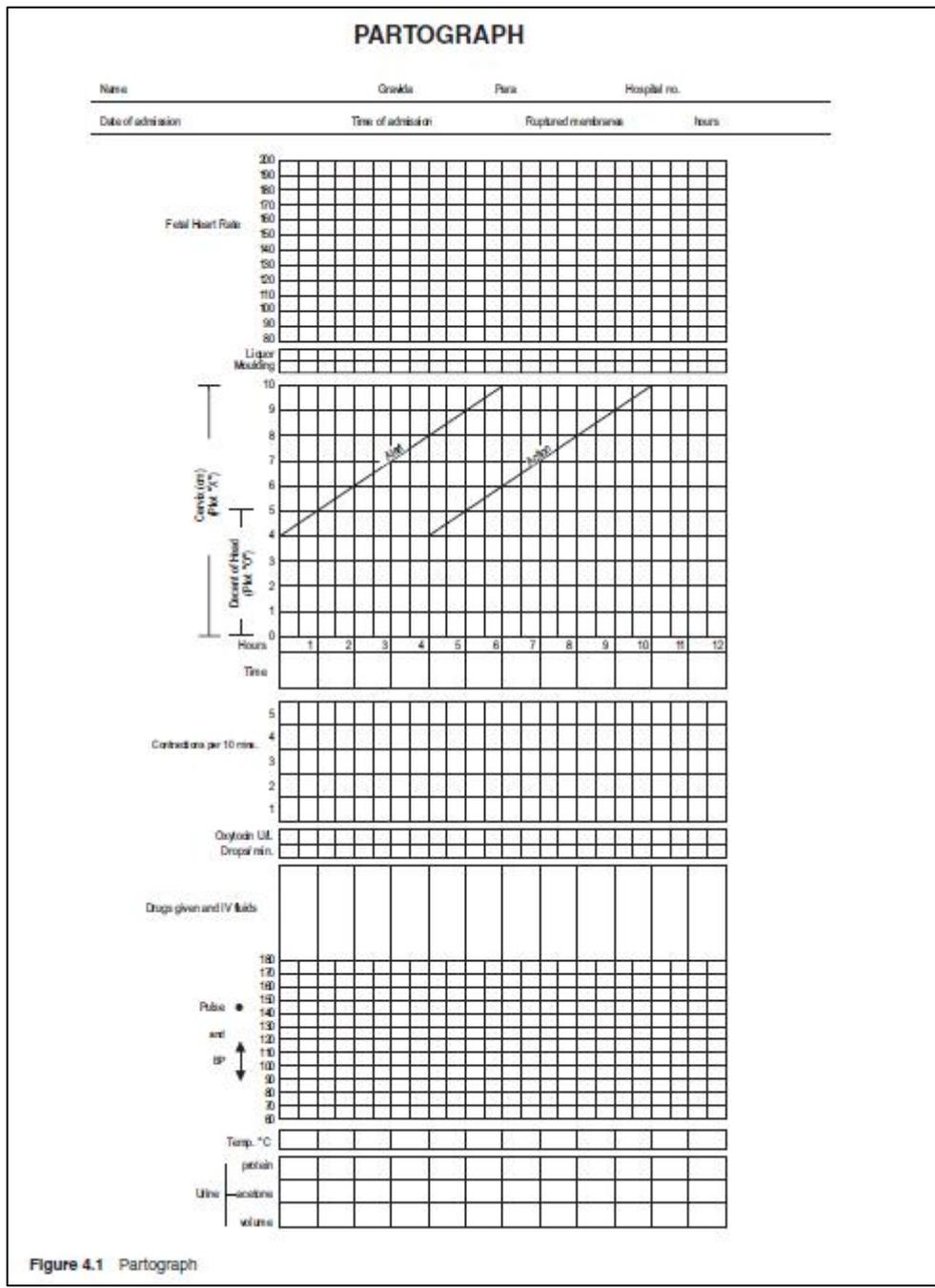


Figure 4.1 Partograph

## **PARTICIPANT HANDOUT 2-H**

### **Partograph Case Study I**

#### **Step 1**

- Mrs. A was admitted at 5 am on December 5, 2000.
- Hospital number 7886
- Membranes ruptured 4 am
- Gravida 3, para 2+0
- On admission, the foetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

#### **Q: What should you record on the partograph?**

*Note:* The client is not in active labour. Record only the details of her history (i.e., first four bullets above), not the descent and cervical dilatation.

#### **Step 2**

**9:00 am**

- The foetal head is 3/5 palpable above the symphysis pubis.
- The cervix is 5 cm dilated.

#### **Q: What would you now record on the partograph?**

*Note:* The client is now in the active phase of labour. Plot this and the following information on the partograph:

- There are three contractions in 10 minutes, each lasting 20 to 40 seconds.
- Foetal heart (FH) rate 120
- Membranes ruptured, amniotic fluid clear
- Skull bones separated, sutures easily felt
- Blood pressure 120/70
- Temperature 36.8°C
- Pulse 80 per minute
- Urine output 200 mL; negative protein and acetone

#### **Q: What steps should be taken?**

#### **Q: What advice should be given?**

#### **Q: What do you expect to find at 1 pm?**

### Step 3

Plot the following information on the partograph:

- 9:30 am: FH 120, contractions 3/10 each 30 sec, pulse 80
- 10 am: FH 136, contractions 3/10 each 30 sec, pulse 80
- 10:30 am: FH 140, contractions 3/10 each 35 sec, pulse 88
- 11 am: FH 130, contractions 3/10 each 40 sec, pulse 88, temp 37
- 11:30 am: FH 136, contractions 4/10 each 40 sec, pulse 84, head is 2/5 up
- 12 noon: FH 140, contractions 4/10 each 40 sec, pulse 88
- 12:30 pm: FH 130, contractions 4/10 each 45 sec, pulse 88
- 1 pm:
  - FH 140, contractions 4/10 each 45 sec, pulse 90, temp 37
  - The foetal head is 0/5 palpable above the symphysis pubis
  - The cervix is fully dilated.
  - Amniotic fluid clear
  - Skull bones separated, sutures easily felt
  - Blood pressure 100/70
  - Urine output 150 mL; negative protein and acetone

**Q: What steps should be taken?**

**Q: What advice should be given?**

**Q: What do you expect to happen next?**

### Step 4

Record the following information on the partograph:

- 1:20 pm: spontaneous delivery of a live female infant, wt. 2.850 g

**Q: How long was the active phase of the first stage of labour?**

**Q: How long was the second stage of labour?**

**Source:** World Health Organization. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, pp. 69–70. Used by permission.

## **PARTICIPANT HANDOUT 2-I**

### **The Partograph: Responsibilities of Nurses and Midwives**

Specific responsibilities of nurses and midwives vary across different facilities. Follow local protocol to:

- Use data from the partograph to think critically and make clinical decisions on the basis of sound knowledge.
- Use data from the partograph to consult with medical personnel for timely intervention.
- Record data accurately and in a timely fashion.
- Inform the woman in labour of findings, allay any anxieties she may be experiencing, and engage a family member to support her.
- Refer the client as needed when findings deviate from normal and according to local protocol.
- Stabilise the client being transferred (referred to a higher-level facility). When her condition indicates a need for fluids, help the client empty her bladder. Also:
  - Give antibiotics
  - Give analgesia
  - Provide emotional and physical support
  - Continue to monitor the condition of the client and her foetus
  - Stay with the client and accompany her to the facility accepting the referral

## PARTICIPANT HANDOUT 2-J Prolonged Labour

### Definition

*Prolonged labour* occurs when two conditions are met: (a) the woman experiences regular, rhythmic, painful contractions accompanied by cervical dilatation and (b) labour lasts longer than 24 hours (WHO, 2008).

Phase	Labour is prolonged when:
Latent	Phase exceeds eight hours
Active	Phase exceeds 12 hours

Even when obstruction does not occur, prolonged labour in and of itself can be harmful to both the woman and the foetus.

### Causes of Prolonged Labour: The “Three P’s”

The causes of prolonged labour can be described in terms of the “Three P’s”:

- Powers: Uterine contractions are poor or uncoordinated. (The word *powers* refers to the power of the uterine muscles.)
- Passenger: The foetal head is too large, or the foetal position is abnormal. (The word *passenger* refers to the foetus.)
- Passage: The pelvis is abnormal, or a tumour or other obstruction blocks the pelvis or birth canal. (The word *passage* refers to the foetus’s movement through the bony pelvis.)

### Management of Prolonged Latent Phase

If the woman has been in the latent phase for more than eight hours and there is little sign of progress, the provider assesses as follows:

- If there has been no change in cervical effacement or dilatation and there is no foetal distress, the provider reviews the diagnosis. The woman may not be in labour (see description of false labour on Participant Handout 2-E).
- If there has been a change in cervical effacement or dilatation, the provider ruptures the membranes with an amniotic hook or a Kocher clamp and induces labour. The woman is assessed every four hours. If she has not entered the active phase of labour after eight hours of induction, she is delivered by caesarean section.
- If there are signs of infection (fever, foul-smelling vaginal discharge), labour is augmented immediately with oxytocin. Antibiotics are given until delivery, according to the facility’s guidelines. If the woman delivers vaginally, antibiotics are discontinued postpartum. If the woman has a caesarean section, antibiotics are continued.

### Management of Prolonged Active Phase

The first step is to assess the uterine contractions:

- If contractions are inefficient (less than three contractions in 10 minutes, each lasting less than 30 seconds), the provider suspects inadequate uterine activity and refers as indicated by local protocol.

- If contractions are efficient (three contractions in 10 minutes, each lasting 30 to 40 seconds), the provider suspects cephalopelvic disproportion, obstruction, malposition, or malpresentation and refers as indicated by local protocol.

If there are no signs of cephalopelvic disproportion or obstruction, the contractions are regular and strong, and the membranes are intact, the provider ruptures the membranes with an amniotic hook or a Kocher clamp.

The provider continues to monitor maternal and foetal well-being and the progress of labour. He/she is prepared to refer according to local protocol if normal progress does not resume. Providing general labour support may improve contractions and accelerate progress. Examples of such support include:

- Encouraging the woman's birth companion to rub her back, wipe her face and brow with a moist cloth, and help her to move about
- Explaining all procedures to the woman, asking for her permission, and discussing findings with her
- Respecting the woman's wishes
- Encouraging the woman to empty her bladder regularly
- Encouraging breathing techniques

### **Management of Prolonged Expulsive Phase**

Maternal expulsive efforts increase foetal risk by reducing the delivery of oxygen to the placenta. While providers should allow spontaneous pushing, they should not encourage prolonged effort or holding the breath. If malpresentation and obvious obstruction have been ruled out, labour should be augmented with oxytocin.

If there is no descent after augmentation **and**:

- If the foetal head is at 0 station, delivery is by assisted vacuum delivery or forceps.
- If the foetal head is between 1/5 and 3/5 above the symphysis pubis or the leading bony edge of the head is between 0 station and -2 station and birth is taking place in a location where caesarean section is not possible, delivery is by assisted vacuum delivery.
- If the foetal head is more than 3/5 above the symphysis pubis or the leading edge of the head is above -2 station, delivery is by caesarean section.

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## **PARTICIPANT HANDOUT 2-K**

### **Obstructed Labour**

#### **Definition**

*Obstructed labour* occurs when the foetus cannot descend through the pelvis because an insurmountable barrier prevents its descent. Obstruction usually occurs at the pelvic brim, but it may also occur in the cavity or at the outlet of the pelvis. Delivery requires operative intervention (WHO, 2008).

#### **Causes of Obstructed Labour**

Causes of obstructed labour are as follows:

- A mismatch between the presenting part of the foetus and the woman's pelvis (Usually, the disproportion is cephalopelvic, involving the foetal head and the woman's pelvis [i.e., a small pelvis with a foetal head of normal size, a normal pelvis with a large foetus, or a small pelvis with a large foetal head]. Abnormal presentations [e.g., brow, shoulder, face with chin posterior, after-coming head in breech presentation] can also result in cephalopelvic disproportion.)
- Foetal abnormality (e.g., enlarged foetal head, as in hydrocephalus)
- Abnormalities of the woman's reproductive tract (e.g., tumour, stenosis of the cervix or vagina)

#### **Signs and Symptoms**

Obstructed labour is suspected when three conditions occur:

- The foetus fails to descend in the presence of good uterine contractions.
- The presenting part remains high.
- Dilatation of the cervix is slow and often incomplete.

The partograph, when filled out correctly based on periodic assessment of the mother and baby, can indicate all three of these conditions.

Over time, if obstructed labour is not managed, the following maternal manifestations may occur:

- Rapid pulse
- Maternal exhaustion
- Signs of dehydration
- Genital oedema
- Fever
- Bandl's ring
- Severe caput succedaneum

#### **Management of Obstructed Labour**

When obstructed labour occurs, providers must work quickly and prioritise the following tasks, completing the most urgent ones first.

1. **Rehydrate the woman.** The goal is to maintain plasma volume and prevent or treat dehydration and ketosis.
  - Use a large needle (number 18) or cannula to establish an I.V. flow.

- If the woman is in shock, give normal saline or Ringer's lactate. Run in 1 L as quickly as possible, then repeat 1 L every 20 minutes until the pulse slows to less than 90 beats per minute and the systolic blood pressure is 100 mm Hg or higher. If the woman has trouble breathing, reduce the IV to 1 L in four to six hours.
  - If the woman is not in shock but is dehydrated and ketotic, give 1 L rapidly and repeat if she is still dehydrated and ketotic. Then reduce to 1 L in four to six hours. Encourage the woman to empty her bladder; support her as needed.
  - Keep accurate records of urinary output and all infused IV fluids.
2. **Give antibiotics, if indicated.** If there are signs of infection, the membranes have ruptured for 18 hours or more, or the period of gestation is 37 weeks or less, give antibiotics according to the facility's guidelines.
  3. **Give supportive care.** If possible, the woman's birth companion should stay with her to provide comfort and support. Providers must explain all procedures to the woman, seek her permission for them, discuss the results with her, listen, and demonstrate sensitivity to her feelings.
  4. **Deliver the baby.** A doctor assesses the woman and the progress of labour and decides on the mode of delivery. If the foetus is alive, delivery is by caesarean section, depending on the indications. Assisted vacuum delivery may be appropriate if the woman is in the second stage of labour and meets the standard preconditions for this type of delivery.

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## **PARTICIPANT HANDOUT 2-L**

### **Partograph Case Study 2**

#### **Step 1**

- Mrs. B was admitted at 10 am on 5 December 2000.
- Hospital number 1443
- Membranes intact
- Gravida 1, para 0+0

Record the information above on the partograph, together with the following details:

- The foetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated
- There are two contractions in 10 minutes, each lasting less than 20 seconds
- FH 140
- Blood pressure 100/70
- Temperature 36.2°C
- Pulse 80 per minute
- Urine output 400 mL; negative protein and acetone

**Q: What is your diagnosis?**

**Q: What action will you take?**

#### **Step 2**

Plot the following information on the partograph:

- 10:30 am: FH 140, contractions 2/10 each 15 sec, pulse 90
- 11 am: FH 136, contractions 2/10 each 15 sec, pulse 88, membranes intact
- 11:30 am: FH 140, contractions 2/10 each 20 sec, pulse 84
- 12 noon:
  - FH 136, contractions 2/10 each 15 sec, pulse 88, temp 36.2
  - The foetal head is 5/5 palpable above the symphysis pubis.
  - The cervix is 4 cm dilated, membranes intact.

**Q: What is your diagnosis?**

**Q: What action will you take?**

### Step 3

Plot the following information on the partograph:

- 12:30 pm: FH 136, contractions 1/10 each 15 sec, pulse 90
- 1 pm: FH 140, contractions 1/10 each 15 sec, pulse 88
- 1:30 pm: FH 130, contractions 1/10 each 20 sec, pulse 88
- 2 pm
  - FH 140, contractions 2/10 each 20 sec, pulse 90, temp 36.8, blood pressure 100/70
  - The foetal head is 5/5 palpable above the symphysis pubis.
  - The cervix is 4 cm dilated. Urinary output is 300 mL; negative protein and acetone.
  - Membranes intact

**Q: What is your diagnosis?**

**Q: What action should be taken now?**

Plot the following information on the partograph:

- Artificial rupture of membranes, amniotic fluid clear
- The cervix is 4 cm dilated, skull bones separated, sutures easily felt
- Labour augmented with oxytocin 2.5 units in 500 mL IV fluid at 10 drops per minute (dpm)

### Step 4

Plot the following information on the partograph:

- 2:30 pm: 2 contractions in 10 minutes, each lasting 30 seconds; infusion rate increased to 20 dpm; FH 140, pulse 88, blood pressure 120/80
- 3 pm: 3 contractions in 10 minutes, each lasting 30 seconds; infusion rate increased to 30 dpm; FH 140, pulse 90
- 3:30 pm: 3 contractions in 10 minutes, each lasting 30 seconds; infusion rate increased to 40 dpm; FH 140, pulse 88
- 4 pm: The foetal head is 2/5 palpable above the symphysis pubis; the cervix is 6 cm dilated; 3 contractions in 10 minutes, each lasting 30 seconds; infusion rate increased to 50 dpm
- 4:30 pm: FH 140, contractions 3/10 each sec, pulse 90

**Q: What actions should be taken now?**

### Step 5

Plot the following information on the partograph:

- 5 pm: FH 138, pulse 88, contractions 3/10 each 40 sec, maintain at 50 dpm
- 5:30 pm: FH 140, pulse 90, contractions 3/10 each 45 sec, maintain at 50 dpm
- 6 pm: FH 140, pulse 90, contractions 4/10 each 50 sec, maintain at 50 dpm
- 6:30 pm: FH 144, pulse 90, contractions 4/10 each 50 sec, maintain at 50 dpm

**Step 6**

Plot the following information on the partograph:

- 7 pm:
  - The foetal head is 0/5 palpable above the symphysis pubis
  - The cervix is fully dilated
  - FH 144, contractions 4/10 each 50 sec, pulse 90

**Step 7**

Record the following information on the partograph:

- 10 pm: Spontaneous delivery of a live male infant, wt. 2.654 g

**Q: How long was the active phase of the first stage of labour?**

**Q: How long was the second stage of labour?**

**Q: Why was it necessary to augment labour?**

**Source:** World Health Organization (WHO). 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, pp. 69–70. Used by permission.

## **PARTICIPANT HANDOUT 2-M**

### **Partograph Case Study 3**

#### **Step 1**

- Mrs. C was admitted at 10 am on December 5, 2000.
- Hospital number 6639
- Membranes ruptured 9 am
- Gravida 1, para 3+0

Record the information above on the partograph, together with the following details:

- The foetal head is 3/5 palpable above the symphysis pubis.
- The cervix is 4 cm dilated.
- There are three contractions in 10 minutes, each lasting 30 seconds.
- FH: 140
- Amniotic fluid is clear.
- Sutures are apposed.
- Blood pressure: 120/70.
- Temperature: 36.8°C
- Pulse: 80 per minute
- Urine output: 200 mL; negative protein and acetone

#### **Step 2**

Plot the following information on the partograph:

- 10:30 am: FH 130, contractions 3/10 each 35 sec, pulse 80
- 11 am: FH 136, contractions 3/10 each 40 sec, pulse 90
- 11:30 am: FH 140, contractions 3/10 each 40 sec, pulse 88
- 12 noon: FH 140, contractions 3/10 each 40 sec, pulse 90, temp 37, head 3/5 up
- 12:30 pm: FH 130, contractions 3/10 each 40 sec, pulse 90
- 1 pm: FH 130, contractions 3/10 each 40 sec, pulse 88
- 1:30 pm: FH 120, contractions 3/10 each 40 sec, pulse 88
- 2 pm:
  - FH 130, contractions 4/10 each 45 sec, pulse 90, temp 37, blood pressure 100/70
  - The foetal head is 3/5 palpable above the symphysis pubis.
  - The cervix is 6 cm dilated; amniotic fluid is clear.
  - Sutures are overlapped but reducible.

### Step 3

Plot the following information on the partograph:

- 2:30 pm: FH 120, contractions 4/10 each 40 sec, pulse 90, liquor clear
- 3 pm: FH 120, contractions 4/10 each 40 sec, pulse 88, clear, bloodstained
- 3:30 pm: FH 100, contractions 4/10 each 45 sec, pulse 100
- 4 pm: FH 90, contractions 4/10 each 50 sec, pulse 100, temp 37
- 4:30 pm: FH 96, contractions 4/10 each 50 sec, pulse 100, head 3/5 up, meconium liquor
- 5 pm:
  - FH 90, contractions 4/10 each 50 sec, pulse 110
  - The foetal head is 3/5 palpable above the symphysis pubis.
  - The cervix is 6 cm dilated.
  - Amniotic fluid is meconium stained.
  - Sutures are overlapped but reducible.
  - Urine output is 100 mL; protein negative, acetone 1+.

### Step 4

Record the following information on the partograph:

- Caesarean section at 5:30 pm, live female infant with poor respiratory effort born, wt. 4.850 g

**Q: What is the final diagnosis?**

**Q: At 12 noon, what observation should have caused concern, and what other examination would have helped in deciding on a course of action?**

**Q: What action was indicated at 2 pm, and why?**

**Q: At 5 pm, a decision was taken to do a caesarean section immediately and a live female infant was delivered at 5:30 pm. Was this a correct action?**

**Q: What problems may be expected in the newborn?**

**Source:** World Health Organization (WHO). 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, pp. 74–75. Used by permission.

## **PARTICIPANT HANDOUT 2-N**

### **Referral Systems**

#### **Definition**

A *referral system* is the process in health care service delivery of transferring a client:

- From one level of care to another
- From one service provider to another
- From one service to another

The aim of referral is to ensure that clients receive necessary care, treatment, and support.

#### **Types of Referrals**

##### ***Vertical referral***

A client transfers from:

- A lower-level facility to a higher-level facility to access services that are not available at the lower level
- One provider to another provider who has a more complex scope of practise to manage a particular condition (e.g., from a midwife to a doctor)

##### ***Horizontal referral***

A client is referred to the same category of provider or service because:

- She is seeking a second opinion.
- The doctor wants to confer with a colleague.
- Services are temporarily unavailable (e.g., the doctor or midwife is away on leave).

##### ***Consultancy***

A client is referred because she requires a specialist or specialised services.

##### ***Referral to a specialised centre***

A client is referred to a centre that offers specialised services not available at other sites (e.g., a fistula care centre).

##### ***Community referral***

A client is referred from the community to a health facility, or a health facility refers a client to a community organisation (e.g., for support services or for transportation).

#### **Why Is Referral Important?**

##### ***Appropriate services***

The client obtains services that she could not receive if the referral system was not available.

##### ***Promotion of a client's recovery***

Services complement each other and promote early recovery.

##### ***Psychological benefits***

The client feels that service providers are working as a team and that they are collaborating to improve her health; hence, her emotional health is enhanced.

##### ***Diagnosis and treatment***

The likelihood of correct diagnosis and comprehensive treatment is enhanced.

### ***Specialised care***

Clients who need specialised care are able to obtain it.

### ***Continuity of care***

Clients do not fall through the cracks of the health care system.

## **Characteristics of a Functional Referral System**

Well-functioning referral systems share several key characteristics. In a quality referral system:

- Health care providers and facilities within the system share spoken and written data about the client's history and condition.
- The client receives written or graphic information about the referral, including clear instructions about how to reach the site. If the client is unable to comprehend the information (e.g., because she is unconscious), it is given to a person who will accompany her.
- Service delivery guidelines for referral exist and are used.
- A monitoring mechanism for the referral system is in place and is used.
- An easily accessible list of referral sites, locations, and contact persons for each site is used and is periodically updated.
- A mechanism for client follow-up (including assessment of how well the follow-up mechanism is functioning) is in place and is used.
- The site that receives the client:
  - Possesses the staff, skills, equipment, and facilities to provide the needed care or services.
  - Is informed in advance that the client is coming, preferably by spoken communication.
  - Communicates with the referring site about the client's status. This enables the referring site to provide continuity of care when the client returns.

## **The Role of the Community in Referral Systems for Obstetric Fistula**

Local communities play a role in the health care system as it affects pregnant women by helping them to access emergency obstetric services when they are needed. Communities can participate in and strengthen referral systems. When they are well informed about health issues that affect them, communities can:

- Improve transport and communication systems, both of which are required for effective referral
- Generate funds for the transport and care of women affected by obstetric fistula
- Set up a maternity waiting home within or just outside a health facility for women coming from a long distance
- Identify women who are likely to have pregnancy and delivery complications and organise transport for those clients in advance
- Serve as a resource for women, couples, and families as they develop their plans for births and emergencies
- Reintegrate fistula clients back into society

## **References**

Farrell, B. L. 2007. *Family planning-integrated HIV services: A framework for integrating family planning and antiretroviral therapy services*. New York: The ACQUIRE Project and EngenderHealth.

Kenya Ministry of Health, Department of Reproductive Health. 2006. *National reproductive health instructional manual for service providers*. Nairobi.

World Health Organization (WHO). 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

WHO. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva.

## PARTICIPANT HANDOUT 2-0

### Sample Blank Referral Form

Client's name	Address	
Name and designation of person making the referral	Address	
Date and time when client was first seen		
History		
Current problem		
Management		
Main reason(s) for referral		
Date/time of arrival at health centre		
Condition at time of arrival at health centre		
Blood pressure	Foetal heart rate	Bleeding: Yes/No Blood group, if known:
Emergency management given at _____ am/pm		
Any other comments:		

*Source:* World Health Organization. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, p. 102. Used by permission.

## **PARTICIPANT HANDOUT 2-P**

### **The Referral Audit**

Referral audits of facilities and providers participating in a referral system are conducted from time to time to assess how well the system is functioning. The goal of the audit is to provide information for quality improvement, not to punish or blame. Questions addressed during an audit include the following:

- How many clients were referred during the time period being examined?
- What conditions were clients referred for?
- Were the referrals necessary?
- Were clients referred in a timely manner?
- Were referrals not made when they should have been?
- Was transportation available for clients who were referred?
- Were some facilities more likely to refer than others? If so, why?
- Did the referring facility inform the receiving facility in advance?
- Did the receiving facility receive the written medical records needed to provide care for the referred client?
- Did the receiving facility possess the staff, skills, facilities, and equipment needed to care for the referred client?
- Did the receiving facility provide needed care in a timely manner?
- Did the receiving facility provide information to the referring facility for continuity of care?
- Are protocols in place for referring facilities and receiving facilities?
- Are staff knowledgeable about referral procedures?
- Is the community knowledgeable about referral procedures?
- Does the community participate in the referral system?
- Does any aspect of the referral system or health care services need to be improved?
- How can improvements be achieved?

#### **Sources for the Referral Audit**

- Medical records, registers, and monthly statistical reports
- National, district, and local health care officials
- Staff members at participating facilities
- Transportation staff
- Community health personnel
- Community members

## **PARTICIPANT HANDOUT 2-Q**

### **The Referral Audit: Exercise**

Listed below are selected findings from a referral audit. None of the facilities listed below is equipped to provide emergency obstetric care. As you review the information, consider these questions:

1. Were referrals appropriate?
2. Which actions would you recommend?

#### **Primary Health Care Facility 1**

Referred three cases during the year:

1. Client A, a 22-year-old primigravida, arrived at the facility with membranes intact, cervical dilatation of 4 cm, and the foetal head at 3/5. At the facility, her labour exceeded four hours (beyond the alert line on the partograph), with cervical dilatation of 6 cm and no change in the descent of the foetal head. The facility referred her to a higher-level facility.
2. Client B, a 30-year-old primigravida, arrived at the facility during the latent phase of labour. Contractions were regular, but the cervix had not dilated beyond 4 cm after nine hours. The midwife referred her to a higher-level facility.
3. Client C was 28 years old, para 2. Contractions were sluggish in the active phase, with the cervix remaining at 5 cm for three hours. The partograph indicated that the foetal head had moved from 3/5 to 4/5, but had remained at 4/5 without descending, though moulding (+). During the last vaginal exam, the midwife felt some swelling in the foetal scalp (known as caput succedaneum). The midwife referred Client C to a higher-level facility.

#### **Primary Health Care Facility 2**

Referred two cases during the year.

1. Client D was a 16-year-old primigravida. During the active phase of labour, the cervix dilated from 4 cm to 6 cm in an eight-hour period. When the membranes ruptured and were lightly meconium stained, the facility referred her to a higher-level facility.
2. Client E was 35 years old, with three prior births. She had irregular contractions for 15 hours at home. Sometimes she would change position and the contractions would stop; she was tired and eager to give birth. When Client D came to the clinic, her cervix was soft but had not dilated. The clinic referred her to a higher-level facility.

#### **Primary Health Care Facility 3**

Did not refer any cases during the year and did not respond to the request for information.

## **PARTICIPANT HANDOUT 2-R**

### **Has a Client Recently Experienced Prolonged or Obstructed Labour? Factors to Consider**

#### **History**

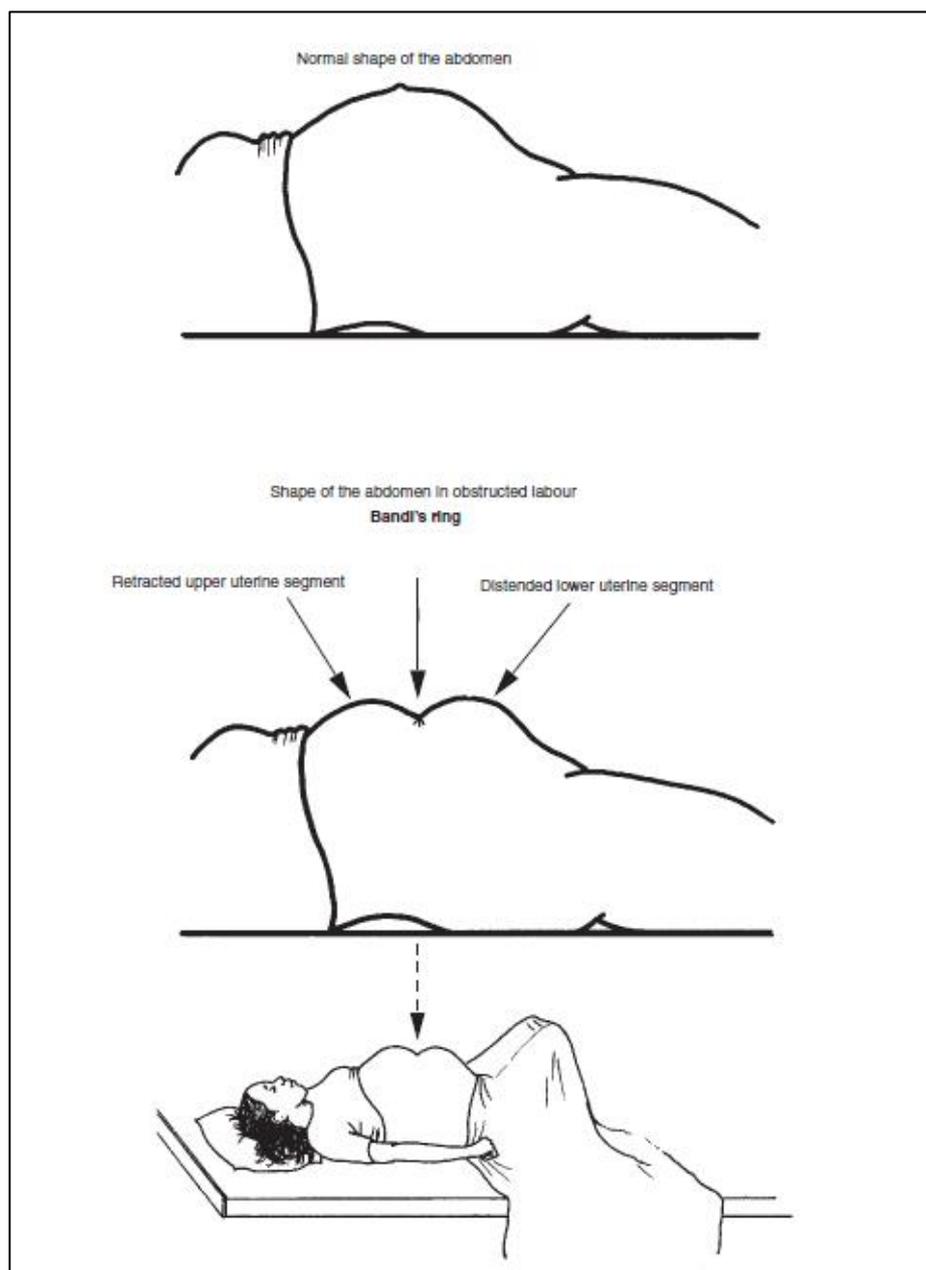
- What is the client's age?
- How many pregnancies has the woman had?
- When did labour start?
- Have the waters broken? If yes, when?
- Does the vaginal discharge have a foul smell?
- What was the outcome of any previous pregnancies (e.g., previous operative birth, stillbirth)?
- Is there any history of pelvic accident or conditions that would cause deformity?

#### **Physical Examination/General and Vital Signs**

- Signs of mental exhaustion
- Signs of physical exhaustion
- Dehydration (dry mouth, sunken eyes, skin slowly returns to flesh when pinched, scanty urinary output)
- Elevated temperature
- Persistent abdominal pain/discomfort
- Shock, which may be due to sepsis or uterine rupture (weak, rapid pulse, >100 bpm; cold, clammy skin; pallor; low blood pressure, systolic <90; confusion; disorientation; unconsciousness)

#### **Abdominal Examination**

- The widest diameter of the foetal head is above the pelvic brim.
- A large caput succedaneum may be fixed in the pelvic brim, making it difficult to determine if the foetal head is engaged.
- Uterus may be tonic (continuously hard) from frequent, long contractions (or contractions may have stopped if the woman or the uterus is exhausted).
- The woman's bladder may be distended.
- If the woman is still in labour, Bandl's ring (retraction ring) may be seen in the area between the upper and lower uterine segments (see the diagram on page 121). It appears as a depression at the level of the woman's umbilicus. The grossly thickened, retracted upper uterine segment is above the depression. Below the Bandl's ring is the distended, dangerously thinned lower uterine segment. Bandl's ring is a late sign of obstructed labour.
- In severe obstruction, when the foetus has died in utero from anoxia, the foetal heart tone is not heard.



**Source:** World Health Organization. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, p. 51. Used by permission.

### Vaginal Examination

- Foul-smelling fluid coming from the vagina
- When catheterised, concentrated urine with blood or meconium
- Vulvar oedema
- Dry vagina from dehydration
- Cervical oedema if woman has pushed for a long time
- Significant caput succedaneum
- Malpresentation of a foetal part (brow, shoulder, face) or prolapsed foetal part (e.g., arm)

### Reference

World Health Organization (WHO). 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery*. 2nd ed. Geneva, pp. 48–50.

## **PARTICIPANT HANDOUT 2-S**

### **Preventing Obstetric Fistula: Managing Clients Who Have Recently Experienced Prolonged or Obstructed Labour**

The aim of managing clients who have experienced prolonged or obstructed labour is to prevent fistula formation or to encourage the spontaneous closure of very small fistula. Management is the same regardless of whether the client has delivered vaginally or by caesarean section.

#### **Management**

- An indwelling catheter, preferably size 16 to 18, is inserted to encourage free drainage of urine.
- The catheter is usually inserted immediately when the client presents with prolonged or obstructed labour and before caesarean section.
- The length of time for catheterisation varies. If there is a very small healing fistula, the catheter is usually kept in place for four to six weeks. If there is no apparent damage, it may be possible to remove the catheter after 14 days.
- Twice a day the perineum and vagina are cleansed with salty water (sitz baths) or a solution of mild detergent in water.
- The staff encourage the woman to drink a large volume of fluids, around 4 to 5 L a day.
- On admission of the client, a speculum examination is performed as soon as possible. If necrotic tissue is present, it is usually left to separate; when this happens, the edges separate and rise above the other tissue. If there is any remaining loose necrotic tissue, it is trimmed off. Many fistula surgeons attest that this tissue lacks nerves and a woman feels no pain if it is trimmed off. The speculum examination and any trimming of necrotic tissue should be done under aseptic conditions.
- If necrotic tissue is present, speculum examination and excision may need to be repeated until the vagina is clean.
- If the woman has any infection, it is treated according to local protocol.
- If required by local protocol, routine prophylaxis against urinary tract infections is given.
- If treatment is successful and before the woman is discharged, she is educated and counselled about the need for family planning, antenatal care in future pregnancies, and delivery in the future at a facility that can safely perform caesarean section (see Module 5). If possible, her husband attends the education session.

Participant Handout 3-F describes how to insert a urinary catheter. Participant Handout 3-M describes how to manage a catheter.

#### **References**

Hancock, B., and Browning, A. 2009. *Practical obstetric fistula surgery*. London: Royal Society of Medicine Press.

Hinrichsen, D. 2004. Obstetric fistula: Ending the silence, easing the suffering. *Info Reports* no. 2. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.

World Health Organization (WHO). 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## TRAINER'S RESOURCE 2-I

### Module 2 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select approximately 20 relevant questions from this list for the Module 2 Pretest and Posttest. The correct answers are shown below in **boldface**, and the source of the correct answer is shown in [brackets].

1. Women who have more than one risk factor for obstetric fistula will develop obstetric fistula.
  - a. True
  - b. False**[Participant Handout 2-B]
  
2. Unexplained stillbirth in a previous pregnancy is a risk factor for obstetric fistula.
  - a. True**
  - b. False[Participant Handout 2-B]
  
3. According to the World Health Organization, most women who receive four focused antenatal care visits will have good pregnancy outcomes.
  - a. True**
  - b. False[Participant Handout 2-D]
  
4. Regular contractions are a sign of true labour.
  - a. True**
  - b. False[Participant Handout 2-E]
  
5. Foetal descent begins in the second stage of labour.
  - a. True
  - b. False**[Participant Handout 2-E]
  
6. Which of the following signs indicate the second stage of labour, late phase?
  - a. Cervix dilated 8 cm, foetal descent continues
  - b. Cervix dilated 10 cm, presenting part reaches pelvic floor**
  - c. Cervix dilated 10 cm, woman has no urge to push[Participant Handout 2-E]
  
7. During labour, why is an abdominal examination always done before a vaginal examination?

**To identify scarring, evidence of cesarean section, and Bandl's ring**

[Participant Handout 2-F]

8. Which symbol do you use on the partograph to indicate that the bones of the foetal head are just touching each other?
- 0
  - +**
  - ++
  - +++

[Participant Handout 2-F]

9. On the partograph, plotting of cervical dilatation begins at \_\_\_\_\_ cm.
- 4**
  - 6
  - 8

[Participant Handout 2-F]

10. During the latent phase of the first stage of labour, the cervix should reach \_\_\_\_\_ cm of dilatation within eight hours.

- 3
- 4**
- 5

[Participant Handout 2-F]

11. The portion of the foetal head above the brim is at \_\_\_\_\_ fingers' width or less; this means the head is probably engaged.

- 2**
- 3
- 4

[Participant Handout 2-F]

12. On the partograph, what do diagonal lines represent?

- Mild contractions lasting less than 20 seconds
- Moderate contractions lasting 20 to 40 seconds**
- Strong contractions that last longer than 40 seconds

[Participant Handout 2-F]

13. During labour, how often does the provider check the woman's blood pressure?

- Every hour
- Every two hours
- Every four hours**

[Participant Handout 2-F]

14. What are the normal limits of a woman's pulse during labour?

- 50 to 80
- 60 to 90**
- 70 to 100

[Participant Handout 2-F]

15. How often does the provider encourage a woman to pass urine during labour?

- Every two hours**
- Every three hours
- Every four hours

[Participant Handout 2-F]

16. When findings on the partograph reach the action line, the nurse or midwife consults a doctor or refers the client without delay according to local protocol.
- a. **True**
  - b. False
- [Participant Handout 2-F]
17. How often are vaginal examinations done during labour?
- a. Approximately every three hours
  - b. **Approximately every four hours**
  - c. Approximately every five hours
- [Participant Handout 2-F]
18. The latent phase of labour is prolonged when it exceeds \_\_\_\_\_ hours.
- a. 6
  - b. **8**
  - c. 12
- [Participant Handout 2-J]
19. The three Ps stand for \_\_\_\_\_.
- Powers, Passenger, Passage**
- [Participant Handout 2-J]
20. Abnormal foetal position can cause prolonged labour.
- a. **True**
  - b. False
- [Participant Handout 2-J]
21. What is the first step to take if the active phase of labour is prolonged?
- a. Rupture the membranes
  - b. **Assess uterine contractions**
  - c. Augment labour with oxytocin
- [Participant Handout 2-J]
22. During the prolonged expulsive phase of labour, maternal pushing can reduce delivery of oxygen to the placenta.
- a. **True**
  - b. False
- [Participant Handout 2-J]
23. What is the first step to take to manage obstructed labour?
- a. **Rehydrate the woman**
  - b. Give antibiotics
  - c. Deliver the baby
- [Participant Handout 2-K]
24. Referral from a lower-level facility to a higher-level facility is an example of vertical referral.
- a. **True**
  - b. False
- [Participant Handout 2-N]

25. Name at least three sources of information for a referral audit.

Possible responses include:

- **Medical records, registers, and monthly statistical reports**
- **National, district, and local health care officials**
- **Staff members at participating facilities**
- **Transportation staff**
- **Community health personnel**
- **Community members**

[Participant Handout 2-P]

26. Describe at least two ways in which the community can participate in the referral system.

Possible responses include:

- **Help improve transport and communication systems, both of which are required for effective referral**
- **Help generate funds for the transport and care of women affected by obstetric fistula**
- **Set up a maternity waiting home within or just outside a health facility for women coming from a long distance**
- **Identify women who are likely to have pregnancy and delivery complications and organise transport for those clients in advance**
- **Serve as a resource for women, couples, and families as they develop their plans for births and emergencies**
- **Reintegrate fistula clients back into society**

[Participant Handout 2-N]

27. Check all the signs below that may indicate the woman has recently experienced prolonged or obstructed labour.

- \_\_\_\_\_ **Mental exhaustion**  
\_\_\_\_\_ Slow pulse  
\_\_\_\_\_ High blood pressure  
\_\_\_\_\_ **Weak, rapid pulse**  
\_\_\_\_\_ **Low blood pressure**  
\_\_\_\_\_ Moist vagina  
\_\_\_\_\_ **Foul-smelling vaginal discharge**

[Participant Handout 2-R]

28. To help prevent obstetric fistula, providers encourage women who have experienced prolonged or obstructed labour to drink around \_\_\_\_\_ L of fluid a day.

- a. 2 to 3
- b. 4 to 5**
- c. 6 to 8

[Participant Handout 2-S]

29. If a provider suspects that a woman has recently experienced prolonged labour, she inserts an indwelling catheter after observing the client for 24 hours.

- a. True
- b. False**

[Participant Handout 2-S]

30. If a provider suspects that a woman has recently experienced obstructed labour, she is admitted and a speculum examination is performed as soon as possible.

**a. True**

b. False

[Participant Handout 2-S]

**TRAINER'S RESOURCE 2-2**  
**Identifying Risk Factors for Obstetric Fistula during**  
**Pregnancy: Case Studies:**  
**Answer Key**

Underscores indicate risk factors for prolonged or obstructed labour.

Emphasise to the participants that presence of a risk factor does not mean that a woman will experience prolonged or obstructed labour.

**Case 1: Tigrest**

1. Tigrest was married at 12.
2. She lives in a remote village.
3. Tigrest is not literate and has never been to school.
4. Tigrest became pregnant at age 14.

**Case 2: Pendo**

1. Pendo is 17.
2. She is poor.
3. She is malnourished.
4. She has had had one previous pregnancy, which ended in stillbirth.
5. Pendo has had female genital cutting.

**Case 3: Aberesh**

1. Aberesh is 25.
2. She has had two previous pregnancies, both of which resulted in the safe delivery of two healthy babies.
3. In one of her pregnancies, Aberesh had high blood pressure.

*Note:* Aberesh does not have risk factors for prolonged or obstructed labour. Nevertheless, she may still experience these conditions.

**Case 4: Naneye**

1. Naneye is 16.
2. She has a contracted pelvis.
3. Naneye has had one previous pregnancy, during which she endured prolonged labour.

**TRAINER'S RESOURCE 2-3**  
**Sample Pledge:**  
**Providing Focused Antenatal Care**

I pledge:

- To provide focused antenatal care to the women I serve
- To work to overcome challenges to antenatal care
- To educate girls and women and their communities about the importance of antenatal care and skilled care during labour and delivery

## **TRAINER'S RESOURCE 2-4**

### **Signs and Stages of Labour: Exercise**

#### **Signs of Labour**

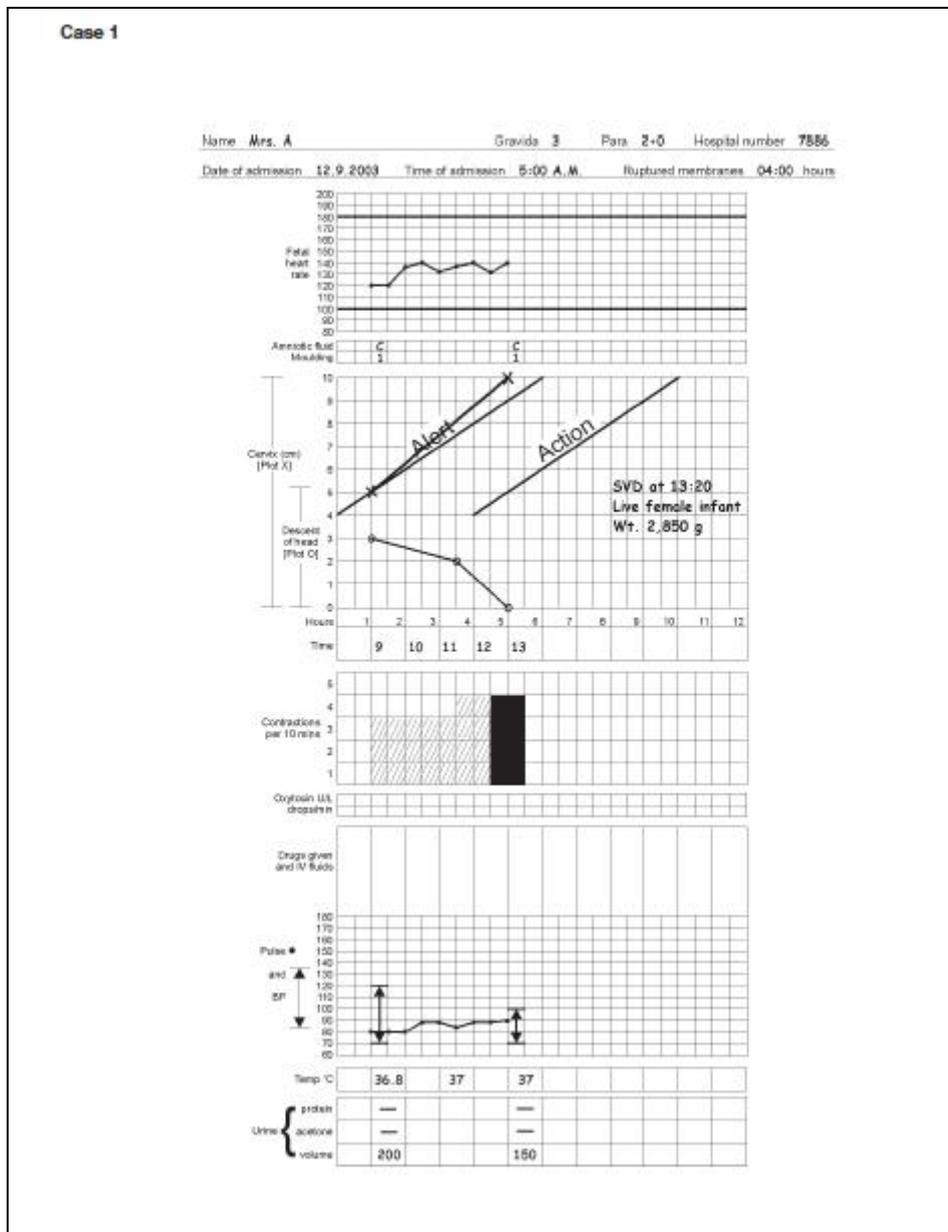
1. The dilation of the cervix is 5 cm. (True sign)
2. The amniotic sac is leaking. (True sign)
3. Contractions are painful and irregular. (False sign)
4. Contractions stop when the woman changes her position. (False sign)
5. The woman notices bloody show. (True sign)
6. Contractions are regular and last more than 30 seconds. (True sign)
7. The hardening of the uterus is palpable. (True sign)

#### **Phases and Stages of Labour**

1. The woman feels no urge to push. (Stage: second; phase: early)
2. Foetal descent begins. (Stage: first; phase: active)
3. The dilatation of the cervix is 3 cm. (Stage: first; phase: latent)
4. The woman feels the urge to push. (Stage: second; phase: late)
5. The placenta is expelled. (Stage: third; no phase)
6. The cervix is dilating at a rate of 1 cm per hour. (Stage: first; phase: active)
7. The presenting part of the foetus reaches the pelvic floor. (Stage: second, phase: late)

## TRAINER'S RESOURCE 2-5

### Partograph Case Study I: Answer Key (Normal Labour)



*Source:* World Health Organization. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery—Midwifery education modules*, 2<sup>nd</sup> ed. Geneva, pp. 76–77

**Step 1**

**Q.** What should you record on the partograph?

**A.** See partograph for Case 1.

**Step 2**

**Q.** What should you now record on the partograph?

**A.** See partograph for Case 1.

**Q:** What steps should be taken?

**A:** Inform Mrs. A of the findings and tell her what to expect; encourage her to ask questions; provide comfort measures, hydration, and nutrition.

**Q:** What advice should be given?

**A:** Advise Mrs. A. to assume her position of choice, drink plenty of fluids, and eat as desired.

**Q:** What do you expect to find at 1 pm?

**A:** Progress to at least 8 cm dilatation

**Step 3**

**Q:** What steps should be taken?

**A:** Prepare for the birth.

**Q:** What advice should be given?

**A:** Advise Mrs. A to push only when she has the urge to do so.

**Q:** What do you expect to happen next?

**A:** Spontaneous vertex delivery

**Step 4**

**Q:** How long was the active phase of the first stage of labour?

**A:** Five hours

**Q:** How long was the second stage of labour?

**A:** Twenty minutes

**TRAINER'S RESOURCE 2-6**  
**Prolonged Labour and Obstructed Labour:**  
**Quiz—Answer Key**

**Q:** If a woman's labour lasts longer than 24 hours, she is in prolonged labour. True or false?

**A:** True

**Q:** Obstruction most often occurs at the outlet of the pelvis. True or false?

**A:** False; obstruction most often occurs at the pelvic brim.

**Q:** What do the three Ps stand for?

**A:** Powers, Passenger, and Passage

**Q:** A woman has been in the latent phase for more than eight hours and there is little sign of progress, but cervical effacement and dilatation have been progressing. What does the provider do?

**A:** The provider ruptures the membranes with an amniotic hook or a Kocher clamp and induces labour. The woman is assessed every four hours. If she has not entered the active phase of labour after eight hours of induction, she is delivered by caesarean section.

**Q:** Abnormal presentation of the shoulder can be a cause of obstructed labour. True or false?

**A:** True

**Q:** If a woman is in obstructed labour, the first management step is to give antibiotics. True or false?

**A:** False. The first step is to rehydrate the woman.

**Q:** Which of the contractions below are considered efficient?

A: Two contractions in 10 minutes, each lasting 30 seconds

B. Three contractions in 10 minutes, each lasting 40 seconds [Correct]

C: Three contractions in 10 minutes, each lasting 25 seconds

**A:** Choice B is the correct answer.

**Q:** Providers should encourage the woman to hold her breath when pushing. True or false?

**A:** False. Holding the breath can reduce the delivery of oxygen to the placenta.

**Q:** Cephalopelvic disproportion can be the result of a small pelvis with a foetal head of normal size. True or false?

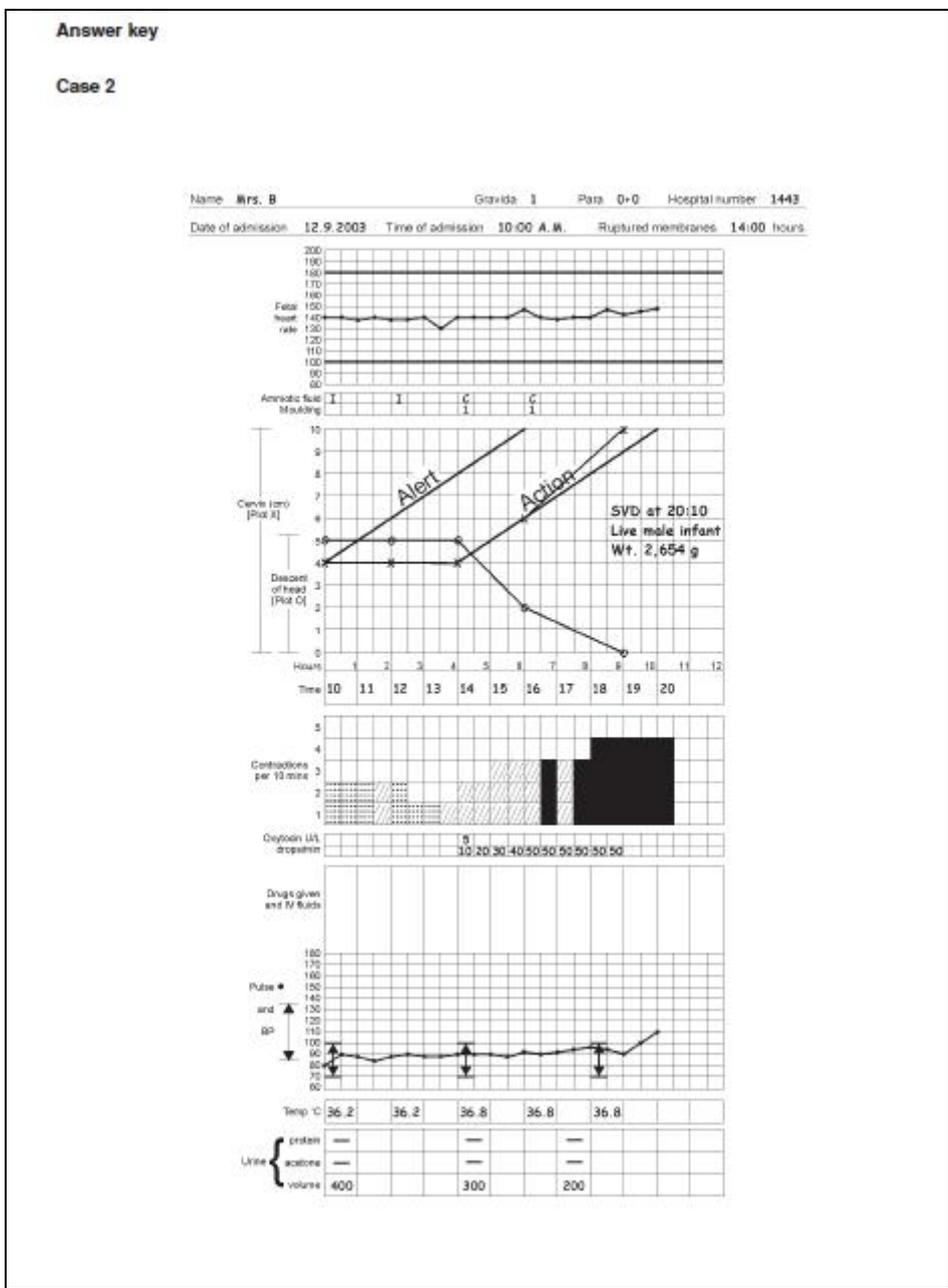
**A:** True

**Q:** During the latent phase of labour, there is little or no descent of the presenting part. True or false?

**A:** True

## TRAINER'S RESOURCE 2-7

### Partograph Case Study 2: Answer Key (Prolonged Labour)



**Source:** World Health Organization. 2008. *Managing prolonged and obstructed labour. Education materials for teachers of midwifery: Midwifery education modules*, 2<sup>nd</sup> ed., pp. 78–79.

**Step 1**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Q.** What is your diagnosis?

**A.** Mrs. B is in active labour.

**Q.** What action will you take?

**A.** Inform Mrs. B of findings and what to expect; encourage her to ask questions; encourage her to be mobile and to drink and eat as desired.

**Step 2**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Q.** What is your diagnosis?

**A.** Failure to progress; poor uterine action, but good foetal and maternal condition.

**Q:** What action will you take?

**A:** Inform Mrs. B of findings and what to expect; continue to encourage her to ask questions; continue to encourage her to be mobile and to drink and eat as desired; make preliminary plans for surgical intervention should this be necessary, or refer to a facility where this is possible.

**Step 3**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Q:** What is your diagnosis?

**A:** Failure to progress; poor uterine action, although improved at 2 pm; foetal and maternal condition continues to be good.

**Q:** What action should be taken now?

**A:** Labour should be augmented with oxytocin following artificial rupture of membranes; inform Mrs. B of findings and what to expect; provide reassurance and support; answer questions; encourage her to drink and assume her position of choice.

**Step 4**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Q:** What action should be taken now?

**A:** Labour should be augmented with oxytocin; continue to provide reassurance, comfort, and support; continue oxytocin augmentation; provide comfort (psychological and physical); encourage drink and nutrition.

**Step 5**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Step 6**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Step 7**

Ask the participants to compare the recordings on their partographs with the partograph for Case 2.

**Q:** How long was the active phase of the first stage of labour?

**A:** Nine hours

**Q:** How long was the second stage of labour?

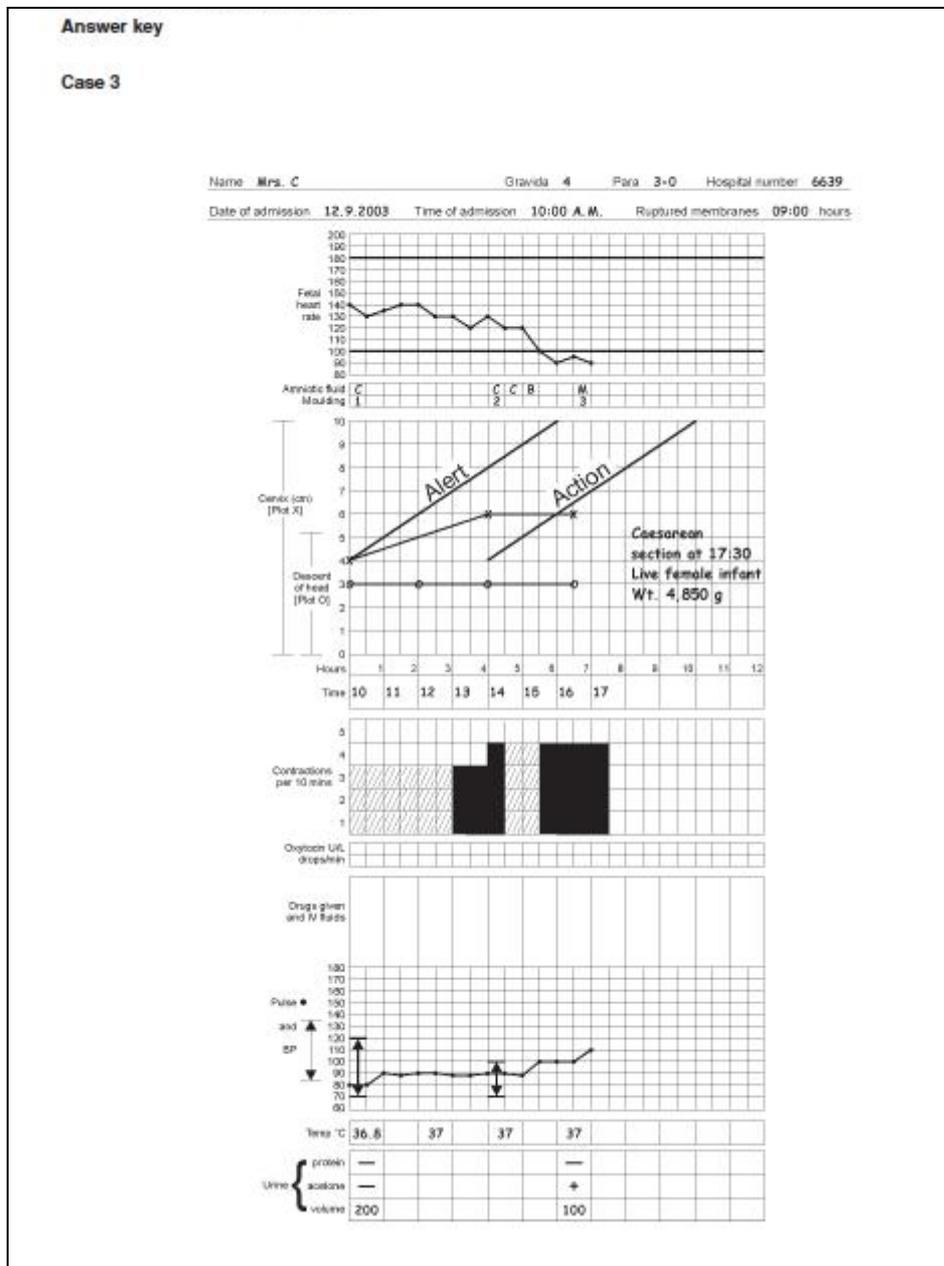
**A:** One hour, 10 minutes

**Q:** Why was it necessary to augment labour?

**A:** Mrs. B failed to progress in labour because of poor uterine action.

## TRAINER'S RESOURCE 2-8

### Partograph Case Study 3: Answer Key (Obstructed Labour)



**Source:** World Health Organization (WHO). 2008. *Managing prolonged and obstructed labour. Education materials for teachers of midwifery: Midwifery education modules*, 2<sup>nd</sup> ed. Geneva. pages 80–81.

**Step 1**

Ask the participants to compare the recordings on their partographs with the partograph for Case 3.

**Step 2**

Ask the participants to compare the recordings on their partographs with the partograph for Case 3.

**Step 3**

Ask the participants to compare the recordings on their partographs with the partograph for Case 3.

**Step 4**

Ask the participants to compare the recordings on their partographs with the partograph for Case 3.

**Q:** What is the final diagnosis?

**A:** Failure to progress (obstructed labour)

**Q:** At 12 noon, what observation should have caused concern and what other examination would have helped in deciding on a course of action?

**A:** The head remained three-fifths above the symphysis pubis, despite adequate contractions. A vaginal examination to assess cervical dilatation and assessment of moulding would have been appropriate at this time, even though the last one had been done two hours before.

**Q:** What action was indicated at 2 pm, and why?

**A:** Caesarean section should have been considered at this time because cervical dilatation was slow, and there had been no further descent of the head, despite good contractions.

**Q:** At 5 pm, a decision was taken to do a caesarean section immediately, and a live female infant was delivered at 5:30 pm. Was this a correct action?

**A:** Yes, because the foetal condition was deteriorating and labour had failed to progress despite strong contractions; in addition, Mrs. C's pulse was rising and there was acetone in her urine.

**Q:** What problems may be expected in the newborn?

**A:** Birth asphyxia, meconium aspiration

<p style="text-align: center;"><b>TRAINER'S RESOURCE 2-9</b> <b>The Referral Audit: Exercise—Answer Key</b></p>
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**Primary Health Care Facility 1**

1. Client A: appropriate referral for prolonged active phase of labour and failure of the presenting part to descend
2. Client B: appropriate referral for prolonged latent phase of labour
3. Client C: appropriate referral for obstructed labour

**Primary Health Care Facility 2**

1. Client D: Appropriate referral for prolonged active phase of labour was made, but referral should have been made six hours earlier. Action: Review referral protocols with facility staff.
2. Client E: inappropriate referral; false labour. Action: Review signs of false labour with facility staff.

**Primary Health Care Facility 3**

Actions: Contact the facility manager; ask about referrals and why the site did not respond to the request for information. Visit the facility and conduct a record review. Review protocols for referrals with facility staff.



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# MODULE 3: MANAGEMENT OF OBSTETRIC FISTULA

## Introduction

Nurses and midwives play a major role in the care of women who live with obstetric fistula and seek health care. They are responsible for many of the procedures that help prevent infection at all stages of the client's treatment. Nurses and midwives often perform the initial assessment of women living with obstetric fistula. They also manage clients who present early. For women who decide to undergo repair surgery, nurses and midwives perform preoperative care, assist in the operating theatre, and care for the client after surgery. Catheter management is an important nursing function.

## Prerequisites

- Successful completion of modules 1 and 2 of this curriculum (or equivalent knowledge and experience)
- Basic competence in the following areas, acquired either through course work or practical experience:
  - Infection prevention
  - History taking
  - Physical examination of a woman
  - Digital examination of the vagina
  - Speculum examination of the vagina
  - Record keeping
  - Insertion and care of an indwelling catheter
  - Informed consent for surgical procedures
  - Preparing a client for surgery
  - Nursing skills in the operating theatre
  - Postoperative care
  - Development of nursing care plans
  - Client discharge and follow-up

## Module Objectives

Upon completion of this module, the participants will be able to:

- Describe how infections can be transmitted
- Identify factors associated with infection transmission for clients living with obstetric fistula
- List seven standard infection prevention precautions
- Demonstrate knowledge of instrument processing
- Demonstrate how to aseptically insert a urinary catheter, taking precautions to minimise trauma and to prevent infection
- Outline correct disposal methods for fistula care waste
- Correctly take the history of a client living with obstetric fistula
- Describe the elements and range of findings of the initial physical examination for a client living with obstetric fistula
- Describe how to inspect the external female genitalia and thighs of a client living with obstetric fistula
- Describe how to perform a gentle digital vaginal examination and a vaginal speculum examination on a client living with obstetric fistula

- Record assessment findings in appropriate forms and registers
- Describe the management of fistula clients who present immediately after delivery
- Describe the management of clients following insertion of an indwelling catheter
- Describe admission procedures for clients living with obstetric fistula
- Explain the informed consent process, including use of the sample form
- Describe how to prepare a client with obstetric fistula for repair surgery
- Describe nursing management of the client with fistula during repair surgery
- Explain the responsibilities of the scrub nurse and the circulating nurse that are important or unique to fistula repair surgery
- Correctly set the trolley for fistula repair surgery
- Describe postoperative care within and beyond the first 24 hours after surgery
- Describe nursing management of selected complications after repair of obstetric fistula: blocked catheter, vaginal haemorrhage, wound sepsis, breakdown of repair, and anuria
- Describe how to discharge a client, provide discharge counselling, and arrange for follow-up care

### Overview of Module Content

Sessions/Parts	Total time
1. Infection Prevention	Varies <sup>1</sup>
A. Principles of Infection Prevention	1 hour
B. Infection Prevention in Practise	Time varies
2. Assessing Clients Living with Obstetric Fistula	2 hours, 30 minutes
A. History and Initial Physical Assessment	1 hour
B. Inspection of External Genitalia and Thighs, and Vaginal Examination	1 hour, 30 minutes
3. Managing Clients Who Present with Fistula Immediately after Delivery	Up to 1 hour, 45 minutes <sup>2</sup>
A. Management Principles	15 minutes
B. Management of an Indwelling Catheter	20 minutes to 1 hour, 30 minutes
4. Preoperative Care of Clients Undergoing Fistula Repair	1 hour, 25 minutes
A. Admission Procedures	15 minutes
B. Informed Consent and Preoperative Care	1 hour, 10 minutes
5. Management of Clients with Obstetric Fistula during Repair Surgery	1 hour, 10 minutes, to 1 hour, 40 minutes <sup>3</sup>
6. Postoperative Management of Clients after Surgical Repair of Obstetric Fistula	3 hours, 10 minutes (excluding practicum)
A. Postoperative Care and Complications	1 hour, 30 minutes
B. Discharge and Follow-Up	1 hour
C. Module 3 Evaluation	40 minutes
<b>Total time</b>	<b>11 hours or more</b>

1. Depending upon the participants' ability to perform urinary catheterisation and the time needed for the practicum (see Training Steps)
2. Depending upon the participants' knowledge of catheter management (see Training Steps)
3. Depending upon the activities chosen (see Training Steps)

### Evaluation

- Trainer's Resource 3-1: Module 3 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select 10 to 15 relevant questions from Trainer's Resource 3-1 for the Module 3 Pretest and Posttest.

## SESSION I

### Infection Prevention

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Describe how infections can be transmitted
- Identify factors associated with infection transmission for clients living with obstetric fistula
- List seven standard infection prevention precautions
- Demonstrate knowledge of instrument processing
- Demonstrate how to aseptically insert a urinary catheter, taking precautions to minimise trauma and to prevent infection
- Outline correct disposal methods for fistula care waste

#### POINTS TO REMEMBER

- Clients living with obstetric fistula are at high risk for infection. Thus, infection prevention is critical in their care.
- Infections contracted by clients living with obstetric fistula include urinary tract infections, dermatitis, kidney infections, and ascending infections after insertion of an indwelling catheter.

#### Training Methods

- Presentation
- Discussion
- Pair exercise
- Homework
- Quiz
- Assessment
- Simulation practise
- Demonstration
- Game
- Practicum

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Part B, Activity 2: Pelvic models, equipment, and supplies for urinary catheterisation
- Part B, Activity 3: Items for waste disposal game (Trainer's Resource 3-3), prize(s) for winning team(s)
- Participant Handout 3-A: How Infections Are Transmitted
- Participant Handout 3-B: Infection Risks among Clients Living with Obstetric Fistula
- Participant Handout 3-C: Infection Prevention: Standard Precautions
- Participant Handout 3-D: Infection Prevention: Instrument Processing
- Participant Handout 3-E: Urinary Catheterisation: Assessment
- Participant Handout 3-F: Urinary Catheterisation

- Participant Handout 3-G: Medical Waste in Fistula Care Services: Disposal Methods on the Unit
- Trainer’s Resource 3-1: Module 3 Evaluation and Answer Key (if conducting a pretest)
- Trainer’s Resource 3-2: Infection Prevention: Instrument Processing—Quiz
- Trainer’s Resource 3-3: Urinary Catheterisation: Assessment: Answer Key
- Trainer’s Resource 3-4: Fistula Care Services: Disposal of Medical Waste

### Advance Preparation

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 3-A, 3-B, 3-C, 3-D, 3-E, 3-F, and 3-G.
4. Duplicate Participant Handouts 3-A, 3-B, 3-C, 3-D, 3-E, 3-F, and 3-G for the participants.
5. Give all homework assignments before the training activities begin.
6. Part B, Activity 2: Determine how you will review and/or teach urinary catheterisation. The activity chosen depends upon the skills of the participants, the number of participants, and the number of pelvic models available. You will need one pelvic model for every four to five participants. Obtain the supplies and equipment needed for the activity.
7. Part B, Activity 3: Obtain samples of the items listed in Trainer’s Resource 3-4. **Important: The items should not be contaminated in any way; they are for illustrative purposes only.** Obtain a prize to give to the winning team (e.g., pieces of candy). Be sure to have extras in case there is a tie.
8. Part B, Activity 4: Arrange for the practicum.

#### TRAINING TIPS

Part B, Activity 2 includes an assessment of the participants’ knowledge of urinary catheterisation. The length of the activity will vary, depending upon what the participants already know. Take this into account as you plan the training schedule.

*Infection Prevention: A Reference Booklet for Health Care Providers*, available on EngenderHealth’s web site ([www.engenderhealth.org](http://www.engenderhealth.org)), is an excellent resource for this module. If participants do not have access to the Internet, consider duplicating copies of the information for them or obtaining copies of *Infection Prevention* from EngenderHealth.

**Session Time (total):** Varies, depending upon the time required for Part B, Activity 2, and for the practicum

## SESSION I

### Training Steps

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#### **PART A: PRINCIPLES OF INFECTION PREVENTION**

**Time:** 1 hour

##### **Activity 1: Presentation and Discussion (Review) (15 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of the session is review *the principles of infection prevention*. Ask the participants what questions they have about the session objectives.
3. Ask the participants how infections are transmitted and how they can be prevented.
4. Summarise the activity, recognising the participants' contributions. Add any points that the group has not addressed, using Participant Handout 3-A as a reference. Ask the participants if they have any questions. Emphasise that:
  - When a woman has fistula, infection can be transmitted in two ways: (a) Normal flora are introduced into an area of the body where they are not normally found; or (b) pathogens are introduced into the body.
  - Infection prevention is critical for fistula clients because they are at high risk for infection.
 At the end of the activity, distribute copies of the handout to the group.

##### **Activity 2: Pair Exercise (20 minutes)**

1. Place the participants in pairs. Ask them to identify factors that put women living with fistula at risk for infection and the types of infections the women are likely to contract. Give each pair five minutes to work.
2. Convene the larger group. Ask volunteers to call out a factor or a type of infection and to avoid repeating what has already been said.
3. Summarise the activity, recognising the participants' contributions. Add any points that the group has not addressed, using Participant Handout 3-B as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

##### **Activity 3: Discussion and Presentation (Review) (25 minutes)**

1. Ask the participants to list seven standard precautions for infection prevention. Record the precautions on a sheet of flipchart paper.
2. Summarise the activity, recognising the participants' contributions. Add any points that the group has not addressed, using Participant Handout 3-C as a reference.
3. Ask the participants to provide examples of how the standard precautions apply to obstetric fistula. Sample responses include:
  - Wash your hands before and after inserting a urinary catheter.
  - Wear sterile gloves when inserting a urinary catheter.
  - Wear a mask if you are likely to cough during urinary catheterisation.
  - Follow infection prevention procedures during repair surgery.
  - Follow infection prevention procedures when using sharps.
  - Process reusable items using the four-step instrument processing procedure: decontamination, cleaning, sterilisation or high-level disinfection, and use or storage (see Participant Handout 3-D).

- Dispose of items in appropriately labeled receptacles and away from possible contact with others.
4. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout.

## **PART B: INFECTION PREVENTION IN PRACTISE**

**Time:** Varies, depending on time required for Activity 2 and practicum

### **Activity 1: Homework and Quiz (30 minutes for quiz)**

1. As a homework assignment, ask the participants to study Participant Handout 3-D on instrument processing.
2. Using Trainer's Resource 3-2, ask the group to respond to the quiz questions.
3. At the end of the quiz, ask the participants if they have any questions.

### **Activity 2:**

**Option 1:** Assessment, Simulation Practise

**Option 2:** Homework, Demonstration, Simulation Practise (time for this activity will vary depending upon the knowledge and skills of the participants)

#### **TRAINING TIP**

Some medical institutions now post training videos online. If you wish, obtain an online video or another type of video that shows the proper way to perform urinary catheterisation, according to the protocols of your institution. Show this video during Part B, Activity 2.

### **Option 1**

1. Distribute copies of Participant Handout 3-E, and ask the participants to respond to the assessment questions. They may respond orally or in writing.
2. If the participants' responses are not consistent with Trainer's Resource 3-3, review the procedure with the participants and provide stations for them to practise catheterisation, following the steps outlined in Participant Handout 3-F. Give them copies of the handout before they begin practising. While one participant practises, the others give feedback, using the handout. Circulate among the stations, providing feedback as needed.
3. Encourage the participants to refer to Participant Handout 3-F in actual practise. This will help ensure consistency and quality of care.

### **Option 2**

1. As a homework assignment, ask the participants to study Participant Handout 3-F on urinary catheterisation.
2. When the group convenes, demonstrate catheterisation using a pelvic model.
3. Ask the participants if they have any questions or comments.
4. Provide stations at which the participants can practise the procedure following the steps outlined in Participant Handout 3-F. Give them copies of the handout before they begin practising. While one participant practises, the others give feedback, using the handout. Circulate among the stations, providing feedback as needed.
5. Encourage the participants to regularly refer to Participant Handout 3-F in actual practise. This will help ensure consistency and quality of care.

**Activity 3: Homework, Discussion, and Game (30 minutes for discussion and game)**

1. As a homework assignment, ask the participants to study Participant Handout 3-G on waste disposal.
2. When the group convenes, ask the participants if they have any questions or comments about the handout.
3. Place the items described in Trainer's Resource 3-4 on a table. Divide the group into teams of four to six people. For each item, ask each team to describe on a piece of flipchart paper how to dispose of the item once it has been soiled. Trainer's Resource 3-4 provides examples of items, type of waste, and disposal methods. Once the teams have finished the task, review the answers and award a prize to the team that has the most correct answers. Have additional prizes available in case there is more than one winner.

**Activity 4: Practicum**

1. Arrange for the participants to carry out a clinical practicum on urinary catheterisation, which should be supervised by clinical staff trained and experienced in urinary catheterisation. Appendix A includes a checklist (page 407) on urinary catheterisation that can be utilised in this practicum.
2. After the practicum, ask the participants the following questions:
  - What did they find most useful during the practicum?
  - What do they need additional practise on?
  - What questions or comments do they have about the practicum?

## **SESSION 2**

### **Assessing Clients Living with Obstetric Fistula**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Correctly take the history of a client living with obstetric fistula
- Describe the elements and range of findings of the initial physical examination for a client living with obstetric fistula
- Describe how to inspect the external female genitalia and the thighs of a client living with obstetric fistula
- Describe how to perform a gentle digital vaginal examination and a vaginal speculum examination on a client living with obstetric fistula
- Record assessment findings in appropriate forms and registers

#### **POINTS TO REMEMBER**

- Aspects of history taking that are especially important for fistula clients include:
  1. How long the client was in labour with the pregnancy that led to the fistula
  2. Where she delivered
  3. How long she has been incontinent
  4. Who has been caring for her
- As part of the physical assessment, the nurse or midwife visually inspects the client's external genitalia and thighs.
- Doctors typically perform a preliminary gentle physical examination of the vagina in an examining room before performing repair surgery. The guiding principle should be to look before touching and to touch only if necessary. If a woman is very apprehensive about such an exam or is in a great deal of pain, the examination may be done under anaesthesia just before repair surgery. Before performing any physical examination of the vagina, the nurse or midwife should consult the fistula surgeon. A nurse's or midwife's examination of the vagina is preliminary to the surgeon's examination.
- Filling out medical records accurately and completely is essential for quality of care.

#### **Training Methods**

- Presentation
- Discussion
- Homework
- Fill-in-the-blanks exercise
- Case study
- Demonstration
- Simulation practise
- Practicum

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 3-H: Assessing Clients Living with Obstetric Fistula
- Participant Handout 3-I: Physical Examination of Clients Living with Vesicovaginal or Rectovaginal Fistula

- Participant Handout 3-J: The Medical Record for Obstetric Fistula: Taking the Medical History
- Participant Handout 3-K: The Medical History for Obstetric Fistula: Case Study
- Trainer's Resource 3-5: Physical Examination of Clients Living with Vesicovaginal or Rectovaginal Fistula: Answer Key
- Trainer's Resource 3-6: Medical Record for Case Study: Taking the Medical History: Answer Key
- Part B, Activity 1: One pelvic model for every four to five participants; one set of instruments for a vaginal speculum examination for every four to five participants (examination gloves, water-soluble lubricant, vaginal or Sims speculum, kidney basin, cotton swabs or balls, sponge-holding forceps, light source that can be positioned)

### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 3-H, 3-I, 3-J, and 3-K.
4. Duplicate Participant Handouts 3-H, 3-I, 3-J, and 3-K for the participants.
5. Give all homework assignments before the training activities begin.
6. Part A, Activity 3: Review the medical records completed by the participants before the participants convene as a group. Or if the participants will be reviewing each other's work, make copies of the answer key for the group (Trainer's Resource 3-6).
7. Part B, Activity 1: Prepare the area for the demonstration and practise.
8. Part B, Activity 2: Arrange for the practicum.

#### **TRAINING TIP**

Facilities differ in their policies regarding which staff can perform digital vaginal examinations and vaginal speculum examinations. Take this into account as you plan and conduct this module. For instance, if the participants are unlikely to perform these procedures, you may want to omit this content from the module.

**Session Time (total):** 2 hours, 30 minutes (excluding practicum)

## SESSION 2

### Training Steps

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#### PART A: HISTORY AND INITIAL PHYSICAL ASSESSMENT

Time: 1 hour

##### TRAINING TIP

Part A, Activities 1 and 2: If necessary, modify Participant Handout 3-H to be consistent with the scope of practise of nursing staff in your institutional settings.

#### Activity 1: Presentation and Discussion (20 minutes)

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of the session is describe *how to take the history of a woman living with obstetric fistula and perform the initial physical assessment*.
3. Ask the participants what questions they have about the session objectives.
4. Distribute Participant Handout 3-H, which describes how to assess a client living with obstetric fistula. Ask the participants to scan the section of the handout devoted to history taking.
5. Ask the participants to identify aspects of history taking that are especially critical in cases of obstetric fistula. Sample responses include:
  - How long the client was in labour with the pregnancy that led to the fistula
  - Where she delivered
  - How long she has been incontinent
  - Who has been caring for her

#### Activity 2: Homework and Fill-in-the-Blanks Exercise (20 minutes for exercise)

##### TRAINING TIP

You may want to draw an outline of a woman's body as shown on Participant Handout 3-I on the board or on a piece of flipchart paper. Refer to this diagram as you conduct the activity.

1. As a homework assignment, ask the participants to study the section of Participant Handout 3-H devoted to the initial physical assessment.
2. Once the group has convened, distribute copies of Participant Handout 3-I, a diagram of a woman's body from head to toe. Tell the participants that this exercise is a refresher only; it does not cover all aspects of the physical assessment. Encourage the participants to complete the exercise without looking at Participant Handout 3-H. Call out the numbered blanks on the handout and ask the participants to describe:
  - What part or parts of the initial physical exam should be written in the blanks
  - The range of findings for a woman living with obstetric fistulaTrainer's Resource 3-5 provides an answer key.
3. Ask the participants to list other elements of the initial physical assessment that were not addressed by Participant Handout 3-I. Participant Handout 3-H includes the complete list.

**Activity 3: Homework, Case Study, and Discussion (20 minutes for discussion)**

1. Distribute copies of Participant Handouts 3-J and 3-K.
2. As a homework assignment, ask the participants to record Mariam's history (Participant Handout 3-K) on the partial medical record provided on Participant Handout 3-J.
3. Collect the completed assignments and compare them to Trainer's Resource 3-6. Provide feedback on each participant's work. Alternatively, pair up the participants and ask them to correct each other's work; prepare an answer sheet for the pairs to use.
4. When the group convenes, distribute the records with your feedback to the participants. Ask the participants if they have any questions. Review any aspects of the record that were problematic for the participants.
5. Emphasise that filling out medical records accurately and completely is essential to providing quality care.
6. Tell the group that many medical records are not designed to capture specific information about fistula. Ask the participants what they would do in these situations; emphasise that all notations should be concise and relevant to fistula-specific findings. Sample responses include:
  - Encourage the facility to use the record provided in this curriculum.
  - Use the notes section of the record to record fistula-specific data.
  - Staple an additional sheet with fistula-specific data to the main record.

**PART B: INSPECTION OF EXTERNAL GENITALIA AND THIGHS, AND VAGINAL EXAMINATION**

**Time:** 1 hour, 30 minutes (excluding practicum)

**Activity 1: Homework, Demonstration, and Simulation Practise (1 hour, 30 minutes for demonstration and simulation practise)**

1. As a homework assignment, ask the participants to study the sections of Participant Handout 3-H devoted to visual inspection of the external genitalia and the thighs, the gentle digital examination of the vagina, and the speculum examination.
2. When the group convenes, ask the participants if they have any questions or comments about the handout.
3. Emphasise that in some health facilities, nurses and midwives perform vaginal examinations, digitally, with a speculum, or in both ways. The participants should follow the protocols of the institutions in which they work.
4. Emphasise that doctors typically perform a preliminary gentle physical examination of the vagina in an examining room before performing repair surgery. The guiding principle should be to look before touching and to touch only if necessary. If the client is very apprehensive about such an exam or is in a great deal of pain, the examination may be done under anaesthesia just before repair surgery. Before performing any physical examination of the vagina, the nurse or midwife should consult the fistula surgeon. A nurse's or midwife's examination of the vagina is preliminary to the surgeon's examination.
5. Emphasise that the speculum exam for a fistula client differs from a routine speculum examination.
6. Demonstrate inspection of the external genitalia and thighs, digital examination, and speculum examination using a pelvic model.
7. Ask the participants if they have any questions or comments.

8. Divide the participants into groups of four to five and assign each group to a pelvic model. Using Participant Handout 3-H as a guide (or the practicum checklist provided in Appendix A), the participants take turns practising inspection of the external genitalia and thighs, gentle digital examination of the vagina, and speculum examination. While one participant practises, the others give feedback, using the handout.
9. Circulate among the groups, providing feedback, using Participant Handout 3-H. Encourage the participants to regularly refer to the handout in actual practise. This will help ensure consistency and quality of care.

### **Activity 2: Practicum**

1. Arrange for the participants to carry a practicum on the physical examination, which should be supervised by clinical staff trained and experienced in such examinations. Appendix A includes a checklist (page 409) on physical examination that can be utilised in this practicum.
2. After the practicum, ask the participants:
  - What did they find most useful during the practicum?
  - What do they need to practise further?
  - What questions or comments do they have about the practicum?

## SESSION 3

### Managing Clients Who Present with Fistula Immediately after Delivery

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Describe the management of fistula clients who present immediately after delivery.
- Describe the management of clients following insertion of an indwelling catheter.

#### POINTS TO REMEMBER

- Management procedures are similar to those used for clients who have recently experienced prolonged or obstructed labour (see Module 2, Training Session 4). The one exception is the length of continuous bladder drainage. For clients who present with fistula immediately after delivery, continuous drainage by catheter is maintained for a longer period of time: a minimum of four weeks to a maximum of six weeks, according to local protocol.

#### Training Methods

- Presentation
- Assessment
- Group work
- Discussion

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 3-L: Management of Clients Who Present Immediately after Delivery with Obstetric Fistula
- Participant Handout 3-M: Management of an Indwelling Catheter in Obstetric Fistula Clients
- Trainer's Resource 3-7: Catheter Management: Assessment

#### Advance Preparation

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 3-L and 3-M.
4. Duplicate Participant Handouts 3-L and 3-M for the participants.
5. Part B: If the participants complete the assessment as homework, duplicate copies of Trainer's Resource 3-7. If groups will be making presentations on catheter management, give them time to prepare.

#### TRAINING TIP

Part B of this session begins with an assessment of the participants' knowledge of catheter management. The length of the activity will vary, depending upon what the participants already know. Take this into account as you plan the training schedule.

**Session Time (total):** Up to 1 hour, 45 minutes, depending upon the participants' knowledge of catheter management

## SESSION 3

### Training Steps

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#### **PART A: MANAGEMENT PRINCIPLES**

**Time:** 15 minutes

**Activity: Presentation (15 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of the session is to present *how to manage fistula clients who present early, with special emphasis given to catheterisation.*
3. Ask the participants what questions they have about the session objectives.
4. Using Participant Handout 3-L as a reference, describe how to manage fistula clients who present early.
5. Emphasise that management procedures are similar to those used for clients who have recently experienced prolonged or obstructed labour. The one exception is the length of continuous bladder drainage. For clients who present with fistula immediately after delivery, continuous drainage by catheter is maintained for a longer period of time: a minimum of four weeks to a maximum of six weeks, according to local protocol.
6. Ask the participants if they have any questions.

#### **PART B: MANAGEMENT OF AN INDWELLING CATHETER**

**Time:** 20 minutes to 1 hour, 30 minutes (depending on the participants' knowledge)

**Activity: Assessment, Presentation, Group Work, and Discussion (20 minutes to 1 hour, 30 minutes, depending upon the participants' knowledge; may take place over two days, depending on learning needs)**

1. Assess the participants' knowledge of catheter management by asking them the questions on Trainer's Resource 3-7. Alternatively you may ask the participants to respond in writing as a homework exercise and check their work before the group convenes.
2. If the participants answer the questions correctly, distribute copies of Participant Handout 3-M for them to review on their own time. Correct any misinformation, as needed.
3. If the participants do not answer the questions correctly, divide them into two groups. Distribute copies of Participant Handout 3-M. Assign each group a section of the handout to present:
  - The first group presents the longest section, "Preventing catheter-related complications" to the large group. (This group may need more members than the other group because there is more information to present.)
  - The second group presents the section, "Perineal toilet and catheter cleaning."
4. Give the groups time to prepare their presentations (e.g., they may prepare one day and present the next.)
5. After each group presents, encourage other participants to ask questions. Correct any misinformation and add any points that the presenters have not addressed, using Participant Handout 3-M as a reference.

## SESSION 4

### Preoperative Care of Clients Undergoing Fistula Repair

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Describe admission procedures for clients living with obstetric fistula
- Explain the informed consent process, including use of the sample form
- Describe how to prepare a client with obstetric fistula for repair surgery

#### POINTS TO REMEMBER

- Many fistula clients are frightened or embarrassed. Their husbands, other family members, and their communities may have ostracised them. As they consider surgical repair, they are contemplating a decision that could dramatically change their lives and the lives of their families. Empathy and psychological support are extremely important during admission, the informed consent process, and preoperative care, as well as in all other aspects of care.
- Getting informed consent involves more than just obtaining a client's signature on a form. Informed consent involves communication between a client and a provider to confirm that the client has made an informed and voluntary decision to use or receive a medical service, procedure, or surgery.
- The concept of informed consent may be culturally unfamiliar to clients. The provider must explain it clearly and simply.

#### Training Methods

- Presentation
- Homework
- Discussion
- Role play
- Question-and-answer exercise
- Practicum

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 3-N: Admission and Intake Procedures for Clients Living with Obstetric Fistula
- Participant Handout 3-O: Informed Consent for Fistula Repair
- Participant Handout 3-P: Informed Consent Form for Fistula Repair
- Participant Handout 3-Q: Informed Consent: Observer's Checklist for Role Play
- Participant Handout 3-R: Preoperative Care and Preparation of Fistula Repair Surgery Clients
- Trainer's Resource 3-8: Role Play: Informed Consent
- Trainer's Resource 3-9: Preoperative Care: Questions and Answers

### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 3-N, 3-O, 3-P, 3-Q, and 3-R.
4. Duplicate Participant Handouts 3-N, 3-O, 3-P, 3-Q, and 3-R for the participants.
5. Give all homework assignments before the training activities begin.
6. Part B, Activity 1: Prepare for the role play. Review the principles and steps of the informed consent process in Participant Handouts 3-O and 3-P. To allow time for preparation, you may want to choose the volunteer for the role play before the training session begins.
7. Part B, Activity 3: Arrange for the practicum.

#### **TRAINING TIP**

*How to Use the Informed Consent Materials*, available on the web site of the Fistula Care project ([www.fistulacare.org](http://www.fistulacare.org)), is an excellent resource for this module. Encourage participants to download this booklet. If participants do not have access to the Internet, consider duplicating copies of the information for them or ordering copies from the Fistula Care project.

**Session Time (total):** 1 hour, 25 minutes

## SESSION 4

### Training Steps

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#### **PART A: ADMISSION PROCEDURES**

**Time:** 15 minutes

**Activity: Presentation, Homework, and Discussion (15 minutes for presentation and discussion)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of the session is to present *preoperative care for women who will undergo fistula repair surgery*.
3. Ask the participants what questions they have about the session objectives.
4. As a homework assignment, ask the participants to study Participant Handout 3-N on admission procedures for clients living with obstetric fistula.
5. When the group convenes, ask the participants if they have any questions or comments about the handout.
6. Emphasise that many fistula clients are frightened or embarrassed. Their husbands, other family members, and their communities may have ostracised them. As they consider surgical repair, they are contemplating a decision that could dramatically change their lives and the lives of their families. Empathy and psychological support are extremely important during admission, the informed consent process, and preoperative care, as well as in all other aspects of care for fistula clients.

#### **PART B: INFORMED CONSENT AND PREOPERATIVE CARE**

**Time:** 1 hour, 10 minutes

**Activity 1: Homework and Role Play (40 minutes for role play)**

1. As a homework assignment, ask the participants to study Participant Handouts 3-O and 3-P on informed consent.
2. Emphasise that getting informed consent means more than just obtaining a client's signature on a form. Informed consent involves communication between a client and a provider to confirm that the client has made an informed and voluntary decision to use or receive the medical service, procedure, or surgery.
3. Ask a volunteer to play the role of a fistula care client who is being asked to give informed consent for repair surgery; give the volunteer a few moments to review the role described in Trainer's Resource 3-8.
4. Ask the participants to refer to Participant Handout 3-Q during the role play and to make notes about how the role play is going.
5. Working with the volunteer, role-play the informed consent process. The role play concludes with the client repeating key points, asking questions about her concerns, and signing the informed consent form.
6. Ask the participants for feedback about the role play. Respond to their comments.

**Activity 2: Homework, Question-and-Answer Exercise, and Discussion (30 minutes for question-and answer exercise and discussion)**

1. As a homework assignment, ask the participants to study Participant Handout 3-R, about preoperative care and preparation.
2. When the group convenes, ask the participants the questions on Trainer's Resource 3-9. Correct any misunderstandings.

**Activity 3: Practicum**

1. Arrange for the participants to carry out a clinical practicum on preoperative care, which should be supervised by clinical staff trained and experienced in preoperative care. Appendix A includes a checklist (page 412) on preoperative care that can be utilised in this practicum.
2. After the practicum, ask the participants the following questions:
  - What did they find most useful during the practicum?
  - What do they need to practise further?
  - What questions or comments do they have about the practicum?

## **SESSION 5**

### **Management of Clients with Obstetric Fistula during Repair Surgery**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Describe nursing management of the client with fistula during repair surgery
- Explain the responsibilities of the scrub nurse and the circulating nurse that are important or unique to fistula repair surgery
- Correctly set the trolley for fistula repair surgery

#### **POINTS TO REMEMBER**

- During training, the following nursing responsibilities during fistula repair should be stressed:
  - Positioning the client before surgery
  - Noting and recording the number of vaginal packs used and left in situ
  - Correctly setting the trolley according to the surgeon's instructions
  - Maintaining strict aseptic technique
  - Talking to the client and reassuring her throughout surgery

#### **Training Methods**

- Presentation
- Discussion
- Homework
- Game
- Identification exercise
- Simulation practise

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Part A, Activity 2: Tape, temporary adhesive (“blue tack”), or pushpins to be used in the game
- Part A, Activity 3: Pencil and paper for each participant, instruments used in fistula repair surgery (multiple sets may be needed, depending upon the activity chosen)
- Participant Handout 3-S: Fistula Repair Surgery
- Participant Handout 3-T: Nursing Management during Fistula Repair Surgery
- Participant Handout 3-U: The Scrub Nurse, the Circulating Nurse, and the Anaesthetist: Roles and Responsibilities
- Participant Handout 3-V: Instruments Used in Fistula Repair Surgery
- Participant Handout 3-W: Fistula Repair Surgery: The Surgical Trolley

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.

3. Review Participant Handouts 3-S, 3-T, 3-U, 3-V, and 3-W.
4. Duplicate Participant Handouts 3-S, 3-T, 3-U, 3-V, and 3-W for the participants.
5. Part A, Activity 2: Give the homework assignment before the training activities begin. Prepare for the game. Write the heading *Scrub Nurse* on the top of a piece of flipchart paper; write the heading *Circulating Nurse* on another piece of flipchart paper. Post the two flipcharts on the wall of the training room. Referring to Participant Handout 3-U, write the responsibilities of the scrub nurse and circulating nurse on individual pieces of paper. The writing should be large enough for the group to read easily.
6. Part A, Activity 3: Before conducting this activity, confirm with fistula surgeons at your institution that the information in Participant Handouts 3-V and 3-W is consistent with their practises. You may need to modify the handouts. In the case of the photos, you may need to create illustrations, photos, or displays showing how the trolley is arranged. Select the training activities depending upon (a) whether the participants are nursing students or in-service nurses and (b) whether the participants are likely to assist in the operating theatre. For Option 1, obtain samples of instruments used in fistula repair surgery (see Participant Handout 3-V). For Option 2, obtain multiple sets of instruments, depending upon the number of stations needed for the activity.

**TRAINING TIP**

If participants are unlikely to assume the roles of scrub nurse or circulating nurse, you may choose to omit Activities 2 and 3.

**Session Time (total):** 1 hour, 10 minutes, to 1 hour, 40 minutes, depending upon the activities chosen

## SESSION 5

### Training Steps

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**Time:** 1 hour, 10 minutes, to 1 hour, 40 minutes, depending upon the activities chosen

#### **Activity 1: Presentation and Discussion (20 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of the session is to present *the roles and responsibilities of nurses and midwives during repair surgery*.
3. Ask the participants what questions they have about the session objectives.
4. Using Participant Handouts 3-S and 3-T as references, give a presentation describing fistula repair surgery and nursing management during the surgery.
5. Ask the participants if they have any questions or comments.
6. Emphasise that nurses who participate in fistula repair surgery should take care to:
  - Correctly position the client before surgery according to the surgeon's instructions
  - Note and record the number of vaginal packs used and left in situ
  - Correctly set the trolley according to the surgeon's instructions
  - Maintain aseptic technique
  - Talk to the client and reassure her throughout surgery

#### **Activity 2: Homework and Game (Review) (20 minutes for game)**

1. As a homework assignment, ask the participants to study Participant Handout 3-U on the roles and responsibilities of the scrub nurse, the circulating nurse, and the anaesthetist.
2. When the group convenes, display one of the pieces of paper with a responsibility written on it. Ask a participant to correctly place it on either the flipchart labeled "Scrub Nurse" or "Circulating Nurse," using either tape, temporary adhesive ("blue tack"), or pushpins. Ask the group if the participant has responded correctly. Continue in this fashion until all of the responsibilities are correctly positioned on the two flipcharts.
3. Ask the participants if they have any questions or comments.
4. Point out that Participant Handout 3-U also describes the roles and responsibilities of the anaesthetist, another member of the team that assists the surgeon during fistula repair. Nurses sometimes also work as anaesthetists.

#### **Activity 3: Identification Exercise and Simulation Practise (30 minutes to 1 hour, depending upon the options chosen)**

##### **Option 1: For Preservice and In-Service Participants**

1. Tell the participants that the instruments on the table are commonly used in fistula repair surgery. Hold up the instruments one at a time. Ask the group to identify each instrument and to write down the names of any instruments that are unfamiliar to them. Participants who have recently completed a surgical rotation as part of their nursing education will know many of the instruments.
2. Ask the participants to call out the names of instruments that were new to them. Review the purpose of each of these instruments.
3. At the end of the activity, distribute copies of Participant Handout 3-V.

**Option 2: For In-Service Participants Only**

1. Distribute copies of Participant Handout 3-W. Review how the instruments are arranged on the trolley shown in the photographs.
2. Provide stations for the participants to practise setting the trolley, as shown in Participant Handout 3-W. While one participant practises, have the others give feedback, using the handout. Circulate among the stations, providing feedback as needed.

## **SESSION 6**

### **Postoperative Management of Clients after Surgical Repair of Obstetric Fistula**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Describe postoperative care within and beyond the first 24 hours after surgery
- Describe nursing management of selected complications after repair of obstetric fistula: blocked catheter, vaginal haemorrhage, wound sepsis, breakdown of repair, and anuria
- Describe how to discharge a client, provide discharge counselling, and arrange for follow-up care

#### **POINTS TO REMEMBER**

- The three D's of postoperative care are:
  - Make sure that the woman Drinks.
  - Make sure that the woman is Dry.
  - Make sure that all drainages are Draining
- Nurses and midwives play an important role in helping the woman reintegrate into her community.

#### **Training Methods**

- Presentation
- Homework
- Discussion
- Pair exercise
- Quiz
- Role play
- Practicum

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 3-X: Postoperative Care of Fistula Repair Surgery Clients
- Participant Handout 3-Y: Fistula Repair Surgery: Postoperative Complications
- Participant Handout 3-Z: Fistula Repair Surgery: Nursing Care of Selected Complications
- Participant Handout 3-AA: Fistula Repair Surgery: Postoperative Nursing Care Plan
- Participant Handout 3-BB: Fistula Repair Surgery: The Discharge Plan and Follow-Up
- Participant Handout 3-CC: Discharge Counselling for Fistula Repair Surgery: Observer's Checklist for Role Play
- Trainer's Resource 3-1: Module 3 Evaluation and Answer Key
- Trainer's Resource 3-10: Postoperative Care: Quiz
- Trainer's Resource 3-11: Fistula Repair: Postoperative Nursing Care Plan: Answer Key
- Trainer's Resource 3-12: Role Play: Discharge Counselling

### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 3-X, 3-Y, 3-Z, 3-AA, 3-BB, and 3-CC.
4. Duplicate Participant Handouts 3-X, 3-Y, 3-Z, 3-AA, 3-BB, and 3-CC for the participants.
5. Give all homework assignments before the training activities begin.
6. Before teaching this session, review the information on physiotherapy and exercises in *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, published by the World Health Organization (WHO) in 2006.
7. Part B, Activity 3: Arrange for the practicum.

**Session Time (total):** 3 hours, 10 minutes (excluding practicum)

## SESSION 6

### Training Steps

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#### **PART A: POSTOPERATIVE CARE AND COMPLICATIONS**

**Time:** 1 hour, 30 minutes

#### **Activity 1: Presentation, Homework, Discussion, and Quiz (30 minutes for presentation, quiz, and discussion)**

##### **TRAINING TIP**

Encourage participants to download *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* from the WHO web site ([www.who.org](http://www.who.org)) for information on physiotherapy and exercise. If participants do not have access to the Internet, consider duplicating copies of the information for them.

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to describe *the roles and responsibilities of nurses and midwives during postoperative care and in the event of complications*.
3. Ask the participants what questions they have about the **session objectives**.
4. As a homework assignment, ask the participants to study Participant Handout 3-X, on postoperative care.
5. When the group convenes, ask the participants if they have any questions or comments about the handout.
6. Emphasise the three D's presented at the top of the handout.
7. Emphasise that care is given in two distinct phases: *within* 24 hours of surgery and *beyond* 24 hours after surgery. Care differs in each of these phases.
8. Using Trainer's Resource 3-10, ask the group to respond to the quiz questions.
9. At the end of the quiz, ask the participants if they have any questions.

#### **Activity 2: Homework and Discussion (15 minutes for discussion)**

1. As a homework assignment, ask the participants to study Participant Handout 3-Y and 3-Z on postoperative complications.
2. When the group convenes, ask the participants if they have any questions or comments about the handouts.
3. Ask the group what nurses can do to help prevent postoperative complications. Sample responses include:
  - Providing quality catheter care
  - Carefully monitoring the client for bleeding
  - Following standard procedures for perineal cleansing

#### **Activity 3: Presentation, Pair Exercise, and Discussion (45 minutes)**

1. Distribute copies of Participant Handout 3-AA. Review the case with the group.
2. Divide the participants into pairs. Ask each pair to respond to the questions about the case and to complete the nursing care plan. Give each pair 20 minutes to work.
3. Using Trainer's Resource 3-11, review the participants' responses and plans. Provide corrective feedback as needed.

## **PART B: DISCHARGE AND FOLLOW-UP**

**Time:** 1 hour (excluding practicum)

### **Activity 1: Homework and Discussion (15 minutes for discussion)**

1. As a homework assignment, ask the participants to study Participant Handout 3-BB on discharge planning and follow-up.
2. When the group convenes, ask the participants if they have any questions or comments about the handout.
3. Emphasise that nurses and midwives play an important role in helping a woman to reintegrate into her community. Ask the participants if they can suggest other things that nurses and midwives can do beyond what is listed on the handout.

### **Activity 2: Role Play and Discussion (45 minutes)**

1. Emphasise that discharge counselling can help prevent complications and help a woman to reintegrate into her community.
2. Ask a volunteer to play the role of a fistula care client who is being discharged; give the volunteer a few moments to review the role described in Trainer's Resource 3-12.
3. Ask the participants to refer to Participant Handout 3-CC during the role play and to make notes about how the role play is going.
4. Working with the volunteer, role-play discharge counselling.
5. Ask the participants for feedback about the role play. Respond to their comments.

### **Activity 3: Practicum**

1. Arrange for the participants to carry out a clinical practicum in postoperative care, which should be supervised by clinical staff trained and experienced in postoperative care. Appendix A includes a checklist (page 412) on postoperative care that can be utilised in this practicum.
2. After the practicum, ask the participants:
  - What did they find most useful during the practicum?
  - What do they need to practise further?
  - What questions or comments do they have about the practicum?

## **PART C: MODULE 3 EVALUATION**

**Time:** 40 minutes

### **Activity 1: Posttest (20 minutes)**

1. Distribute the Module 3 Evaluation (based on the questions provided in Trainer's Resource 3-1) to the participants and tell them they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

### **Activity 2: Review/Debrief (20 minutes)**

1. Review the answers to the Module 3 Evaluation (using the Answer Key in Trainer's Resource 3-1).
2. Ask the participants if they have any questions.

#### **TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.

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# **MODULE 3 RESOURCES**



## **PARTICIPANT HANDOUT 3-A**

### **How Infections Are Transmitted**

Infections are caused by microorganisms, which are tiny organisms that can only be seen under a microscope. Microorganisms are everywhere—on your skin, in the air you breathe, and in people, animals, plants, soil, and water.

Some microorganisms are normally present on your skin and in your respiratory, intestinal, and genital tracts. These are called normal flora. Other microorganisms are normally not found on or in the human body and are usually associated with disease. These are known as pathogens. Under certain circumstances, all microorganisms, including normal flora, can cause infection or disease.

Infections are transmitted when normal flora are introduced into an area of the body where they are not usually found or when pathogens are introduced into the body. In cases of obstetric fistula, infections can be transmitted in both of these ways. The only way to prevent infections is to stop the transmission of microorganisms.

The risk for unsafe injection practises has been well documented for the three primary bloodborne pathogens: human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV). In 2000, the estimated global disease burden for these pathogens from unsafe injection practises was as follows (WHO, 2010):

- 21 million HBV infections (32% of new HBV infections)
- 2 million HCV infections (40% of new HCV infections)
- 260,000 HIV infections (5% of new HIV infections)

These pathogens also contribute to illness among health workers. An estimated 4.4% of HIV infections and 39% of HBV and HCV infections are attributed to occupational injury (WHO, 2010). Among health workers who do not receive prophylactic treatment after a needlestick injury, the risk for infection is 23% to 62% for HBV and 0% to 7% for HCV (WHO, 2010).

#### **References**

EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

World Health Organization. 2010. *WHO best practises for injections and related procedures toolkit*. Geneva.

## **PARTICIPANT HANDOUT 3-B**

### **Infection Risks among Clients Living with Obstetric Fistula**

#### **Factors Associated with Infection Transmission for Clients Living with Obstetric Fistula**

Women living with obstetric fistula are especially susceptible to infection for many reasons, including the following:

- A woman's health is compromised because of prolonged or obstructed labour.
- Women who have prolonged labour in unhygienic conditions are at increased risk for tetanus.
- Urinary or faecal incontinence makes it difficult for a woman to keep herself clean.
- Damage to vulvar, perineal, vaginal, and other tissues allows pathogens to enter the body or normal flora to enter an area of the body where they are not usually found.
- When a woman limits food consumption to avoid soiling herself, her nutrition is compromised, thereby making her more susceptible to infection and contributing to poor healing.
- When a woman limits liquid intake to avoid leaking urine, highly concentrated urine irritates the external genitalia and inner thighs. Broken skin and persistent moisture create an environment conducive to bacteria growth and infections.
- Because women with obstetric fistula often have prolonged stays in health facilities, they are at risk for nosocomial infections (infections originating in a hospital or other health care facility), including antibiotic-resistant bacteria.

#### **Infectious Conditions among Women Living with Obstetric Fistula**

- Tetanus
- Urinary tract infections
- Dermatitis
- Kidney infections
- Ascending infections after insertion of an indwelling catheter
- Nosocomial infections

## **PARTICIPANT HANDOUT 3-C**

### **Infection Prevention: Standard Precautions**

The best way to prevent infections at a health facility is to follow standard precautions. These are a set of recommendations designed to help minimise the risk for exposure to infectious microorganisms by both clients and staff.

Standard precautions include the following:

1. Washing hands
2. Wearing personal protective equipment, such as gloves, eye protection, face shields, and gowns
3. Practicing respiratory hygiene and cough etiquette
4. Preventing injuries from sharps
5. Processing instruments and client-care equipment
6. Ensuring environmental cleanliness and following waste-disposal practises
7. Handling, transporting, and processing used or soiled linens

**Adapted from:** EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

## **PARTICIPANT HANDOUT 3-D**

### **Infection Prevention: Instrument Processing**

#### **Step 1: Decontamination**

Decontamination kills viruses and many other microorganisms, making items safer to handle by the staff who perform cleaning and further processing. To decontaminate items, use a 0.5% chlorine solution or another acceptable disinfectant. Chlorine is usually the cheapest, most universally available disinfectant. A chlorine solution can be made from:

1. Liquid household bleach (sodium hypochlorite)
2. Bleach power (calcium hypochlorite or chlorinated lime)
3. Chlorine-releasing tablets (sodium dichloroisocyanurate)

To ensure effectiveness, a new solution should be made (a) every 24 hours or (b) when the solution becomes heavily soiled.

#### *Steps of Decontamination*

1. Decontaminate instruments and other items immediately after using them. Wearing gloves, place the instruments and other items in a plastic container of 0.5% chlorine solution; the container should have a lid or cover. Do not drop items into the bucket, since this can cause splashing. Be sure that the instruments are completely submerged. Cover the container. Let the instruments and other items soak for 10 minutes. Do not add any more used instruments after timing starts.
2. After 10 minutes, remove the items from the chlorine solution and either rinse with water or clean immediately. Do not leave items in the solution for more than 10 minutes, since excessive soaking can damage them. Always wear utility gloves when removing instruments and other items from a chlorine solution.

#### **Step 2: Cleaning**

While decontamination makes items safer to handle, cleaning removes organic material, dirt, and foreign matter that can interfere with sterilisation or high-level disinfection. Cleaning drastically reduces the number of microorganisms, including bacterial endospores, on instruments and other items. Cleaning of instruments refers to scrubbing with a brush, detergent, and water. When detergent is dissolved in water, it breaks up and dissolves or suspends grease, oil, and other foreign matter, making them easy to remove.

#### *Steps of Cleaning*

Always wear utility gloves, a mask, and protective eyewear when cleaning instruments and other items. Avoid using steel wool or abrasive cleansers.

1. Using a soft brush or old toothbrush, detergent, and water, scrub instruments and other items vigorously to completely remove all blood, other body fluids, tissue, and other foreign matter. To avoid splashing, hold items under the surface of the water while scrubbing and cleaning. Disassemble items that have multiple parts. Be sure to brush in grooves, teeth, and joints where organic material can collect and stick.
2. Rinse items thoroughly with clean running water to remove all detergent.
3. Allow items to air-dry (or dry them with a clean towel). Instruments that will be further processed with chemical solutions must dry completely, to avoid diluting the chemicals; items that will be high-level disinfected by boiling do not need to be dried first.

### Step 3: Sterilisation or High-Level Disinfection

#### *Sterilisation*

Sterilisation ensures that items are free of all microorganisms (bacteria, viruses, fungi, and parasites), including bacterial endospores that can cause infections. It is recommended for items, such as surgical instruments, that come into contact with the bloodstream and tissues under the skin. When sterilisation is not available, high-level disinfection is the only acceptable alternative for these items.

Regardless of which technology you use, always follow the manufacturer's instructions to ensure proper processing.

Health care facilities may use one or more of the following three methods of sterilisation:

- Steam sterilisation (also known as “autoclaving” or “moist heat under pressure”)
- Dry-heat sterilisation (electric oven)
- Chemical sterilisation (also known as “cold sterilisation”)

*Note:* Dry-heat sterilisation tends to blunt sharp instruments (e.g., scissors), resulting in the need to frequently sharpen or replace them.

#### *High-Level Disinfection*

High-level disinfection (known as HLD) eliminates bacteria, viruses, fungi, and parasites, but it does not reliably kill all bacterial endospores, which cause diseases such as tetanus and gas gangrene. When sterilisation is not available or feasible, HLD is the only acceptable alternative for items that come into contact with the bloodstream and tissues under the skin. HLD is also suitable for items that come into contact with broken skin or intact mucous membranes.

Health care facilities use one or both of the following two methods of HLD:

1. HLD by boiling
2. Chemical HLD (e.g., glutaraldehyde or 0.5% chlorine solution)

Chemical HLD is used for heat-sensitive items such as nasendoscopes or when a heat source is not available for boiling.

### Step 4: Use or Storage

Items should be used or correctly stored immediately after processing so that they do not become contaminated. If items are not stored correctly, all the effort and supplies used to process them will have been wasted, and the items may become contaminated.

Specific instructions for storage depend on whether sterilisation or HLD has been performed, the method used, and whether the item is wrapped or unwrapped. No matter which method has been used, instruments and other items should not be stored in solutions; they should always be stored dry. Microorganisms can live and multiply in both antiseptic and disinfectant solutions; leaving items to soak in contaminated solutions can lead to infections.

Because of the high risk for contamination, unwrapped sterile or HLD items should be used immediately or kept in a covered sterile or HLD container for no longer than one week after processing.

*Adapted from:* EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

## **PARTICIPANT HANDOUT 3-E**

### **Urinary Catheterisation: Assessment**

1. What is done to protect the client's rights during catheterisation?
2. What type of glove is used when inserting a urinary catheter?
3. Describe how to cleanse the periurethral mucosa before inserting the urinary catheter.
4. Before inserting the catheter, what anatomical structure does the provider identify?
5. How far is the catheter inserted beyond where urine is observed?
6. How much sterile liquid is usually used to inflate the balloon?
7. Where is the catheter secured on the client's body?
8. Name the characteristics of the urine that the provider assesses after inserting the catheter.
9. What size Foley catheter is recommended for women living with obstetric fistula?

## Participant Handout 3-F Urinary Catheterisation

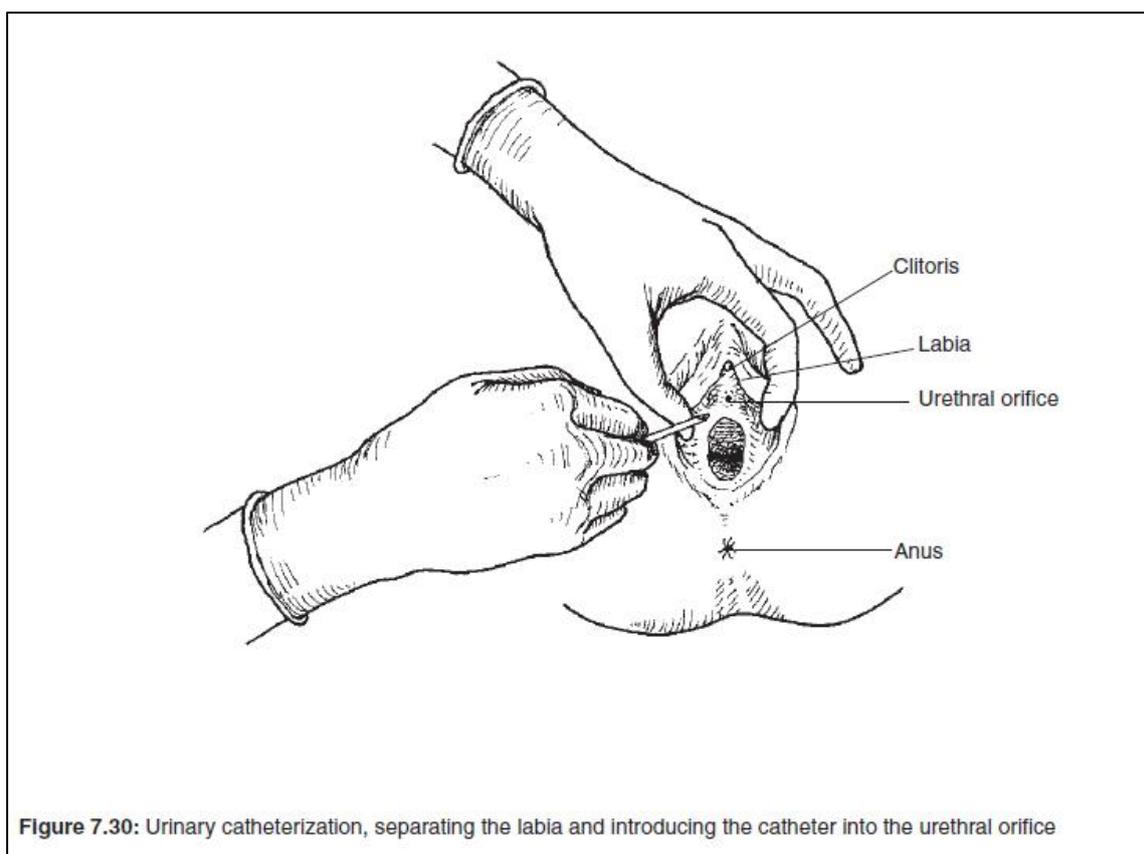
### Equipment

- Sterile gloves
- Sterile drapes
- Cleansing solution (e.g., hospital-concentration Savlon)
- Cotton swabs
- Forceps
- Sterile water (usually 10 cc)
- Foley catheter (usually 16 to 18 French)
- Syringe (usually 10 cc)
- Lubricant: sterile water-based jelly, such as K-Y jelly, or xylocaine (lidocaine) jelly
- If using urinary bags: collection bag, tubing
- If using the “drink, drip, and dry method”: straight, clean silicone tube; a small bucket with a lid

### Steps for Inserting a Urinary Catheter

- Gather the equipment.
- Introduce yourself and explain the procedure to the client before starting. Obtain her consent.
- Help the client into the supine position with legs spread and feet together.
- Protect the client’s privacy and comfort.
- Wash your hands.
- Aseptically open the catheterisation kit and catheter.
- Put on sterile gloves. Prepare the sterile field.
- Check the balloon for patency.
- Generously coat the distal portion of the catheter with sterile lubricant (2 to 5 cm).
- Apply the sterile drapes.
- Explain what you are doing as you perform the catheterisation.
- Using the nondominant hand, separate the labia and identify the urethral meatus.
- Using the dominant hand to hold the forceps, cleanse the periurethral mucosa with cleansing solution. Cleanse anterior to posterior, inner to outer, one swipe per swab. Discard swabs away from the sterile field.
- Keeping the labia separated, pick up the catheter with the sterile gloved hand. Hold the end of the catheter loosely coiled in the palm of the dominant hand.
- Identify the urethral meatus. Gently insert the catheter 1 to 2 cm beyond where you observe urine.
- Inflate the balloon, using the correct amount of sterile liquid (usually 5 mL).
- Gently pull the catheter until the inflated balloon is snug against the bladder neck.
- Connect the catheter to the drainage system.
- Secure the catheter to the client’s inner thigh or abdomen with strong adhesive tape. Be sure there is enough tubing to prevent tension and pulling.

- Place the drainage bag below the level of the bladder, or attach silicone tubing to the catheter and extend it into drainage bucket.
- Assess how the catheter is functioning and the amount, colour, odour, and quality of the urine.
- Remove the gloves. Correctly dispose of the equipment and supplies, following standard precautions. Wash your hands.
- Document the size of the catheter inserted, the amount of water in the balloon, the client's response to the procedure, and your assessment of the urine.



**Source:** WHO, 2008; used with permission.

## References

Hancock, B., and Browning, A. 2009. *Practical obstetric fistula surgery*. London: Royal Society of Medicine Press.

University of Ottawa. [no date given]. Urinary catheter insertion. Retrieved from <http://www.med.uottawa.ca/procedures/ucath>, January 30, 2011.

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## PARTICIPANT HANDOUT 3-G

### Medical Waste in Fistula Care Services: Disposal Methods on the Unit

#### **Sharps**

Sharps, used or unused, include hypodermic and suture needles, scalpel blades, pipettes, and other glass items (such as glass slides and coverslips).

#### ***Disposal***

Use color-coded, labeled, covered, puncture- and leak-proof sharps containers, such as heavy cardboard boxes, tin cans with lids, plastic bottles, or commercially available sharps containers. Empty containers when they are three-quarters full.

#### **Nonsharps Biologic Infectious Waste**

Nonsharps biologic infectious waste consists of material generated in the diagnosis, treatment, or immunisation of clients, including:

- Blood, blood products, urine, faeces, tissue, and other body fluids
- Materials containing fresh or dried blood or body fluids, such as bandages, surgical sponges, and exam and surgical gloves

Always wear heavy utility gloves and shoes when handling or transporting medical waste.

#### ***Disposal of solid waste***

For temporary storage, place the waste in color-coded, labeled, covered, puncture- and leak-proof containers kept in a closed area that is minimally accessible to staff, clients, and visitors. Do not store the waste for more than one or two days; during warmer times of year, do not store waste for more than 24 hours. Temporary storage containers should not be placed at an elevated level where rainwater might cause waste to flow into surrounding rivers, streams, or lakes. Final disposal should not be done at public or municipal dump sites.

#### ***Disposal of liquid waste***

Avoid splashing the waste on yourself, on others, or on the floor or other surfaces. Carefully pour liquid waste down a sink, drain, flushable toilet, or latrine. If this is not possible, bury the liquid waste in a pit. Before putting anything down a drain, sink, or toilet, think about where the drain empties. It is hazardous for liquid medical waste to run through open gutters or storm drains; to empty into streams, rivers, or lakes; or to seep from a septic tank. Rinse the sink, drain, or toilet thoroughly to remove residual waste, again avoiding splashing. Clean these areas with a disinfectant cleaning solution at the end of the day (or more often, if they are heavily used or soiled). Decontaminate the container that held the liquid waste by filling it with a 0.5% chlorine solution and soaking it for 10 minutes before washing. Wash your hands before and after removing the gloves.

#### **Nonsharps Noninfectious Waste (General Waste)**

This nonhazardous waste poses no risk for injury or infection. It is similar in nature to household trash. Examples include paper, boxes, packaging, soft plastic containers, and food-related trash.

### Disposal

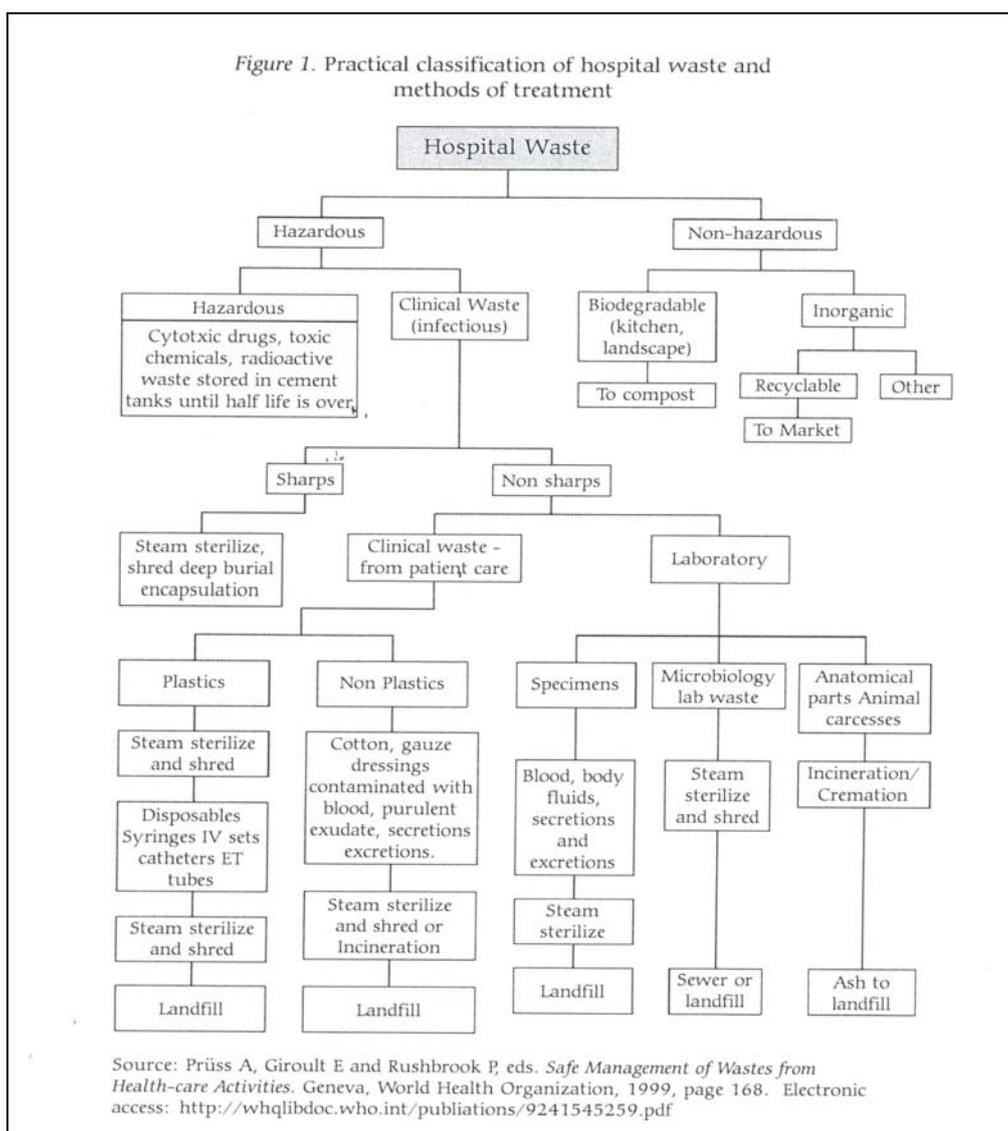
Place waste in customary bins, such as office wastebaskets or waste containers for food. Take nonsharps noninfectious waste to the regular community waste-disposal point.

### Hazardous Waste

Hazardous waste consists of materials that are potentially toxic or poisonous, including cleaning products, disinfectants, expired drugs, laboratory reagents, cytotoxic drugs, and radioactive compounds.

### Disposal

Consult local experts about safe disposal methods.



### References

EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

Prüss, A., Giroult, E., and Rushbrook, P., eds. 1999. *Safe management of wastes from health-care activities*. Geneva: World Health Organization.

## PARTICIPANT HANDOUT 3-H

### Assessing Clients Living with Obstetric Fistula

#### **HISTORY**

For the provider:

- Greet the client warmly.
- Explain that you are going to ask her some questions about her health and the health of her children.
- Provide psychological support to the client, since she may be feeling shame or embarrassment.
- Empathise with the client.
- React to the client's suffering and embarrassment with respect.

At a minimum, history taking includes the following:

- Age, parity, and past obstetric history
- Any history of genital cutting
- Number and sex of children, dates of delivery, and their current state of health
- Menstrual history, especially since last delivery
- Pregnancy that caused the fistula:
  - Personnel assisting
  - Duration of labour and how it was managed
  - The baby's lie and presentation, if known
  - Mode of delivery and surgical intervention, if any (e.g., episiotomy, symphysiotomy, destructive surgery)
  - Outcome for the baby
  - Subsequent pregnancy/pregnancies after fistula developed and outcome
- Onset and duration of symptoms for urinary or faecal incontinence
- Any previous attempts to repair the fistula
- Problems with gait or mobility, if any
- Past medical and surgical history, including allergies, if any
- Persons providing client's current care and care after surgery

#### **Social and Psychological History**

- Age at marriage or first pregnancy
- Marital status
- Number of school years completed
- Economic status, including type of housing to gauge income level
- Any signs of depression or anxiety?
- Who has been caring for the client until now?
- Who will care for the client should surgery be required?
- Are there any marital or social problems that have arisen as a consequence of fistula?
- Who referred her to the health care facility?
- How did she travel to the facility?
- How far away is home?
- Did anyone accompany her to the facility?

## **PHYSICAL EXAMINATIONS**

For the provider:

- Explain to the client what will happen during the examinations and why they are being done. Tell her she can ask questions at any time.
- Obtain the client's informed consent before the examinations.
- Prepare the client for the possibility of experiencing discomfort or pain. Reassure her, especially if she is frightened.
- If possible, provide a companion to support the client during the exam, especially if she is feeling uncomfortable or frightened.
- Make the client as comfortable as possible.
- Use gentle technique.
- Protect the client's privacy. Cover her to avoid unnecessary exposure.
- Talk to the client throughout the exam.
- Always tell the client when you are about to touch her.
- At the end of the exam, tell the client what you have found.

### **Initial Physical Assessment**

#### **General assessment**

- Height
- Weight
- Signs of malnutrition
- Signs of anaemia
- Pulse
- Blood pressure
- Respiration
- Temperature
- Gentle palpation of the abdomen
- Pain or numbness in her legs or feet?

#### **Mobility**

- Can the client walk unaided?
- Does she have foot drop on one or both sides?
- Can she stand from lying down without help?
- Does she have any limitation of movement in her hips, knees, or ankles?
- Can she move all her joints without help?
- Is she limping?
- Any limb contractures?
- Any weakness?
- Does she walk as if she is hiding something?

#### **Visual inspection of the external genitalia and thighs**

- Skin inflammation/ammoniacal dermatitis
- Excoriation or ulceration of the perineum or thighs
- Infection of the skin
- Faecal contamination
- Bleeding
- Genital cutting, episiotomy, or tears

**Examination of the abdomen**

- Inspect for scars, swellings
- Palpate for masses, pain

**Physical Examination of the Vagina**

Doctors typically perform a preliminary gentle physical examination of the vagina in an examining room before performing repair surgery. The guiding principle should be to look before touching and to touch only if necessary. If the client is very apprehensive about such an exam or is in a great deal of pain, examination may be done under anaesthesia just before repair surgery. Before performing any physical examination of the vagina, the nurse or midwife should consult the fistula surgeon. A nurse's or midwife's examination of the vagina is preliminary to the surgeon's examination.

**Gentle Digital Examination of the Vagina**

Inform the client what you will be doing and what she can expect to feel before you do it. During the examination, look for the following:

- Presence of the uterus
- Presence of necrotic tissue (the tissue must be healthy before fistula repair can be done; necrotic tissue may need to be removed before repair surgery)
- Presence and severity of scar tissue or fibrous tissue
- Presence of shortened anterior vaginal wall
- Presence of vaginal stenosis
- Depth and patency of the vagina
- Location and number of fistulas
- The approximate size of each fistula
- Any urethral involvement
- Presence of any rectovaginal fistula, noting location, size, scarring, any anal involvement, and stricture
- Presence of bladder stones
- Any other pelvic pathology

**Speculum Examination of the Vagina**

*Note:* This examination differs somewhat from routine speculum examinations.

- Prepare the instruments that will be used.
- Inform the client what you will be doing and what she can expect to feel before you do it.
- If the client has rectovaginal fistula (RVF) only, have her empty her bladder.
- Position the client on the examination table in the exaggerated lithotomy or Sims position. If in lithotomy, ask her to move her buttocks to the edge of the table. (If the table can be adjusted to the Trendelenburg position, position the client head down to the degree of best exposure.) Drape the client for privacy.
- Position the light source.
- Wash and dry your hands and put on gloves.
- Lubricate the Sims speculum with water (or water-soluble lubricant, if not taking any specimens).
- Touch the client on the inside of her thigh with the back of your hand to prepare her for being touched; help her to relax and tell her that she will feel the speculum going into the birth canal.

- Separate the client's labia with the thumb and index finger of your nondominant gloved hand.
- Hold the Sims speculum in your other gloved hand, with fingers around the handle at the angle of the speculum.
- Insert the speculum into the vagina at an oblique angle past the hymenal ring.
- Gently rotate the speculum to a horizontal angle and, while pressing firmly downwards, insert the speculum the length of the vaginal canal. Avoid catching the pubic hair or pinching. Be sure to spread the labia wide enough to avoid pushing the labia inwards.
- Maintain downwards pressure. View the anterior vaginal walls for any fistula and also view the cervix. If there are vaginal bands or scarring, this step must be done very gently; it may not be possible without anaesthesia.
- Manipulate the Sims speculum further into the vagina so the cervix is well exposed.
- If a specimen is to be taken, support the Sims speculum downwards with the nondominant hand. Take the specimen with the dominant hand.
- Inspect the condition, size, shape, and colour of the cervix. Assess for the presence of discharge (urine, mucus, purulence, and/or blood), polyps, cysts, ulcerations, and scars.
- Note the presence of any vaginal discharge or odour. Note the presence of other liquids pooled in the speculum blade. Take a specimen if indicated.
- Inform the client that she may feel some discomfort. Rotate the Sims speculum through 180°. View the posterior vaginal wall from the perineum to the posterior pouch of Douglas. Note any fistula or perineal tears. Note colour, masses, cysts, plaque, or defects.
- Rotate the speculum to the oblique position and remove it.
- Place the speculum into the decontamination bucket without splashing.
- Wipe the client's genitalia and perineum of any discharge or lubricant from the examination.
- If you will be doing a bimanual digital examination, prepare the client.

### **LABORATORY TESTS**

The following tests may be used to rule out other abnormalities and to formulate a suitable treatment plan:

- Haemoglobin, sickling test, blood typing, HIV
- Stool exam for parasites
- An I.V. urogram, especially for women with apparent ureterovaginal fistula or high vesicovaginal fistula/bladder neck involvement
- Urinalysis and culture to rule out coexisting urinary tract infection
- Blood urea, electrolyte, and creatinine to assess kidney function
- Complete blood cell count to rule out systemic infection
- Wet mount for vaginal infections
- Screening for sexually transmitted infections
- Immunisation status (check records if available); any needed vaccinations should be provided

Additional tests for vesicovaginal fistula (performed at the surgeon's discretion) include:

- Cystoscopy to see the fistula and assess its location in relation to the ureters and trigone, ensure bilateral ureteral patency, and exclude foreign body (or suture placement) in the bladder

- A biopsy of the fistula tract and urine cytology, especially in clients with suspected urogenital malignancy
- Radiologic studies prior to surgical repair of a vesicovaginal fistula to fully assess the fistula and exclude the presence of multiple fistulas
- An I.V. pyelogram to exclude concurrent ureterovaginal fistula or ureteral obstruction
- A targeted fistulogram, if conservative therapy including expectant management, continuous bladder drainage, fulguration, or fibrin occlusion therapy is to be recommended.

Additional tests for RVF (performed at the surgeon's discretion) include the following:

- Flexible endoscopy (sigmoidoscopy or colonoscopy) might be performed to fully evaluate the possibility of inflammatory bowel disease.
- When inflammatory bowel disease is in the differential diagnosis, endoscopy with biopsies must precede any operative approach to the fistula because the treatment depends on the diagnosis.

## **DIAGNOSTIC CRITERIA: VESICOVAGINAL FISTULA**

### **History**

Keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are used:

- Clients typically present after a difficult delivery, complaining of continuous, painless drainage of urine. The presentation is usually within the first three days after obstructed labour, but it may be as late as seven days.
- Some clients report exacerbation during physical activity. (This can lead to a misdiagnosis of stress incontinence.)
- If the fistula is small, leakage might be intermittent, depending on bladder distention or physical activity.
- Some clients may complain of vaginal discharge or blood in urine.
- If there is concurrent ureteric involvement, the client might experience nonspecific symptoms such as fever, chills, flank pain, or gastrointestinal symptoms that are caused by kidney infection.

### **Physical Examination**

Keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are used:

- Pooling of fluid in the vagina may be noted. The fluid should be sent for analysis if the diagnosis is unclear.
- A careful speculum exam to see the entire anterior vaginal wall should be performed to identify the fistula. In many cases, the fistula is readily visible. The location of the fistula in relation to the vaginal apex and bladder trigone should be inspected and the quality of the surrounding tissue (inflammation, oedema, scarring, or infection) noted.
- In some cases of small fistula, no obvious hole may be visible. Bimanual exam with careful palpation of the anterior wall might locate the fistula, with its surrounding area of induration.
- If no fistula is noted despite high clinical suspicion, a simple dye exam test of the bladder can be performed in the consultation room. The bladder is filled with a liquid dye (normal saline with indigo carmine) using a urinary catheter, and repeat pelvic exam with a speculum is performed to visualise the anterior wall. The client is asked to cough and bear down, and the leakage of liquid dye confirms the location of the fistula.

- If this test is negative, a tampon should be inserted and the client can then be asked to perform 10 to 15 repetitions of a maneuver that increases intra-abdominal pressure, such as climbing steps or jumping in place. The presence of a fistula can then be confirmed when the tampon is removed and dye can be seen beyond the most distal edge of the tampon.
- A variation of this technique is the double-dye test, in which the client is given a dye orally (phenazopyridine or pyridium), the bladder is filled, and a tampon is inserted. The presence of blue staining (indigo carmine) suggests vesicovaginal or urethra-vaginal fistula, while red staining (pyridium) suggests ureterovaginal fistula.
- In some settings, the client is examined under anaesthesia in a separate session, and a dye test is used to identify fistula. In other settings, this is done at the beginning of the main operation and is followed immediately by definitive surgery in the same session.

## **DIAGNOSTIC CRITERIA: RECTOVAGINAL FISTULA**

### **History**

Keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are used:

- A few clients have no symptoms.
- Most clients report passage of flatus or stool through the vagina.
- Clients may report symptoms arising from vaginitis or cystitis, such as vaginal discharge or frequent and painful urination.
- At times, a foul-smelling vaginal discharge develops, but obvious stool might not be seen from the vagina unless the client has diarrhea.
- The clinical client might also have faecal incontinence due to associated damage to the anal sphincter.

### **Physical Examination**

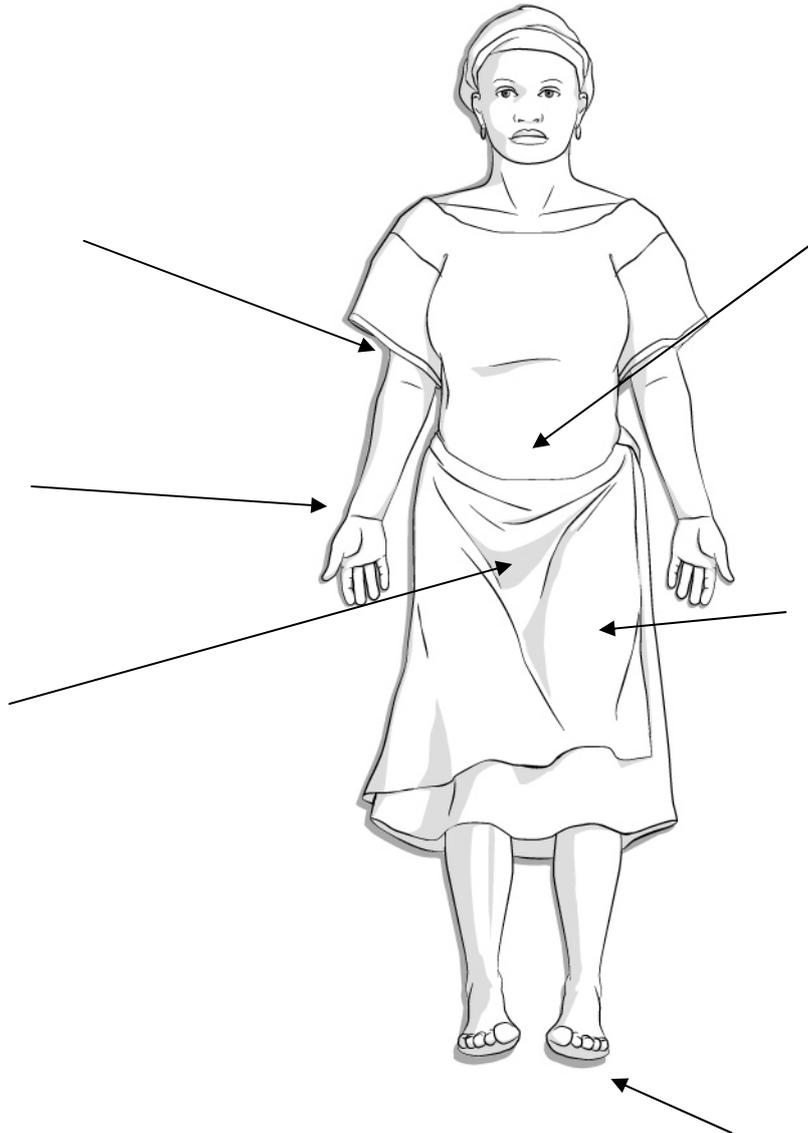
Keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are used:

- Physical examination is essential to confirm the diagnosis and estimate the size and location of the fistula, evaluate the function of the sphincters, and assess the possibility of inflammatory bowel disease or local neoplasm.
- Outpatient examination usually consists of a rectovaginal examination (visual and palpation). The fistula opening may be seen as a small dimple or pit and occasionally can be gently probed for confirmation. The examination might include proctoscopy or proctosigmoidoscopy, if these is available.
- Placing a vaginal tampon, instilling methylene blue into the rectum, and examining the tampon after 15 to 20 minutes can often establish the presence of RVF. If the tampon is unstained, another part of the gastrointestinal tract may be involved.

### **References**

- Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.
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- Varney, H., Kriebs, J. M., and Gegor, C. L. 2004. *Varney's midwifery*, 4th ed. Sudbury, MA: Jones and Bartlett.
- World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

**PARTICIPANT HANDOUT 3-I**  
**Physical Examination of Clients Living with Vesicovaginal**  
**or Rectovaginal Fistula**



**PARTICIPANT HANDOUT 3-J**  
**The Medical Record for Obstetric Fistula:**  
**Taking the Medical History**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Parity: \_\_\_\_\_

Past obstetric history: \_\_\_\_\_

\_\_\_\_\_

Genital cutting? Yes  No

**Living children:**

Number: \_\_\_\_\_ Sex: \_\_\_\_\_

Dates of delivery: \_\_\_\_\_

Menstrual history since last delivery: \_\_\_\_\_

**Pregnancy that caused the fistula:**

Who assisted at the delivery? \_\_\_\_\_

Duration of labour: \_\_\_\_\_

Baby's lie and presentation: \_\_\_\_\_

Mode of delivery: Vaginal  Caesarean

Any surgical intervention (e.g., episiotomy, symphysiotomy, destructive surgery)? \_\_\_\_\_

\_\_\_\_\_

Outcome for the baby? \_\_\_\_\_

Any pregnancies after fistula developed? \_\_\_\_\_ Outcome: \_\_\_\_\_

When did the woman first notice symptoms of incontinence? \_\_\_\_\_

Incontinence: Urinary  Faecal

Any attempts to repair the fistula? Yes  No

If yes, describe: \_\_\_\_\_

Any trouble with mobility? \_\_\_\_\_

Any serious illnesses? \_\_\_\_\_

Any previous surgery? \_\_\_\_\_

Any allergies? \_\_\_\_\_

Who cares for the client now? Who will care for her after repair surgery? \_\_\_\_\_

\_\_\_\_\_

## **PARTICIPANT HANDOUT 3-K**

### **The Medical History for Obstetric Fistula: Case Study**

#### **Mariam R.**

Mariam traveled by bus to the hospital, which is 48 km from her village. Mariam is 16 years old. She is not literate and has never been to school. When Mariam first gave birth about six months ago at home, the traditional birth attendant (TBA) assisted her.

Mariam's labour was very long. The attendant did not use any herbs or cutting to manage Mariam's labour. On the second day, the TBA said Mariam should go to the hospital. Mariam's husband was away, she had no money, and no one was available to take Mariam to the hospital. On the third day, Mariam finally gave birth to a stillborn baby girl; it was a vaginal delivery.

Six days after Mariam gave birth, she noticed that she was leaking urine, but she was too ashamed to mention this to anyone, especially after the shame of giving birth to a stillborn child. When her husband came back, he noticed the smell and threw her out of the house. Soon after, he took a second wife. Mariam returned to her parents' home; her mother has been caring for her.

A mobile health team came through Mariam's village and talked about fistula and the possibility of it being repaired. With help from her parents, Mariam made her way to the hospital; her father accompanied her. Mariam has not received any treatment for incontinence. She has never had any genital cutting. Mariam is not having problems with mobility. Her menstrual periods returned to normal after the delivery. She has never had any surgery or serious illnesses; as far as she knows, she is not allergic to anything. If she has fistula surgery, her parents can help care for her.

## **PARTICIPANT HANDOUT 3-L**

### **Management of Clients Who Present Immediately after Delivery with Obstetric Fistula**

If women with obstetric fistula are treated immediately after delivery or within a few days, about 15% to 20% of simple or small fistulas close on their own with conservative management.

The treatment regimen is identical in almost all respects to that used for women who have survived prolonged or obstructed labour (see Participant Handouts 2-J, 2-K, and 2-R). Continuous bladder drainage by catheter, however, is maintained for a longer period of time: a minimum of four weeks to a maximum of six weeks, according to local protocol.

#### **Reference**

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-M**

### **Management of an Indwelling Catheter in Obstetric Fistula Clients**

An indwelling catheter is an invasive device and is associated with significant complications. Infection and encrustation are common and often lead to urethral trauma and blockage of the catheter. Other complications include urethritis and urethral erosion, tearing, or other damage.

Long-term use of catheters increases the risk for complications. Catheter-associated urinary tract infections are one of the most common hospital-acquired infections.

An indwelling catheter irritates the mucosa of the bladder and urethra, impairs local defense mechanisms, and provides an ideal environment for bacterial growth.

#### **Preventing Catheter-Related Complications**

Use catheter size 16 or 18 French. Use of larger diameter catheters is associated with higher rates of urinary tract infection and is more likely to result in obstruction of the periurethral glands and of normal urethral secretions.

Use a 10 cc balloon, instilled with 5 mL of sterile water. Larger balloons increase the volume of the urine that pools below the level of the catheter lumen, thus increasing the risk for infection.

Minimise urethral trauma during catheter insertion by using generous amounts of sterile lubricant.

Maintain the aseptic, closed catheter system (opening the system increases the risk for complications).

- Disinfect the catheter and the collecting tube junction when connected.
- Disinfect the sampling port before and after sampling urine.

Maintain perineal hygiene (see below).

Wash your hands before and after handling catheters and before and after emptying or taking urine samples from the collection bag. Use disposable gloves when handling catheters and disposal bags.

Be sure that the drainage container is below the level of the bladder.

Ensure that the urine bag is not distended (with urine or air), as this will impede drainage of the bladder.

To minimise urethral trauma:

- Stabilise the catheter by anchoring it to the client's inner thigh or abdomen with strong adhesive tape. Be sure there is enough tubing to prevent tension and pulling.
- Be sure the client does not lie on the catheter.
- Be sure the catheter and tubing are not twisted or kinked.

Urine should drip at all times (open drainage).

Maintain adequate hydration to continuously flush the system. Throughout her stay at the health facility, the client should be encouraged to drink at least 5 L of water a day.

Staff, not the client, supervise urinary bags. Avoid delays in identifying and resolving catheter blockages, which can lead to wound breakdown and recurrence of the fistula. Check urinary bags hourly to ensure that the urine is flowing and that the bags are emptied; quickly examine the contents for quantity, smell, and appearance.

Encourage the client to monitor her own urine and to empty her collecting bag or inform staff if the bag is filled up. The bag should be emptied every eight hours or when the volume is greater than 400 mL. The client should wash her hands before and after handling the bags.

An alternative to urinary bags is the “drink, drip, and dry method.” Attach a simple straight clean silicone tube to the Foley catheter. The tube then drips into a small bucket with a lid that has a hole for the tube. The client herself monitors her own urine; she reports immediately if no urine is coming out or if it is smelly, cloudy, or insufficient.

Separate and label graduated containers for each client’s waste and each client’s drain. Write the client’s name and type of waste on the label of each container. Do not allow the spigot or spout on the drainage bag to touch the sides of the graduated container when emptying the bag.

Clean drainage bags daily with a 0.5% chlorine solution.

Monitor the client’s skin around the adhesive tape used to attach the catheter to the thigh or abdomen; adhesive tape may cause skin irritation.

If necrotic tissue is present, it is usually left to separate; when this happens, the edges separate and rise above the other tissue. If there is any remaining loose necrotic tissue, it is excised. Many fistula surgeons attest that this tissue lacks nerves and the client feels no pain if it is trimmed off. Any excision of necrotic tissue should be done under aseptic conditions.

Do not take urine cultures from an old urinary drainage system. If infection is suspected, take a sample from a newly inserted urinary drainage system.

A short course of antibiotics at the time of catheter removal may decrease the likelihood of catheter-acquired infections.

Before the client is transported, empty drainage. Do not clamp the catheter when the client is being transported.

When a client has two drainage devices, keep the devices on opposite sides of the bed.

Use irrigation only for urology and genitourinary trauma clients who are likely to have tissue or blood clots obstructing drainage. The use of irrigation is ineffective in preventing or eradicating bacteria in indwelling catheters.

If infection develops, treatment is according to local protocol.

## Perineal Toilet and Catheter Cleaning

The client has a sitz bath at least twice a day until the catheter is removed.

After the vaginal pack and the labial pack (if used) are removed, it is essential to scrupulously clean the perineal area. This can be done by sitz baths or by perineal and catheter care.

The procedure for perineal toilet and catheter cleaning is as follows:

1. Prepare a trolley with syringes (10 cc and 50 cc), gauze swabs, gloves, and saline.
2. Place the client on a bedpan. Drizzle saline over the outer edge of the labia. Gently separate the labia with a gloved hand and drizzle more saline over them. Gently dry the area, ensuring that all dirt, blood, and mucus are removed.
3. Gently wipe around the catheters, ensuring that no crust has formed. Do not pull on the catheter during cleaning.
4. Flush the catheters with just enough saline to keep them unblocked. Do not use pressure when flushing catheters.

To avoid spreading bacteria from the rectum to the vagina, always cleanse women from front (meatal area) to back (anus), using salty water or a solution of mild soap in water. Avoid using bactericidal solutions or gels on the meatus, as these items do not reduce the risk for urinary tract infection and can be irritating, thus increasing the risk for infection.

If the weather is very hot, cleaning may need to be done more often.

## References

- EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.
- Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.
- Hancock, B., and Browning, A. 2009. *Practical obstetric fistula surgery*. London: Royal Society of Medicine Press.
- Newman, D. K. 2007. The indwelling urinary catheter: Principles for best practise. *Journal of Wound, Ostomy and Continence Nursing* 34(6):655–661.
- World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-N**

### **Admission and Intake Procedures for Clients Living with Obstetric Fistula**

Admission procedures vary among health facilities. The nurse or midwife follows local protocol. Certain practises are customary in most health care facilities. These include the following:

- Ideally, the client is admitted by a nurse or midwife who speaks the same or at least a common language. The admitting staff member answers any questions the client has, explains what will happen, and reviews the procedures of admission.
- Staff protect the client's privacy and dignity.
- Staff assess the client's ability to give and receive information.
- As soon as possible, the client's history is taken, and she receives a physical examination (see Participant Handout 3-F). These procedures usually take place at outpatient facilities, but they may be repeated upon admission. Laboratory tests are conducted as needed.
- Staff provide information to the client about the following, as appropriate:
  - Exams and findings
  - The client's condition and its causes (including dispelling any myths or misconceptions about fistula)
  - The possibility of treatment and treatment options
  - Length and potential outcome of treatment
  - Success rates for the type of repair surgery she may have
  - Self-care
- The admitting staff member introduces the client to other clients in the ward and to the staff who will be caring for her. The staff member familiarises the client with the hospital and the ward (e.g., shows her where the toilets and showers are located). The client learns about the ward's activities and schedule (e.g., meal times). She is told how to get help if she needs something.
- The client may need a bath to refresh herself. If possible, staff give the client a hospital dress; her own clothes are kept in a secure place to take home once she has been discharged.
- If the weather is cold, staff give the client a blanket, if available, to help keep her warm.
- The facility provides a well-balanced diet for the client and treats any intestinal parasites. If she is very weak, she receives supportive nursing care and a nutritious diet in a form she can tolerate so she does not become dehydrated.
- The client may need help with her personal care (e.g., bed baths).
- The nurse documents and reports all findings on the appropriate forms and refers the client to a doctor, as required.
- To facilitate early decision making, a doctor sees all clients on admission.
- If the client's condition is not treatable, the staff provides information on community support networks and discuss with her how she will go on with her life.

#### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-0**

### **Informed Consent for Fistula Repair**

#### **Definition**

Informed consent involves communication between a client and a provider to confirm that the client has made an informed and voluntary choice to use or receive a medical service, procedure, or surgery.

#### **More about Informed Consent**

Informed consent is one component of the counselling process (covered in Module 5 of this curriculum). The outcome of counselling is an informed decision.

Informed consent uses simple language, terms, and visual aids that the client understands.

Informed consent can only be obtained after the client has been given adequate and relevant information, in a language and terms she understands, about:

- The nature of her condition, the causes, and the medical procedure
- The risks and benefits of fistula repair surgery
- Alternatives to fistula repair surgery

Voluntary consent cannot be obtained by means of special inducement (incentive or disincentive), force, fraud, deceit, duress, bias, or other forms of coercion or misrepresentation, including unwarranted deferral or repeated postponement of surgery.

The concept of informed consent may be culturally unfamiliar to clients. The provider needs to clearly and simply explain it.

Just because the client signs a consent form does not necessarily mean that she requests the procedure with full knowledge of the facts.

Documenting informed consent helps to ensure that the process has occurred and that the health care facility is complying with legal requirements.

While nurses and midwives can obtain and document informed consent, the primary responsibility for ensuring informed consent rests with the surgeon who performs the repair.

The surgeon who performs the repair is responsible for providing answers to client questions that the nurse or midwife is unable to answer.

When staff do not speak the client's language, an interpreter should be available to ensure that the client understands the informed consent process.

## **Five Elements of Informed Consent**

Information should be presented in simple language and with simple illustrations that the client can easily understand.

### ***Treatment options***

- The repair procedure indicated for the client
- Whether the procedure can be done at the facility or whether the client will have to be referred to another location
- The costs associated with the procedure (e.g., transportation, follow-up visits)

### ***Procedure details***

- The type of surgery to be performed
- The benefits of the procedure
- Whether more than one procedure will be needed
- Anaesthesia to be used
- Pain management
- The expected postoperative course
- Follow-up, including the need for sexual abstinence for a time and for family planning
- The possibility of postoperative side effects

### ***Associated risks***

- Risks associated with any surgical procedure (e.g., bleeding, infection, death)
- Risks specific to fistula repair (e.g., damage to nearby organs)
- Infertility, which may or not be a result of repair surgery

### ***Potential outcomes***

- If the procedure succeeds, the client will have no more leaking and associated discomfort. If she becomes pregnant again, she will need to receive antenatal care and deliver by caesarean section.
- If the procedure does not succeed, leaking will continue, sometimes to a lesser degree.
- Some women experience infertility after repair surgery. This can usually be prevented by abstaining from sexual intercourse for a time after repair surgery (usually three months), delaying pregnancy for at least one year after surgery by using family planning, obtaining antenatal care for future pregnancies, and delivering by caesarean section.
- Some women experience narrowing of the vagina after repair, leading to pain during intercourse. If this occurs, the client may need additional treatment; in a few cases, the condition may not be treatable and the couple will need to adjust to it.

### ***Options to decide for or against the procedure***

- *If the client decides to have the procedure:* The nurse or midwife confirms her understanding of the procedure, the benefits, the risks, the potential outcomes, the need to abstain from sexual intercourse for a period of time after repair surgery (usually three months), and the need to delay pregnancy for at least one year after surgery by using family planning.
- *If the client decides not to have the procedure:* The nurse or midwife confirms that she understands the procedure and understands available options. The nurse or midwife assures the client that she will not lose any health benefits that she has received before and that she can still have the repair in the future if she changes her mind. The nurse/midwife assesses any other health needs the client has and refers her appropriately.

### **The Informed Consent Form**

Informed consent forms should be available in the most common languages of the facility's service area and, to the extent possible, in other languages.

The nurse or midwife reads the entire form aloud to the client. If the client can read, she should have a form to read along with the nurse or midwife. If the client cannot read, a witness should have a form to read along with. If the witness cannot read, he or she should at least be present when the form is read aloud to the client.

After asking if the client understands the information on the form and if she requests the procedure, the nurse or midwife then obtains the required signature or marks.

- For clients who can read and write, the informed consent form must be signed by (a) the client and (b) the operating doctor or his or her designated assistant.
- For clients who cannot read or write, the informed consent form must be signed by (a) the client, using a thumbprint or mark, and (b) the operating doctor or his or her designated assistant. In such cases, it is advisable for the client to have a witness (e.g., a support person of her choosing) present during the informed consent process, to ensure recollection of information. The witness should also sign the consent form in the designated area.

The signature of the doctor or assistant means that the person has verified the client's signature, thumbprint, or mark and has established that the fistula repair client understands and agrees to undergo the surgery.

Each signature must be dated, and the date of each signature must be before or on the day of surgery.

### **Reference**

Fistula Care Project. 2010. *How to use the informed consent materials*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 3-P Informed Consent Form for Fistula Repair

### Fistula Care: Informed Consent form

*Instructions: Read through the form with the client and print the client's full name in the space provided on the first line below. Ask the client to put her initials in the space provided before each number after she has read the statement. After the client has read or heard the statement, ask her to put either her initials, fingerprint, or other agreed-upon mark on the signature line. Follow the instructions for the signature of a witness. Ask the physician or her/his designate to sign this form before preoperative preparations begin.*

I, \_\_\_\_\_, the signed, request that a fistula repair surgery be performed on my person. (client's name)

I make this request of my own free, informed will, without having been forced, pressured, or given any special inducements. I understand the following:

1. The procedure to be performed on me is a surgical procedure, the details of which have been explained to my understanding.
2. This surgical procedure involves risks of complications such as bleeding, injury to other organs, and infection, including death.
3. This procedure offers the benefits of eliminating the fistula and its associated symptoms of leaking, soiling, or both.
4. No surgical procedure can be guaranteed to work 100% on all people; there is a potential for symptoms to continue; there also may be a need for additional surgery, or additional surgery may not be an option.
5. This surgical procedure will not guarantee future desired fertility.
6. The outcomes of this surgical procedure include a period of abstinence (3–6 months postrepair), followed by the use of family planning for a period of time before I can attempt to conceive.
7. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

\_\_\_\_\_  
Date                      Signature or mark of the client

\_\_\_\_\_  
Date                      Signature of operating physician or designate

*If the client cannot read, a witness of the client's choosing, and speaking the same language, must sign the following declaration:*

\_\_\_\_\_  
Date                      Signature of witness

*Source:* Fistula Care. 2010. *How to use the informed consent materials.* New York: EngenderHealth.

**PARTICIPANT HANDOUT 3-Q**  
**Informed Consent:**  
**Observer's Checklist for Role Play**

<b>Did the counsellor explain:</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
The treatment options?			
The type of surgery to be performed?			
The potential benefits of the procedure?			
Whether more than one procedure will be needed?			
Anaesthesia and pain management?			
Follow-up, including the need for sexual abstinence and family planning use?			
The need for the client to receive antenatal care in future pregnancies and to deliver by cesarean section?			
The risks associated with the procedure, including the risks specific to fistula repair?			
The risk for future infertility?			
If the procedure succeeds: That the client will have no more leaking?			
If the procedure does not succeed: That leaking will continue, perhaps to a lesser degree?			
If the client decides not to have the procedure: That the client will not lose any health benefits, and that she can have the repair in the future?			

## **PARTICIPANT HANDOUT 3-R**

### **Preoperative Care and Preparation of Fistula Repair Surgery Clients**

Throughout all preoperative care and preparation, the nurse or midwife provides psychological support, assists the client, explains what is being done, and answers her questions. The nurse or midwife notes any abnormalities and reports them to the surgeon.

Sometimes, due to limited availability of fistula repair services, the client must wait at home until her repair surgery can be scheduled and/or performed. While specific preoperative instructions for the client will vary, depending upon her condition, the resources she has at home, and local medical protocols, those instructions typically include information about how to care for the fistula, the need for sitz baths, and the importance of good nutrition.

#### **Bathing**

The client has a sitz bath twice a day.

#### **Diet and Hydration**

A high-calorie, high-protein diet is essential for all women, both before and after surgery. The social circumstances of women who have lived with fistula for some time may lead to anaemia and malnutrition. Throughout her stay, the client should be encouraged to drink at least 5 L of water a day, to discourage the development of bladder calculi.

Two days before repair surgery, the client is given a light diet only (e.g., potatoes, rice, macaroni, clear soup, low-fibre bread/cereal). She is encouraged to maintain a high oral intake of fluids. The day before surgery, she has a fluid-only diet (tea, juice, soft drinks, water.)

Some surgeons prefer women to be “nil by mouth” from midnight before surgery; others encourage high fluid intake before surgery for women who are undergoing spinal anaesthesia.

#### **Bowel Care**

Rectal washouts with warm soapy water are given until clear water returns.

When spinal anaesthesia is used, most surgeons use enemas before operations to repair vesicovaginal fistula. Spinal anaesthesia relaxes the anal sphincter, with resultant soiling of the operative field. Enemas are recommended for the repair of a rectovaginal fistula. When enemas are used, they are given at least twice before surgery.

For rectovaginal fistula or a complex fistula, some surgeons give castor oil 30 cc with plenty of water two days before surgery.

#### **Medications before Surgery**

Medications should be given according to local protocols, but may include iron supplementation and antihelminthics (drugs used to treat infections caused by parasitic worms). Preoperative sedation, such as 10 mg madazolam or 100 mg phenobarbitone, is optional. If sedation is given, it is administered the night before surgery, the morning of surgery, or

according to the hospital's protocol. Many surgeons prescribe prophylactic antibiotics for women undergoing fistula repair surgery.

### **Preoperative Physiotherapy**

For all women, particularly those likely to be on bed rest after surgery, regular exercise before repair surgery is important, to promote good circulation and to maintain muscle strength. *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, which was published by the World Health Organization (WHO) in 2006, provides examples of recommended exercises. These exercises should begin as soon as the client is admitted.

Pelvic floor exercises can also begin at admission, depending on the particular case. The client needs to understand that she should gently squeeze these muscles only when advised to do so, particularly when the catheter is in place.

*Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* provides information on physiotherapy for women who have nerve damage, muscle weakness, and other specific physical problems.

### **Preparing the Perineum**

Some surgeons prefer to wash and remove hair from the labia and perineum at the onset of surgery; in some units, nursing staff perform these tasks in the unit before surgery.

WHO has noted that shaving is acceptable for fistula repair surgery (2006, page 38). However, evidence indicates that shaving increases the risk for surgical site infection (Pfiedler Enterprises, 2009; EngenderHealth, 2011) because it causes small nicks and breaks in the skin where bacteria can grow and multiply.

Hair should be removed from the labia and perineum only if its presence will interfere with the surgery. When hair is removed:

- An electric or battery-operated clipper or scissor should be used. Razors should be avoided.
- Removal should preferably be done in the operating theatre immediately before surgery and not sooner.

### **Vital Signs**

The client's preoperative vital signs are checked and recorded before surgery and at other times, according to local protocol.

### **Preoperative Anaesthetic Check**

The staff tell the client the type and effect of the anaesthesia that will be used. In a large majority of obstetric fistula cases, spinal anaesthesia is used. The anaesthetist examines the client before the operation.

### **IV Drip**

For surgery, a normal saline solution is used unless the client is hypertensive.

### **Blood**

Most repair cases do not require transfusion. If the surgery requires transfusion, the client may be asked to arrange for two or more units of blood.

## Documentation

Staff note preoperative activities in the client's record. The nurse or midwife checks to see that the informed consent document, with the appropriate signatures or marks, is in the client record. If a signature or mark is missing, he/she obtains it before surgery. The nurse or midwife ensures that the client's signature or mark confirms that an informed consent process has taken place. The surgeon confirms documentation of informed consent before starting the procedure.

## References

Arrowsmith, S. D., Ruminjo, J., and Landry, E. G. 2010. Current practices in treatment of female genital fistula: A cross sectional study. *BMC Pregnancy and Childbirth* 10(73).

EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

Pfiedler Enterprises. 2009. *Preoperative hair removal: Impact on surgical site selection*. Aurora, CO.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## PARTICIPANT HANDOUT 3-S

### Fistula Repair Surgery

#### The Aims of Surgery

- To close the fistula
- To make the client continent
- To enable the client to resume a full and active life

#### Classification

Fistulas are classified in two ways: (1) by their surgical classification and (2) by the possible degree of difficulty of their repair (WHO, 2006). Both are based on the degree of involvement, or not, of the closing mechanism, since this has consequences for the operative technique and the prognosis of the repair.

The *surgical classification* refers to the type of surgical repair that might be required. There is no standardised classification system for obstetric fistula; a number of such systems are used. One example (below) shows how the operative technique becomes progressively more complicated based on the type, from type I to type IIBb. The same principle applies to classification by the size of the fistula, which ranges from small to extensive.

<b>Classification of fistulas by type of surgery required, based on their anatomic/physiologic location</b>			
Type I	Fistula not involving the closing mechanism		
Type II	Fistula involving the closing mechanism		
	A	Without (sub)total urethral involvement	
		a	Without circumferential defect
		b	With circumferential defect
	B	With (sub)total urethral involvement	
		a	Without circumferential defect
		b	With circumferential defect
Type III	Miscellaneous (e.g., ureteric and other exceptional fistula)		
<b>Subclassification of fistula by size</b>			
Small	<2 cm		
Medium	2 to 3 cm		
Large	4 to 5 cm		
Extensive	6 or more cm		

*Source:* Waaldijk, 1995.

Fistulas are also divided into two categories based on the *degree of anticipated difficulty of the repair*:

- Good prognosis/simple fistula that can be repaired by surgeons fully trained and competent in undertaking uncomplicated fistula repairs
- Uncertain prognosis/complicated fistula that require referral to, and repair by, a specialist fistula surgeon

<b>DEGREE OF ANTICIPATED DIFFICULTY OF THE REPAIR FOR DIFFERENT FISTULA CONDITIONS</b>		
<b>Defining criteria</b>	<b>Good prognosis/simple</b>	<b>Uncertain/complicated</b>
Number of fistula	Single	Multiple
Site	Vesicovaginal fistula (VVF)	Rectovaginal fistula (RVF), VVF/RVF, involvement of the cervix
Size (diameter)	<4 cm	≥4 cm
Involvement of the urethra/continence mechanism	Absent	Present
Scarring of vaginal tissue	Absent	Present
Presence of circumferential defect (complete separation of the urethra from the bladder)	Absent	Present
Degree of tissue loss	Minimal	Extensive
Ureter/bladder involvement	Ureters inside the bladder, not draining into the vagina	Ureters draining into the vagina; bladder may have stones
Number of attempts at repair	No previous attempt	Failed previous attempts

Source: WHO, 2006.

### **Anaesthesia**

Spinal anaesthesia is usually preferred; some clients require pethidine and occasionally ketamine to complete the surgery.

### **Surgical Management of Vesicovaginal Fistula**

Most vesicovaginal fistulas can be surgically corrected using a vaginal approach, which is associated with closure rates of up to 90%. Advantages of this procedure include a short operating time, low morbidity (both during and following the procedure), low risk for ureteral injury, and low cost.

Although most vesicovaginal fistulas can be surgically corrected via the vaginal approach, the abdominal route is preferred for fistulas that are high, large, or inaccessible, for complex or multiple fistulas, and for those that have concurrent uterine or bowel involvement or need urinary diversion.

### **Surgical Management of Rectovaginal Fistula**

High symptomatic rectal fistulas occasionally require a temporary diverting colostomy for the client's comfort, but this may add to the client's stress and become inconvenient. The colostomy is not curative but is a temporary help. It is usually performed if repair of a rectovaginal fistula is planned within two weeks, and the colostomy closure is projected to be within four weeks after successful fistula repair.

### **Surgical Management of Combined Fistula (Vesicovaginal and Rectovaginal)**

The surgeon may start with RVF repair to prevent soiling of the vagina and then perform VVF repair. Or the surgeon may begin with the VVF repair and then perform the RVF repair. Some surgeons prefer to repair both fistulas during the same surgery; others choose to repair the fistulas during separate surgeries. The surgeon's preference and expertise determine surgical management of combined fistula.

### **References**

- Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.
- Hancock, B., and Browning, A. 2009. *Practical obstetric fistula surgery*. London: Royal Society of Medicine Press.
- Waaldijk, K. 1995. Surgical classification of obstetric fistula. *International Journal of Gynecology and Obstetrics*, 49(2):161–163.
- World Health Organization (WHO). 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-T**

### **Nursing Management during Fistula Repair Surgery**

#### **Surgical Roles for Nurses and Midwives**

- The assisting/scrub nurse
- The circulating nurse

#### **Intraoperative Counselling**

Counselling needs during the intraoperative period vary, depending on whether the surgery is conducted under general or spinal anaesthesia. Nurses and midwives must always:

- Ensure the client's respect and dignity.
- Maintain emotional support for the client by:
  - Providing positive, empathetic verbal and nonverbal communication
  - Alleviating her fears regarding surgery
  - Offering reassurance, comfort, and reasons for hope
- Provide information about the following as appropriate, based on the client's condition and discussion with the surgical team looking after her:
  - Information on the type of anaesthesia to be used, risks of anaesthesia, and pain
  - Reiteration of the steps involved in the procedure

Theatre staff may tend to focus on the perineum while the repair is being done and ignore the client; this should be avoided.

#### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-U**

### **The Scrub Nurse, the Circulating Nurse, and the Anaesthetist: Roles and Responsibilities**

#### **Responsibilities of the Scrub Nurse**

The scrub nurse must:

- Know which instruments and supplies are needed for the operation
- Understand each step of the repair procedure so that he/she can provide the correct instruments and assistance with minimal requests from the surgeon.
- Help the surgeon put on gloves
- Ensure that all necessary equipment, instruments, and supplies are in the theatre and ready for use
- Set the instruments on the trolley in progressive order of what the surgical team will need 10 minutes before the surgeon scrubs
- Be proactive, handing the surgeon the correct instruments needed for each step of the procedure
- Account for all instruments, gauze, and abdominal packs before and after surgery
- Decontaminate, clean, and dry the instruments after surgery; repack, label, and sterilise or high-level disinfect the instruments; store or prepare them for the next operation

#### **Responsibilities of the Circulating Nurse**

The circulating nurse must:

- Check the client's chart for the signed informed consent form
- Position the client gently on the operating table in the preferred position, so that she is as comfortable as possible and has a small pillow under her head
- Prepare materials and supplies required for the operation, such as sutures, catheters, and the tray for surgical gowns and gloves, without contaminating the assisting nurse or the sterile area of the tray, and opening packages, as needed
- Tie the surgeons' gowns
- Talk to the client and reassure her throughout the procedure
- Monitor the client's vital signs if the anaesthetist is not doing so
- Monitor the urinary catheter, informing the surgeon of any changes in flow or color of urine
- Pass equipment and expendable supplies when requested by the scrub nurse
- Adjust the light when instructed to do so
- Keep a tally of all equipment, supplies, and drugs used during the surgery; note and record the number of vaginal packs used and left in situ
- Clean the room after surgery, using a disinfectant solution, and ensure that the room is ready for use for the next client

### **Responsibilities of the Anaesthetist**

- Review the client for suitability and safety of anaesthesia the day before repair surgery
- Tell the client the type of anaesthesia to be given and how it will make her feel
- Confirm that the client was counselled, has given informed consent, and has signed an informed consent form
- Prepare the anaesthetic trolley, monitoring devices for vital signs, and anaesthesia machine when necessary
- Monitor the client's vital signs before and during surgery
- Give anaesthesia and reverse it after surgery
- Fix IV lines and monitor IV flow and client hydration during surgery
- Perform any necessary resuscitation, in case of emergency
- In liaison with the postoperative care nurse, ensure proper observation of the client for the first three hours after surgery

### **References**

EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

Rothrock, J. C. 2011. *Alexander's care of the patient in surgery*, 14th ed. Elsevier Mosby.

## PARTICIPANT HANDOUT 3-V

### Instruments Used in Fistula Repair Surgery

Product	Description	Quantity
Scissors	Scissors, dissecting, Mayo, straight, 17 cm, SS	1
	Scissors, dissecting, Mayo, curved, 17 cm, SS	1
	Scissors, tonsil, Boyd-Stille, curved, 17 cm, SS	1
	Scissors, Thorek, angled, 90° tip, 20 cm, SS	1
	Scissors, suture, Mayo, straight, 15 cm, SS	1
	Scissors, suture, Mayo, curved, 15 cm, SS	1
	Scissors, McIndoe, curved, 19 cm, SS	1
Needle holders	Needle holder, Mayo-Hegar, straight, 18 cm, tungsten carbide	1
	Needle holder, Mayo-Hegar, straight, 20 cm, tungsten carbide	1
	Needle holder, Mayo-Hegar, curved, 18 cm, tungsten carbide	1
	Needle Holder, Mayo-Hegar, curved, 20 cm, tungsten carbide, 20 cm	1
Scalpel blade holder	Scalpel blade holder, no. 7, Swann-Morton, length 15 cm, SS (for no. 11 blade)	1
Speculum	Speculum, vaginal, Graves bivalve, small, SS	1
	Speculum, vaginal, Graves bivalve, medium, SS	1
	Speculum, vaginal, Graves bivalve, large, SS	1
	Speculum, vaginal, Auvard, 22 cm weighted, 1 kg (optional additional weights: 0.8 kg, 1.2 kg), SS	1
	Speculum, vaginal, Sims single-ended (optional: additional double ended), SS	1
Forceps	Forceps, tissue, Littlewood, 18.5 cm, SS	1
	Forceps, tissue, standard, 14.5 cm, SS	1
	Forceps, tissue, Allis, 15 cm, SS	1
	Forceps, tissue, Allis, 20 cm, SS	1
	Forceps, artery, long, straight, Kelly, 18 cm, SS	1
	Forceps, artery, long, curved, Kelly, 18 cm, SS	1
	Forceps, dissecting, toothed 15 cm, SS	1
	Forceps, dissecting, toothed 20 cm, SS	1
	Forceps, dissecting, nontoothed, 18 cm, SS	1
	Forceps, dissecting, nontoothed, 20 cm, SS	1
	Forceps, sponge-holding, straight, Foerster, smooth, 24 cm, SS	1
	Forceps, sponge-holding, straight, Foerster, serrated, 24 cm, SS	1
	Forceps, artery, nontoothed, curved tip, 20 cm, SS	1
	Forceps, artery, nontoothed, gentle angled tip, 20 cm, SS	1
	Forceps, artery, sharp-angled tip, 20 cm nontoothed, SS	1
	Forceps, artery, small, Hartman (or Halsted mosquito), straight, 15 cm, SS	2
	Forceps, artery, small, Hartman, curved 15 cm, SS	2
	Forceps, artery, Kocher, straight, 20 cm, 1 x 2 teeth, SS	1
	Forceps, artery, Kocher, straight, 15 cm, 1 x 2 teeth, SS	1
	Forceps, cervical, vulsellum, curved, 25 cm (optional: cervical tenaculum, 25 cm), SS	1
Forceps, Cheatle forceps, and jar (optional), SS	1	
Needle	Aneurysm, Deschamps, sharp-pointed, 20 cm, right-sided (optional: left-sided), right-and-left set each, sharp points, SS	1
Retractors	Vaginal thyroid green, U.S. Army/Navy, <i>ecarteurs de farabeuf</i> , single/double end, 22 cm (optional: Langenbeck blade, 13 x 44 mm), SS	1
	Abdominal, self-retaining, Gosset, large, SS	1
Catheter	Female, urethral, 16 cm, SS	1
Sound	Uterine, malleable with eye, calibrated, 30 cm, SS	1
Probe	Sinus, malleable with eye, SS	1
Basin	Kidney, 825 mL, SS (optional: 600 mL)	1
	Gallipot, 100 mL, SS	1
	Plastic, 600 mL	1

## **PARTICIPANT HANDOUT 3-W**

### **Fistula Repair Surgery: The Surgical Trolley**



## PARTICIPANT HANDOUT 3-X

### Postoperative Care of Fistula Repair Surgery Clients

Skilled postoperative care is critical to the success of fistula repair surgery.

#### The Three D's of Postoperative Care

- Make sure that the client Drinks.
- Make sure that the client is Dry.
- Make sure that all drainages are Draining.

#### Immediate Postoperative Care: The First 24 Hours

Regular observations and timely, appropriate action are important. The nurse or midwife must:

- Assess the client's haemodynamic status, checking pulse, blood pressure, pallor, and temperature
- Assess her respiratory rate
- Assess her mental alertness
- Look for primary haemorrhage, checking all potential bleeding sites (vaginal pack, labial graft site, abdominal incision, drainages)
- Note on the client's fluid input/output chart all oral and I.V. fluids, urine output, and other drainage
- If catheter(s) are in place (e.g., ureteric, urethral), check to see that they are draining as expected
- Note the color of the client's urine

**In the first hour after surgery:** If the client received general anaesthesia, check vital signs every 15 minutes in the first hour after surgery. If she received spinal anaesthesia, check vital signs every half hour in the first hour after surgery. Carefully monitor the client's temperature.

**Hours 2 to 24 after surgery:** Check vital signs every half hour for an additional four hours after surgery. If signs are stable after the first five hours, check them every four hours thereafter. If there is any cause for concern or signs of shock, notify the surgeon immediately.

Use of prophylactic antibiotics varies widely, from none to a single I.V. preoperative dose to multiple additional postoperative doses. Common protocols for prophylaxis include:

- Extencilline (long-acting penicillin) in a single dose
- Sulfamethoxazole/trimethoprim or amoxicillin for seven days
- Parenteral antibiotics (usually sulfamethoxazole/trimethoprim) for 24 hours, then continued orally for another week
- Gentamicin 160 mg and metronidazole 500 mg in a single dose

Finally, pain assessment and management are essential, to ensure the client's comfort and pain control with analgesics.

## **Subsequent Postoperative Care**

### **Urine drainage**

Continuous free drainage of urine will ensure that the bladder is kept empty and will allow the suture line to heal. Therefore:

- The nurse or midwife follows the surgeon's orders for removal of the ureteric catheter.
- A urethral catheter should be used for continuous drainage for 10 to 14 days, depending on the type of fistula.
  - Some hospitals will use open catheters that drain into a receptacle, so that there is less danger of bladder distention.
  - Other hospitals promote the use of a Foley catheter with a urine bag to allow easy mobilisation. The closed system has the advantage of preventing contamination.

### **Catheter care**

It is vital to maintain free bladder drainage after fistula repair and to ensure that the client understands the urgency of this recommendation. Therefore:

1. Check urinary bags every hour.
2. Ensure that the catheter or tubing is not twisted or kinked or blocked by a blood clot. The catheter is to remain in place without tension or pulling on the urethra or bladder. The catheter may be fixed to the client's inner thigh or abdomen with strong adhesive tape. The advantage of fixing it to the abdomen is that there is no pulling when the client is mobile. Be sure there is enough tubing to prevent tension and pulling.
3. Ensure that the urine bag is not distended (with urine or air), as this will impede drainage of the bladder; backflow of urine could disrupt the repair site.
4. Note the colour and amount of urine.
5. Check for bleeding.
6. Encourage the client to empty her bag or inform staff if the bag is filled up.
7. If blockage of the catheter is suspected, flush the catheter according to the instructions provided on Participant Handout 3-Z. Sometimes the catheter will need to be changed, an action that usually needs to be done in the operating theatre.
8. Use a larger catheter if significant haematuria is present.
9. Avoid a bladder wash if a Foley catheter is used; there is also debate as to whether or not the bulb should be inflated. Bladder wash may distend the bladder too much and disrupt the repair site.
  - Bladder training:
    - Some hospitals recommend that, starting a few days before the catheter is removed, the catheter should be clamped for short periods and then for progressively longer periods, to accustom the bladder to distention. Then, if the client is dry, the catheter can be completely removed. The risk with this approach is that the provider does not know if the fistula is closed, because a dye test has not been performed.
    - Other hospitals find bladder training unnecessary. It might do more harm than good if the bladder becomes inadvertently overdistended, leading to rupture of the repair site. Instead of using bladder training, they recommend a dye test to confirm that the fistula is closed before removing the catheter. After removal, the provider asks the client to voluntarily and gradually increase the length of time she waits before passing urine.
  - The catheter should be left in place for a longer period if there are concerns about the integrity of the fistula repair in the postoperative period. A dye test can also be performed. If the dye test is positive, indicating persistent leakage, the catheter should be left in place for two to three weeks longer.

### **Vaginal pack**

If a vaginal pack was used, it should be removed 24 hours after surgery unless a doctor instructs the staff to leave it for longer. Concerns about haemostasis and vaginal scarring/stenosis encountered during surgery affect the length of time the pack remains in place.

### **Antibiotics**

Depending on the regimen used, antibiotics may or may not be continued in the postoperative period.

### **Analgesia**

Provide analgesia according to the surgeon's orders or local protocol.

### **Bed rest and mobilisation**

The client should be encouraged to become fully mobile as soon as possible:

- Women who have undergone simple repairs should be encouraged to move around within a day of surgery.
- Those who have had complicated repair, ureteric reimplantation, and so on may need to wait up to seven days after surgery for mobilisation.
- Empty the urine bag before the client gets up. Keep the level of the urine in the bag low when the client is moving around. Care should be taken to prevent a sudden pull on the catheter; affixing the catheter to the abdomen can help prevent such pulling.

### **Hydration**

- Encourage high fluid intake (at least 5 L per day) to enable the client to produce 3 to 4 L of urine per 24 hours.
- Monitor her fluid input and output.

### **Diet**

- If the client has had a vaginal repair, she can resume a normal diet and should drink copious liquids.
- Consult with the surgeon, since dietary protocols vary, especially after repair of rectovaginal fistula or complicated fistula.
- Women who have had a colostomy can follow the diet regimen for vesicovaginal fistula clients.
- Ensure that the client consumes adequate protein.

### **Bowel care**

- Prevent constipation and undue straining.
- Medications may be used to soften the stools.
- Rectal suppositories should be avoided if the client had a rectovaginal fistula.

### **Prevention of deep-vein thrombosis and pulmonary complications**

- Deep-breathing exercises
- Coughing
- Positioning
- Mobilisation as soon as possible, preferably on the first postoperative day
- Pain management

### **Training in pelvic floor exercises and physiotherapy**

Once the client is up and about, encourage her to undertake the exercises described in *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, published by the World Health Organization in 2006.

If the client has problems with limb contractures, foot drop, or nerve damage, the exercises for these conditions, which she should have started during the preoperative period, are continued throughout her rehabilitation.

### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 3-Y**

### **Fistula Repair Surgery: Postoperative Complications**

#### **Early Complications**

Complications that may appear soon after fistula repair surgery include the following:

##### ***Anaesthetic complications***

- From the medications given: dosage problems; allergic reactions
- From the anaesthetic procedure: Complications largely depend on the type of anaesthesia (e.g., general with or without endotracheal intubation; spinal anaesthesia).

##### ***Haemorrhage***

- Primary haemorrhage, which occurs within 24 hours of surgery, is usually from unsecured bleeding points.
- Secondary haemorrhage, which occurs more than 24 hours after surgery, is due to infection with erosion into a vessel, which occurs one to two weeks after surgery. This may also occur from unrecognised slow or small primary bleeding sites and from trauma to the surgical site.

##### ***Infection***

- Wound infection
- Urinary tract infection
- Respiratory tract infection

##### ***Ureteric complications***

- Surgical injury
- Obstruction, oedema
- Blockage of catheter due to kinking or blood clot
- Wound dehiscence and failure of repair, usually after the first week or about days nine to 12 postoperatively

#### **Late Complications**

Complications that may appear later in the healing process include the following:

##### ***Vaginal stenosis and scarring***

- Stenosis or scarring may occur as a result of the surgery or may be present at the time of surgery.
- When present at the time of surgery, it is usually situated as a thick band over the posterior vaginal wall. Management of this band of scar tissue is by lateral incision to release the scar.
- The vaginal pack is left in situ for several days after the fistula repair.
- A well-lubricated vaginal dilator is used to prevent reformation of the vaginal scar and stenosis. The dilator is very gently inserted and left in place for at least 10 minutes each day for a period of six weeks.

- When the scar is more extensive, skin grafts or pedicle grafts may be harvested and rotated into the vagina from surrounding tissues (e.g. buttock, labia, thigh) to cover the tissue deficit following incision and excision of scar tissue to establish a normal vaginal caliber.

### **Persistent urinary incontinence**

- Incontinence is a significant complication of fistula and is frequently ignored or underestimated.
- It may be the result of failed fistula repair, undiagnosed ureteric fistula, missed fistula, genuine stress incontinence, detrusor overactivity/instability, overflow incontinence, infection, or bladder calculi.
- It may be mild or very severe, with the client complaining of continuous leakage of urine.
- Further assessment is required to establish a diagnosis and suitable management.
- Differential diagnosis includes urinary tract infection and renal calculi.

### **Faecal incontinence**

- Accidental injury during reconstruction of the vagina for stenosis can lead to faecal incontinence and necessitate repair.

### **Sexual dysfunction**

- A number of factors, including vaginal scarring/stenosis, dyspareunia, anxiety, and other psychological factors, can lead to sexual problems.

### **Psychosocial dysfunction**

- Many women with fistula have lived through several major traumatic events that can easily cause emotional and mental scars: difficult labour and delivery, stillbirth, fistula, social stigma, or spousal abandonment.

### **Amenorrhoea**

- In some cases the client's menses may return two to four months after surgical repair.
- Some women continue to have amenorrhoea even after repair, and it is often associated with infertility.

### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

Spurlock, J., and Chelmow, D. 2009. Vesicovaginal fistula. Retrieved from <http://emedicine.medscape.com/article/267943-overview>.

## PARTICIPANT HANDOUT 3-Z

### Fistula Repair Surgery: Nursing Care of Selected Complications

Complication	Nursing care
<b>Blocked catheter</b>	
<p>The following three signs indicate a blocked catheter:</p> <ul style="list-style-type: none"> <li>• The client's abdomen is distended and tender and she feels the urge to pass urine (1) on her own or (2) upon gentle pressure on her abdomen.</li> <li>• The client is wet from urine leaking around the catheter or through the repair.</li> <li>• Urine stops dripping into the basin (if open system is used).</li> </ul> <p><b>Blockage can occur at any time and requires immediate attention</b>, to reduce pressure on the operative site.</p> <p>Maintaining catheter care, including hourly checking of urinary bags if they are used, helps prevent blockage.</p>	<p>Examine the catheter for twists or kinks, which can block urine flow. If the urinary catheter is blocked:</p> <ol style="list-style-type: none"> <li>1. Immediately flush the catheter gently and carefully three times with 20 mL normal sterile saline (sodium chloride 9%); withdraw the fluid after each flush. Alternative sterile solutions are (a) water for injection and (b) boric solution (chlorinated lime 1.25 g) and boric acid solution (B.P. 1988: Eusol) mixed with 100 mL purified water.</li> <li>2. After the third flush, connect the urine bag and observe the flow.</li> <li>3. If the flushing is done and nothing comes out on withdrawal, the catheter is not in the bladder.</li> <li>4. Check the flow and colour of urine after flushing.</li> <li>5. After flushing, <b>inform the doctor if urine is bloody or urine flow is absent</b>; the catheter may need to be changed, as per doctor's order.</li> <li>6. Encourage the client to drink at least 5 L of water per day.</li> </ol>
<b>Vaginal haemorrhage</b>	
<p>Vaginal haemorrhage is characterised by vaginal bleeding, including vaginal bleeding through the vaginal pack.</p>	<p><b>This complication requires immediate attention.</b> Assess the amount of bleeding (haemorrhage) and <b>inform the attending doctor</b>, who will decide on further management.</p> <ol style="list-style-type: none"> <li>1. If bleeding is not arterial, a firm vaginal pack may be used.</li> <li>2. If bleeding is arterial, the client will need to be taken back to the operating theatre.</li> <li>3. The surgeon will evaluate the causes of the client's bleeding.</li> <li>4. If the bleeding has been severe, check the client's haemoglobin levels and treat with iron supplementation as needed.</li> </ol>

Complication	Nursing care
<b>Wound sepsis</b>	
<p>Wound sepsis is characterised by fever, foul smell of urine or vaginal discharge, pain on urination or lower abdominal pain, and/or pain and swelling or discharge at the episiotomy site.</p>	<ol style="list-style-type: none"> <li>1. <b>Inform the doctor of the client's symptoms immediately.</b></li> <li>2. Take a sample for culture and sensitivity.</li> <li>3. The doctor will treat infection of the repair site or the urinary tract with appropriate antibiotics in accordance with local protocol.</li> <li>4. If the wound is infected, it may need to be reopened.</li> </ol>
<b>Breakdown of repair</b>	
<p>Breakdown of repair is characterised by the client's being wet from leaking urine.</p>	<p><b>Inform the doctor that the client is leaking urine.</b></p> <p><i>Note:</i> Before removal of the catheter, the doctor will check for completeness of repair using a dye test.</p> <ul style="list-style-type: none"> <li>• If the test is positive, the catheter remains in situ and on free drainage for an additional four to six weeks, to facilitate healing.</li> <li>• If the breakdown occurs early (within five days of surgery), it is unlikely that prolonged drainage will help healing.</li> <li>• Breakdowns that occur seven to 14 days after surgery may respond to prolonged drainage.</li> </ul>
<b>Anuria</b>	
<p>Anuria is characterised by absence of urine in the basin or drainage bag.</p>	<ol style="list-style-type: none"> <li>1. Check that the catheter is not blocked.</li> <li>2. Ensure that the client has been drinking the recommended amounts of fluids.</li> <li>3. Monitor urine flow closely and carefully; if the client is not producing urine, <b>inform the attending doctor</b>, who will decide on further management.</li> </ol>

### References

Hancock, B., and Browning, A. 2009. *Practical obstetric fistula surgery*. London: Royal Society of Medicine Press.

World Health Organization. 2008. *Managing prolonged and obstructed labour: Education materials for teachers of midwifery—Midwifery education modules*, 2nd ed. Geneva.

## **PARTICIPANT HANDOUT 3-AA**

### **Fistula Repair Surgery: Postoperative Nursing Care Plan**

#### **Case Study**

You are the nurse working in the recovery room for fistula repair. The incoming patient Ms. T. is 17 years old. She developed a vesicovaginal fistula during the labour and stillbirth of her first child, a 3 kg girl. Ms. T's parents brought her to the repair facility; they had searched over the past six months for a facility where their daughter could find help.

Ms. T. had a large but simple fistula repaired under spinal anaesthesia; she tolerated the procedure well. Upon receiving Ms. T. from the operating theatre nurse at 1700 hours, you note the following:

- An indwelling urinary catheter is in place, taped to her abdomen. The urine collecting in the bag is pale yellow and minimal. Collection measured 600 cc just before leaving the theatre.
- An IV of dextrose and water is infusing, as per the surgeon's order.
- The vagina has packing.
- The vital signs show a pulse of 60 with regular rhythm; BP 90/62; respirations within normal limits but shallow; occasional shivering, with a core temperature of 37°C.

#### **Case Questions**

- What will be your recovery room nursing care plan for Ms. T.? Use the blank chart on the next page to fill in your management plan and for each management activity, state your expected outcome.
- On the nursing plan chart, indicate how frequently you will monitor Ms. T.
- On the nursing plan chart, indicate under which circumstances you will alert the surgeon of Ms. T's condition.

**Immediate Postoperative Nursing Care Plan within First 24 Hours of Surgery** *(based on the nursing process)*

<b>Nursing Diagnosis</b>	<b>Nursing Interventions</b>	<b>Rationale</b>	<b>Expected outcome</b>	<b>Evaluation</b>
<b>Cardiac function:</b>				
<b>Respiratory function:</b>				
<b>Thermoregulation:</b>				
<b>Urinary function:</b>				
<b>Patent IV:</b>				
<b>Surgical site:</b>				
<b>Pain management:</b>				
<b>Mental alertness:</b>				

## PARTICIPANT HANDOUT 3-BB

### Fistula Repair Surgery: The Discharge Plan and Follow-Up

#### Discharge Counselling and Education

- Describe signs of complications and side effects of fistula repair surgery (see below) and self-care.
- Stress the importance of abstinence from vaginal intercourse during the healing period (usually three months) and the need for follow-up care. (If the client has had a rectovaginal fistula repaired, she will also need to abstain from anal intercourse.)
- Tell the client not to insert any foreign bodies (e.g., tampons) into the vagina for at least three months after surgery.
- Caution the client about reproductive tract infections, including sexually transmitted infections.
- Tell the client that she should wait at least one year before her next pregnancy; stress the importance of family planning once she resumes sexual relations. It may be wise for her to start using a contraceptive method before she resumes sexual relations. Tell the client she can become pregnant as soon as she resumes vaginal intercourse. If necessary, help her choose a contraceptive method.
- Remind the client that for future pregnancies, she must receive antenatal care and deliver by caesarean section in the hospital. Tell her that subsequent vaginal birth could damage the surgical repair and reopen the fistula.
- Advise the client about healthy nutrition and genital hygiene.
- Tell the client to take any medications she has been prescribed correctly (in the correct dosages and at the right times) and to finish the prescriptions.
- Encourage the client to drink adequate amounts of water.
- Tell the client that some urine may leak as a result of activities that cause stress, such as coughing or sneezing. Teach her how to manage stress incontinence.
- Tell the client to avoid the following:
  - Lifting heavy objects before healing is complete
  - Becoming constipated.
- Tell the client that her period may return two to four months after the surgical repair. Tell her that some women who have had fistula repair do not get their periods again.
- Tell the client that she may have mild pain in the area of the surgical scar.
- Include the client's partner and other family members in the counselling and education sessions if appropriate.

If the surgery was not successful, provide information about personal hygiene, management of incontinence (e.g., exercises), possible complications related to the client's condition, and cost-effective sources of supplies (e.g., pads, colostomy bags).

Module 5 has more information on counselling.

#### Abnormal Signs

- Urine or stool leaking continuously
- Fever
- Vaginal discharge that smells bad

- Pain with urination, with or without fever
- Chills
- The need to urinate more frequently or more urgently than normal
- Dizziness, lightheadedness, or fainting
- Severe genital pain
- Nausea or vomiting
- Bleeding that is twice as heavy as a normal period
- Feeling very sad and/or feeling that you cannot take care of yourself

The client must seek medical care if she has any of these signs.

### **Social Reintegration**

Assess the client to determine if she needs help reintegrating into her community. Questions such as these may be helpful:

- How will the client get home? What kind of transportation will she use? Who will accompany her?
- Who will care for her when she returns home?
- Will she return to the home she shared with her partner? Is she divorced?
- What level of education has she achieved?
- Does she have job skills that she can use when she returns to her community?
- Did she face isolation and stigmatisation as the result of fistula?
- If the client is still leaking, how will this affect her reintegration?
- Did she lose the baby in the delivery that led to the fistula?

Possible interventions include the following:

- Provide the client with new clean clothes.
- Provide funds for her transport home and a small amount of cash.
- Escort the client home. Explain her condition and the treatment she has received to her family and neighbors; educate them about obstetric fistula and how it can be prevented.
- Refer the client to literacy or job skills training programmes.
- Refer her to social support organisations and women's groups in her area that can assist her.

Assist the client to the best of your ability, taking into account the policies and procedures of your facility.

### **Follow-Up Care**

Schedule a follow-up appointment within three months of the surgery, based on the surgeon's instructions. The purpose of this visit is to determine the status of continence and to assess the client's overall health and well-being. Be sure that the client has the necessary means and transportation to come back for the visit.

If community health nurses are available, schedule a home visit with the client before the follow-up visit at the health facility.

### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

**PARTICIPANT HANDOUT 3-CC**  
**Discharge Counselling for Fistula Repair Surgery:**  
**Observer's Checklist for Role Play**

<b>Did the counsellor:</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Describe the signs of complications and side effects that may follow fistula repair surgery?			
Describe self-care?			
Stress the importance of sexual abstinence during the healing period (usually three months)?			
Stress the importance of delaying pregnancy for at least one year after repair surgery?			
Discuss the importance of family planning once the client resumes sexual relations?			
Stress the importance of follow-up care?			
Caution the client about reproductive tract infections, including sexually transmitted infections?			
Remind the client that she must receive antenatal care if she becomes pregnant again?			
Remind the client that she must deliver by cesarean section if she becomes pregnant again?			
Advise the client about healthy nutrition?			
Include the client's partner and other family members in the counselling session, if appropriate?			
Schedule a follow-up appointment or refer the client for a follow-up visit at a facility near her home?			

## **TRAINER'S RESOURCE 3-I**

### **Module 3 Evaluation and Answer Key**

#### **TRAINING TIP**

Based on the sessions and content covered, select approximately 20 relevant questions from this list for the Module 3 Pretest and Posttest. The correct answers are shown below in **boldface**, and the source of the correct answer is shown in [brackets].

1. In obstetric fistula, infections can be transmitted:
  - a. When normal flora are introduced into an area of the body where they are not normally found
  - b. When pathogens are introduced into the body
  - c. In both of these ways**  
[Participant Handout 3-A]
  
2. List seven standard infection prevention precautions.
  - a. Washing hands
  - b. Wearing personal protective equipment, such as gloves, eye protection, face shields, and gowns
  - c. Observing respiratory hygiene and cough etiquette
  - d. Preventing injuries from sharps
  - e. Processing instruments and client care equipment
  - f. Ensuring environmental cleanliness and following waste disposal practises
  - g. Handling, transporting, and processing used/soiled linens[Participant Handout 3-C]
  
3. A 0.5% chlorine solution can effectively decontaminate surgical instruments.
  - a. True**
  - b. False[Participant Handout 3-D]
  
4. In cases of obstetric fistula, the urinary catheter can be secured to:
  - a. The abdomen only
  - b. The inner thigh only
  - c. Either the abdomen or the inner thigh
  - d. Either the abdomen or the inner thigh, as long as there is no tension or pulling on the tubing**[Participant Handout 3-F]
  
5. What type of container should be used when disposing of scalpel blades and other sharps?  
A container that is color-coded, labeled, covered, leak- and puncture-proof  
[Participant Handout 3-G]
  
6. When disposing of nonsharps biologic infectious waste, what is the best way to protect your hands?  
Wearing heavy utility gloves  
[Participant Handout 3-G]

7. Check the items below that are part of the medical history of a woman living with obstetric fistula.  
*Note:* All items should be checked.  
√ Genital cutting  
√ Duration of the labour that led to fistula  
√ Any previous attempts to repair the fistula  
√ Problems with gait or mobility  
[Participant Handout 3-H]
8. Before performing a speculum examination on a woman living with rectovaginal fistula, the provider asks the client to empty her bladder.  
**a. True**  
b. False  
[Participant Handout 3-H]
9. Why is it necessary to identify necrotic tissue when examining the vagina of a woman living with obstetric fistula?  
The tissue must be healthy before fistula repair can be done. Necrotic tissue may need to be removed before repair surgery.  
[Participant Handout 3-H]
10. What might you see when examining the thighs of a woman living with vesicovaginal fistula?  
Skin inflammation, ammoniacal dermatitis, excoriation or ulceration, skin infection, faecal contamination  
[Participant Handout 3-H]
11. When examining a woman with vesicovaginal fistula, the nurse or midwife may note pooling of fluid in the vagina.  
**a. True**  
b. False  
[Participant Handout 3-H]
12. A few clients living with rectovaginal fistula have no symptoms.  
**a. True**  
b. False  
[Participant Handout 3-H]
13. A urinalysis is required for all vesicovaginal cases.  
a. True  
**b. False**  
[Participant Handout 3-H]
14. The following conditions may indicate the presence of obstetric fistula.  
a. Foot drop  
b. Limping  
c. Inability to stand from lying down without help  
**d. All of the above**  
[Participant Handout 3-H]

15. If women with obstetric fistula are treated immediately after delivery or within a few days, about \_\_\_\_\_ of simple or small fistulas close on their own.
- 5 to 10%
  - 15 to 20%**
  - 30 to 40%
  - 50%
- [Participant Handout 3-L]
16. Infection and encrustation are common with indwelling urinary catheters. They can lead to urethral trauma and blockage of the catheter.
- True**
  - False
- [Participant Handout 3-M]
17. Gloves are necessary when handling urinary catheters.
- True**
  - False
- [Participant Handout 3-M]
18. Clients with obstetric fistula should be encouraged to drink at least 5 L of water every day.
- True**
  - False
- [Participant Handout 3-M]
19. Before the client has repair surgery, how often should staff check urinary bags?
- Every 30 minutes
  - Every hour**
  - Every two hours
- [Participant Handout 3-M]
20. When a woman with obstetric fistula has an indwelling urinary catheter, how often should she have a sitz bath?
- Once a day
  - Twice a day**
  - Three times a day
- [Participant Handout 3-M]
21. Sterile saline water (sodium chloride 9%) can be used to flush a urinary catheter.
- True**
  - False
- [Participant Handout 3-Z]
22. The informed consent process confirms that the client has made an informed and voluntary choice to use or receive a medical service, procedure, or surgery.
- True**
  - False
- [Participant Handout 3-O]

23. When a woman signs an informed consent form, this means that she fully understands the medical treatment she is about to receive.
- True
  - False**
- [Participant Handout 3-O]
24. For fistula repair procedures, who is primarily responsible for ensuring the client's informed consent?
- The nurse in the preoperative unit
  - The surgeon who performs the repair**
  - The facility where the repair is done
- [Participant Handout 3-O]
25. Shaving the perineum increases the risk for infection at the surgical site.
- True**
  - False
- [Participant Handout 3-R]
26. Which route is usually used for the repair of vesicovaginal fistula?
- Vaginal**
  - Abdominal
- [Participant Handout 3-S]
27. The prognosis for the repair of a simple vesicovaginal fistula is usually better than the prognosis for the repair of a rectovaginal fistula.
- True**
  - False
- [Participant Handout 3-S]
28. What are the three D's of postoperative care for fistula repair?
- Make sure the client Drinks.
  - Make sure the client is Dry.
  - Make sure all drainages are Draining.
- [Participant Handout 3-X]
29. List at three types of early postoperative complications after fistula repair.  
[See Participant Handout 3-Y for possible responses.]
30. When should a follow-up appointment be scheduled for women who have had repair surgery?
- Within one month of repair surgery
  - Within two months of repair surgery
  - Within three months of repair surgery**
- [Participant Handout 3-BB]

## TRAINER'S RESOURCE 3-2

### Infection Prevention: Instrument Processing—Quiz Key

1. List the four steps of instrument processing in the correct order.
  1. **Decontamination**
  2. **Cleaning**
  3. **Sterilisation or high-level disinfection**
  4. **Use or storage**
2. 0.5% chlorine solution can effectively decontaminate instruments and other health care items. True or false?

**True.** 0.5% chlorine solution can be made cheaply from locally available bleach. To avoid damage, health care workers should remove instruments and other items from the chlorine solution after 10 minutes and rinse them.
3. Bleach powder can be used to make a 0.5% chlorine solution. True or false?

**True.** Liquid household bleach and chlorine-releasing tablets can also be used.
4. A stiff brush should be used when cleaning instruments. True or false?

**False.** A soft brush is preferable.
5. During decontamination, how long should instruments and other items remain in the 0.5% chlorine solution?

**10 minutes.** If items remain in the solution for longer, they may be damaged.
6. What type of gloves should be worn when removing instruments and other items from the 0.5% chlorine solution?

**Utility gloves**
7. List the three types of sterilisation used for instruments that come into contact with the bloodstream or tissues under the skin.
  - Steam sterilisation (also known as “autoclaving” or “moist heat under pressure”)
  - Dry-heat sterilisation (electric oven)
  - Chemical sterilisation (also known as “cold sterilisation”)
8. High-level disinfection eliminates bacteria, viruses, fungi, parasites, and bacterial endospores. True or false?

**False.** HLD does not eliminate bacterial endospores. For this reason, sterilisation is preferred over HLD for items that come in contact with the bloodstream and tissues under the skin.
9. The word “autoclaving” is a synonym for steam sterilisation. True or false?

**True.** Steam sterilisation is also known as “moist heat under pressure.”
10. It is safe to store surgical instruments and other items in antiseptic and disinfectant solutions. True or false?

**False.** Microorganisms can live and multiply in these solutions; items left soaking in contaminated solution can lead to infections.

*Adapted from:* EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers*, 2nd ed. New York.

**TRAINER'S RESOURCE 3-3**  
**Urinary Catheterisation: Assessment:**  
**Answer Key**

**Q:** What is done to protect the client's rights during catheterisation?

**A:** Explain the procedure to her, obtain her consent, protect her comfort and privacy

**Q:** What type of gloves are used when inserting a urinary catheter?

**A:** Sterile

**Q:** Describe how to cleanse the periurethral mucosa before inserting the urinary catheter.

**A:** Cleanse anterior to posterior, inner to outer, one swipe per swab.

**Q:** Before inserting the catheter, what anatomical structure does the provider identify?

**A:** Urethral meatus

**Q:** How far is the catheter inserted beyond where urine is observed?

**A:** 1 to 2 cm

**Q:** How much sterile liquid is usually used to inflate the balloon?

**A:** 5 mL

**Q:** Where is the catheter secured on the client's body?

**A:** The client's inner thigh or abdomen

**Q:** Name the characteristics of the urine that the provider assesses after inserting the catheter.

**A:** Amount, colour, odour, and quality

**Q:** What size Foley catheter is recommended for women living with obstetric fistula?

**A:** 16 to 18 French

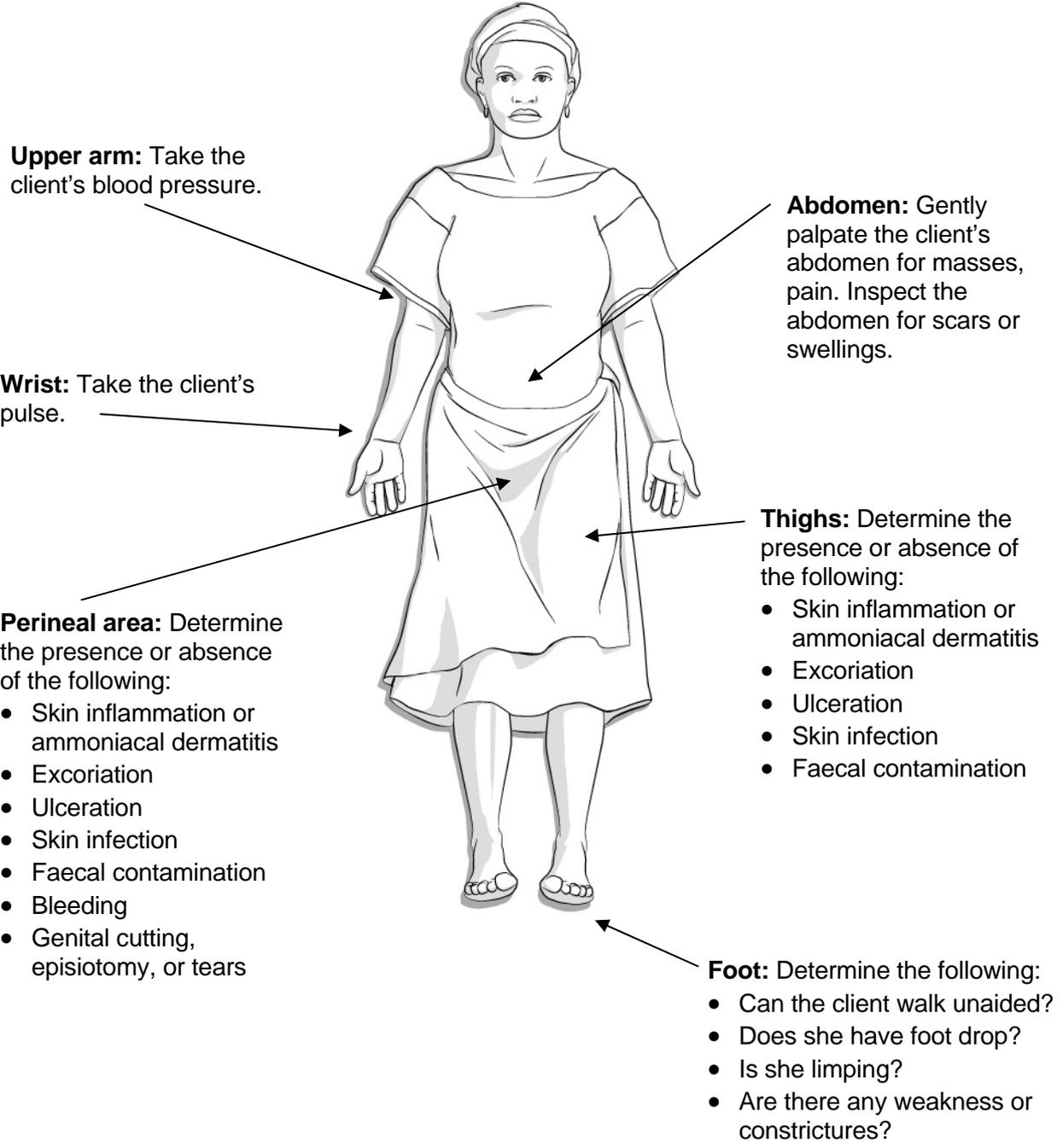
## TRAINER'S RESOURCE 3-4

### Fistula Care Services: Disposal of Medical Waste

Item	Type of waste	Disposal method
Scalpel blade	Sharps	Place in a container that is color-coded, labeled, covered, and puncture- and leak-proof.
Vaginal packs	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Temporarily store the waste in a color-coded, labeled, covered, puncture- and leak-proof container kept in a closed area with limited access.
Surgical sponge	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Temporarily store the waste in a color-coded, labeled, covered, puncture- and leak-proof container kept in a closed area with limited access.
Office papers	Nonsharps noninfectious waste	Place in a customary bin, such as an office wastebasket.
Hypodermic needle	Sharps	Place in a container that is color-coded, labeled, covered, and puncture- and leak-proof.
Catheter tubing	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Temporarily store the waste in a color-coded, labeled, covered, puncture- and leak-proof container kept in a closed area with limited access.
Exam gloves	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Temporarily store the waste in a color-coded, labeled, covered, puncture- and leak-proof container kept in a closed area with limited access.
Packaging materials for medical supplies	Nonsharps noninfectious waste	Place in a customary bin, such as an office wastebasket.
Gauze	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Temporarily store the waste in a color-coded, labeled, covered, puncture and leak-proof container kept in a closed area with limited access.
Urine	Nonsharps biologic infectious waste	Wear heavy utility gloves and shoes. Carefully pour liquid waste down a sink, drain, flushable toilet, or latrine.

See Participant Handout 3-G for more information on disposal.

**TRAINER'S RESOURCE 3-5**  
**Physical Examination of Clients Living with Vesicovaginal or Rectovaginal Fistula: Answer Key**



**TRAINER'S RESOURCE 3-6**  
**Medical Record for Case Study:**  
**Taking the Medical History: Answer Key**

Name: Mariam R

Age: 16 Parity: 1

Past obstetric history: one stillbirth

Genital cutting? No

**Living children:**

Number: 0 Sex: Not applicable

Dates of delivery: Not applicable

Menstrual history since last delivery: Normal

**Pregnancy that caused the fistula:**

Who assisted at the delivery? Traditional birth attendant

Duration of labour: 3 days

Baby's lie and presentation: Not known

Mode of delivery: Vaginal

Any surgical intervention (e.g., episiotomy, symphysiotomy, destructive surgery)? None

Outcome for baby? Stillbirth

Any pregnancies after fistula developed? No Outcome: Not applicable

When did client first notice symptoms of incontinence? 6 days after delivery

Incontinence: Urinary

Any attempts to repair the surgery? No

Any trouble with mobility? No

Any serious illnesses? No

Any previous surgery? No

Any allergies? No

Who cares for the client now? Who will care for her after repair surgery? Parents

## **TRAINER'S RESOURCE 3-7**

### **Catheter Management: Assessment**

**Q:** An indwelling urinary catheter is an invasive device and is associated with significant complications.

**A:** True

**Q:** What is the recommended balloon size?

**A:** 10 cc

**Q:** What is the recommended catheter size?

**A:** 16 to 18 French

**Q:** How often should urinary bags be checked?

**A:** Every hour

**Q:** Drainage bags should be cleaned daily with what type of solution?

**A:** 0.5% chlorine solution

**Q:** How often should a woman with an indwelling catheter have a sitz bath?

**A:** At least twice a day

**Q:** Should the catheter be clamped when the client is being transported?

**A:** No

## **TRAINER'S RESOURCE 3-8**

### **Role Play: Informed Consent**

#### **Naina**

Naina is a 19-year-old woman who has lived with urinary leaking for the last four years, following a stillbirth. Her family and husband were with her during her long labour, but the decision to take Naina to the hospital was not made until she had been in labour for three days.

After delivery, Naina was always wet and smelling of urine. Her husband took her back to the hospital, and the couple were directed to your facility for evaluation and repair. Naina has a vesicovaginal fistula. The doctors think that the repair will be relatively uncomplicated. Both Naina and her husband are anxious about the repair surgery, which is scheduled for three days from today.

## **TRAINER'S RESOURCE 3-9**

### **Preoperative Care: Questions and Answers**

**Q:** Before fistula repair surgery, how many litres of water should the client drink every day?

**A:** At least 5 L

**Q:** The day before repair surgery, the client has a fluid-only diet. What are examples of the types of fluids she can have?

**A:** Tea, juice, soft drinks, water

**Q:** If the surgeon orders enemas before repair surgery, how often are they given?

**A:** At least twice before surgery

**Q:** Why is regular exercise recommended before repair surgery?

**A:** It helps to promote good circulation and to maintain muscle strength.

**Q:** Evidence indicates that shaving the perineum increases the risk for surgical site infection. True or false?

**A:** True

## **TRAINER'S RESOURCE 3-10**

### **Postoperative Care: Quiz**

**Q:** For the first hour after surgery, how often should vital signs be checked?

**A:** Every 15 minutes

**Q:** During the first 24 hours after surgery, where should the nurse or midwife check for bleeding?

**A:** Vaginal pack, labial graft site, abdominal incision (if any), drainages

**Q:** How much fluid should the client drink 24 hours and beyond after surgery?

**A:** At least 5 L of water every 24 hours

**Q:** If a vaginal pack was used, when should it be removed?

**A:** 24 hours after surgery, unless advised otherwise by a doctor

**Q:** Which solutions can be used to flush a blocked catheter?

**A:** Sterile saline, water for injection, and boric solution and boric acid solution mixed with purified water (see Participant Handout 3-Z)

**Q:** Women who have undergone simple repairs should be encouraged to move around within \_\_\_\_\_ hours of surgery.

**A:** 24

**Q:** Can rectal suppositories be used following repair of rectovaginal fistula?

**A:** No

**Q:** What can be done to prevent deep-vein thrombosis after fistula repair surgery?

**A:**

- Deep-breathing exercises
- Coughing
- Positioning
- Mobilisation
- Pain management

## TRAINER'S RESOURCE 3-11

### Fistula Repair: Postoperative Nursing Care Plan: Answer Key

Immediate Postoperative Nursing Care Plan within First 24 Hours of Surgery ( <i>based on the nursing process</i> )				
Nursing Diagnosis	Nursing Interventions	Rationale	Expected outcome	Evaluation
<b>Immediate postoperative period (within the first 24 hours): Vital functions</b>				
<p><b>Cardiac function:</b> Decreased output.</p> <p>May be related to anaesthetic agents, other medications, fluid or blood loss or replacement, peripheral pooling of blood, alterations in rhythm</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Monitor/record vital signs Q 15 minutes, during first hour (note: while patients with spinal anaesthesia are routinely monitored every 30 minutes, this patient should be monitored every 15 minutes given her BP and pulse upon arrival in the recovery room)</li> <li><input checked="" type="checkbox"/> Assess level of consciousness</li> <li><input checked="" type="checkbox"/> Monitor/record:               <ul style="list-style-type: none"> <li>• Drainage from surgical site</li> <li>• Intake and output</li> </ul> </li> <li><input checked="" type="checkbox"/> Administer fluid, if indicated or ordered</li> <li><input checked="" type="checkbox"/> If hypotensive, elevate legs unless contraindicated (check with surgeon)               <ul style="list-style-type: none"> <li>• Increase rate of fluid administration</li> </ul> </li> <li><input checked="" type="checkbox"/> Maintain patency of IV line; check with surgeon re increasing the rate of IV in light of hypotension</li> <li><input checked="" type="checkbox"/> Administer medication as per doctor's order to improve cardiac function</li> <li><input checked="" type="checkbox"/> Warm patient to 36°C (96.8°F), if temperature drops</li> <li><input checked="" type="checkbox"/> Administer humidified oxygen</li> <li><input checked="" type="checkbox"/> Notify surgeon of abnormal findings or signs of shock; if BP drops, temperature elevates, respirations become rapid in addition to being shallow</li> </ul>	Determine effect of medication still in circulation	Patient will maintain adequate cardiac output on discharge from the recovery room	<ul style="list-style-type: none"> <li>• Normotensive</li> <li>• Skin warm, dry</li> <li>• Oriented to person and place</li> <li>• Strong regular pulse</li> </ul>

<b>Immediate Postoperative Nursing Care Plan within First 24 Hours of Surgery</b> <i>(based on the nursing process)</i>				
<b>Nursing Diagnosis</b>	<b>Nursing Interventions</b>	<b>Rationale</b>	<b>Expected outcome</b>	<b>Evaluation</b>
<p><b>Respiratory function:</b> Ineffective breathing</p> <p>May be related to medication/anaesthesia, type of procedure, pain, or tracheobronchial obstruction</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Assess respiratory status</li> <li><input checked="" type="checkbox"/> Determine level of consciousness</li> <li><input checked="" type="checkbox"/> Administer humidified oxygen</li> <li><input checked="" type="checkbox"/> Elevate head of bed if not contraindicated</li> <li><input checked="" type="checkbox"/> Encourage patient to take deep breaths or sustain maximal inspirations</li> <li><input checked="" type="checkbox"/> Assess patient's levels of comfort; administer pain medication as needed or as per protocol.</li> <li><input checked="" type="checkbox"/> Notify surgeon of abnormal findings or signs of shock; if breathing becomes rapid in addition to being shallow</li> </ul>	Determine the need to reverse medication effect	Patient will maintain ventilation, perfusion, and adequate expansion of lungs on discharge from recovery room	<ul style="list-style-type: none"> <li>• Regular respiratory rate</li> <li>• Bilateral breath sounds clear and equal</li> <li>• BP and pulse normal range</li> </ul>
<p><b>Thermoregulation:</b> Possible ineffective thermoregulation</p> <p>May be due to surgical procedure, anaesthetic agents, length of surgery, age of client, environment</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Measure body temperature upon reception (document degree and route)</li> <li><input checked="" type="checkbox"/> Assess peripheral circulation</li> <li><input checked="" type="checkbox"/> Monitor vital signs (and oxygen saturation)</li> <li><input checked="" type="checkbox"/> Observe for shivering</li> <li><input checked="" type="checkbox"/> Initiate measures to warm patient if hypothermic: <ul style="list-style-type: none"> <li>• Place warm blankets on body and head</li> <li>• Use locally available warming devices</li> </ul> </li> <li><input checked="" type="checkbox"/> Alert surgeon if temperature becomes elevated and initiate management of hyperthermia, as per orders</li> <li><input checked="" type="checkbox"/> Maintain ongoing temperature monitoring until discharge from recovery room</li> </ul>	Determine effect of anaesthesia or environment	Patient will maintain normothermia, core temperature of 36°–38°C (96°–100.4°F) on discharge from recovery room	<ul style="list-style-type: none"> <li>• Core temperature of 36°–38°C (96°–100.4°F)</li> </ul>

<b>Immediate Postoperative Nursing Care Plan within First 24 Hours of Surgery</b> (based on the nursing process)				
<b>Nursing Diagnosis</b>	<b>Nursing Interventions</b>	<b>Rationale</b>	<b>Expected outcome</b>	<b>Evaluation</b>
<p><b>Urinary function:</b> Assess for imbalance between intake and output</p> <p>May be due to low intake, blood loss, obstruction in urinary catheter system, trauma to urinary system</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Assess amount, colour of urine collecting in bag (or bucket) <ul style="list-style-type: none"> <li>• Compare output to charted IV fluids administered</li> </ul> </li> <li><input checked="" type="checkbox"/> Chart catheter in use</li> <li><input checked="" type="checkbox"/> Monitor intake and output amounts, including colour of urine</li> <li><input checked="" type="checkbox"/> Inspect condition of urinary catheter for kinks (or blockages) when urine output is less than expected</li> <li><input checked="" type="checkbox"/> Notify surgeon of imbalance in fluids or change in amount and colour of urine. Notify surgeon if Foley does not open after flushing or if urine is bloody after flushing.</li> </ul>	<p>Fluid balance indicates normal renal function</p> <p>Pale-coloured urine indicates adequate hydration to prevent blocked catheters; keep urine dilute, preventing stone formation; prevent ascending urinary tract infection</p> <p>Keep urinary bladder empty</p>	<p>Patient will maintain fluid balance and pale-coloured urine on discharge from recovery room</p>	<ul style="list-style-type: none"> <li>• Urine pale yellow</li> <li>• Fluid intake and output balanced</li> </ul>
<p><b>Patent IV for maintaining adequate fluid intake</b></p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Check IV tubing for kinking and flow; check insertion site for swelling and redness</li> <li><input checked="" type="checkbox"/> If nursing practise does not include restarting IVs, alert surgeon if IV is not working</li> </ul>	<p>Ensure patency of IV tubing and fluid intake</p>	<p>Patient will maintain IV flow as per orders</p>	<ul style="list-style-type: none"> <li>• IV patency maintained</li> </ul>
<p><b>Surgical site(s):</b> Assess for altered integrity of the site(s)</p> <p>May be due to trauma during surgery, trauma with urinary catheter, poor wound healing, infection (beyond immediate postoperative period)</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Assess presence of bleeding at surgical site(s), e.g., vaginal (Martius graft site if used); around urinary catheter and ureteric catheter site (if used)</li> <li><input checked="" type="checkbox"/> Assess abdomen for rigidity</li> <li><input checked="" type="checkbox"/> Notify surgeon if signs of bleeding at operative site</li> </ul>	<p>Identify overt signs of bleeding and compare amounts during recovery room period</p> <p>Check potential bleeding sites; primary haemorrhage from unsecured bleeders will occur within the first 24 hours</p> <p>Rigid abdomen indicates abdominal bleeding</p>	<p>Patient will maintain homeostatic on discharge from recovery room</p>	<ul style="list-style-type: none"> <li>• Surgical site without active bleeding; intact</li> <li>• Abdomen soft</li> </ul>

<b>Immediate Postoperative Nursing Care Plan within First 24 Hours of Surgery</b> <i>(based on the nursing process)</i>				
<b>Nursing Diagnosis</b>	<b>Nursing Interventions</b>	<b>Rationale</b>	<b>Expected outcome</b>	<b>Evaluation</b>
<b>Pain management</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Check for level of pain</li> <li><input checked="" type="checkbox"/> In anticipation of spinal anaesthesia wearing off, pain relief may be offered ahead of time to keep the woman comfortable</li> <li><input checked="" type="checkbox"/> Alert surgeon if pain is intense and unrelieved by prescribed analgesia</li> </ul>	Maintain patient comfort	Patient will exhibit an acceptable comfort level (as per local pain/comfort rating scale)	Patient comfort maintained
<b>Mental alertness (indicator of haemodynamic well-being)</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Assess mental alertness</li> <li><input checked="" type="checkbox"/> Alert surgeon if patient becomes confused and/or disoriented</li> </ul>	Ensure cognitive function	Patient will demonstrate appropriate cognitive function	Patient alert and oriented to present

**TRAINER'S RESOURCE 3-12**  
**Role Play: Discharge Counselling**

Naina has had repair surgery for vesicovaginal fistula. The procedure went well and Naina is about to go home. Her husband is with her; he will accompany her home. Her husband and mother-in-law will care for her at home.



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# MODULE 4: CLIENTS' RIGHTS, INFORMATION, EDUCATION, AND COMMUNITY INVOLVEMENT

## Introduction

Clients' rights set the standard for both nursing and midwifery practise with women, couples, and families seeking fistula care services and for community-based fistula care initiatives. Information and education are powerful tools in preventing and managing obstetric fistula. Decisions about fistula are not made by affected woman alone. Individuals, families, and communities must be well informed before they can collaborate in prevention, treatment, and reintegration. With accurate information in hand, communities can help to change social norms and practises that put women at risk for obstetric fistula.

## Prerequisites

- Successful completion of modules 1, 2 and 3 of this curriculum (or equivalent knowledge and experience)
- Basic competence in information, education, and communication, either through course work or from practical experience
- Basic competence in behaviour change communication, either through course work or practical experience
- Basic competence in community involvement, either through course work or practical experience

## Module Objectives

Upon completion of this module, the participants will be able to:

- List the seven clients' rights
- Describe the seven clients' rights as they relate to health care services for women, couples, and families affected by obstetric fistula
- Identify traditional and cultural factors affecting the reproductive health of women and girls that contribute to obstetric fistula
- Define commonly used terms, including *information, education, and communication* (IEC) and *behaviour change communication* (BCC)
- Describe how IEC supports clients' rights
- Describe the factors that affect a person's willingness and ability to adopt healthy behaviours
- Describe the responsibilities of nurses and midwives in providing IEC about obstetric fistula
- Describe how to effectively select and use IEC materials related to obstetric fistula
- Identify issues to consider when designing a group health education session about the prevention of obstetric fistula
- Define *community involvement, community sensitisation, and community mobilisation*
- Identify the leadership structure in their own communities, including the leadership for fistula prevention and treatment

- Identify resources available for prevention and management of obstetric fistula in the community
- Explain strategies that communities can use to help sustain fistula prevention and management services
- Define *advocacy*
- Describe the steps in advocacy
- Explain the importance of advocacy for fistula prevention, management, and reintegration
- For fistula prevention, management, and reintegration, describe local advocacy challenges and how to overcome them
- Define *male involvement*
- Describe how men can be involved in the prevention and management of obstetric fistula
- Describe ways in which to create awareness among men about how traditional gender attitudes and practises contribute to obstetric fistula
- Define *networking*
- Describe how to use networking to support fistula prevention and management, and to help women affected by fistula reintegrate into their communities

### Overview of Module Content

Sessions/Parts	Total time
1. Clients' Rights in Fistula Care	1 hour, 30 minutes
2. Community Factors Contributing to Fistula	30 minutes
3. Information, Education, and Communication for Behaviour Change	2 hours, 25 minutes
A. Introduction to IEC and BCC	1 hour
B. IEC and BCC for Fistula Care Clients	40 minutes
C. Conducting Group Education Sessions: Preventing Obstetric Fistula	45 minutes
4. Community Involvement and Mobilisation	1 hour, 10 minutes
5. Advocacy	1 hour, 15 minutes
A. Introduction to Advocacy	30 minutes
B. Advocacy for Fistula Prevention, Management, and Reintegration	45 minutes
6. Male Involvement	1 hour, 10 minutes
7. Networking with Partners and Stakeholders	1 hour, 20 minutes
A. Networking with Partners and Stakeholders	40 minutes
B. Module 4 Evaluation	40 minutes
<b>Total time</b>	<b>9 hours, 20 minutes</b>

### Evaluation

- Trainer's Resource 4-1: Module 4 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select 10 to 15 relevant questions from Trainer's Resource 4-1 for the Module 4 Pretest and Posttest.

## **SESSION I**

### **Clients' Rights in Fistula Care**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- List the seven clients' rights
- Describe the seven clients' rights as they relate to health care services for women, couples, and families affected by obstetric fistula

#### **POINTS TO REMEMBER**

- Clients' rights set the standard for fistula care.
- The quality of fistula care services and clients' rights are inextricably linked.

#### **Training Methods**

- Presentation
- Discussion
- Small-group work

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 4-A: Clients' Rights
- Trainer's Resource 4-1: Module 4 Evaluation and Answer Key

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handout 4-A.
4. Duplicate Participant Handout 4-A for the participants.
5. Part A, Activity 1: On a piece of flipchart paper, list the seven clients' rights from Participant Handout 4-A. List only the rights and not the text related to fistula. Cover the flipchart before it is shown during the activity.

**Session Time (total):** 1 hour, 30 minutes

## SESSION I

### Training Steps

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#### **PART A: CLIENTS' RIGHTS**

**Time:** 1 hour, 30 minutes

#### **Activity 1: Presentation and Discussion (30 minutes)**

##### **TRAINING TIP**

Some participants may already be familiar with the seven clients' rights presented in this activity. Adapt your presentation about the rights to what participants know or do not know.

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to present *the rights all clients have to quality health care*.
3. Ask the participants what questions they have about the session objectives.
4. Ask a volunteer to share with the group a situation in which she or he felt that a client did not receive quality health care. The story may come from the volunteer's personal or professional experience. Before the volunteer begins, tell him or her not to reveal the client's name or the place where the incident occurred. Have a story from your own experience in case no volunteers offer one of their own.
5. Once the volunteer has shared the story, display the seven clients' rights on the flipchart. Ask the group to identify the clients' right(s) that the story highlights. Stress that quality of care and clients' rights are inextricably linked.
6. Present the list of seven clients' rights displayed on the flipchart. Ask the group if they are familiar with the rights. Adapt your presentation to what the group already knows.

#### **Activity 2: Small-Group Work (1 hour)**

1. Divide the group into seven small groups, one group for each clients' right. If necessary, a group can be assigned more than one right. Ask the groups to:
  - List how the right applies to women living with obstetric fistula
  - Describe what can be done to promote that right for women living with obstetric fistula
2. Allow 15 minutes for each group to work. They may use flipchart paper to record their work. Ask each group to appoint a presenter-notetaker.
3. Convene the large group. Give the presenter from each small group five to 10 minutes to summarise their ideas. Ask for comments.
4. Summarise the activity, recognising the groups' contributions. Add any points that the groups have not addressed, using Participant Handout 4-A as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

## **SESSION 2**

### **Community Factors Contributing to Fistula**

#### **Session Learning Objective**

Upon completion of this session, the participants will be able to:

- Identify traditional and cultural factors affecting the reproductive health of women and girls that contribute to obstetric fistula

#### **POINTS TO REMEMBER**

- Traditional and cultural factors play a major role in obstetric fistula.

#### **Training Methods**

- Presentation
- Discussion

#### **Materials and Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 1-E and 1-F from Module 1.

#### **TRAINING TIP**

Throughout this session, the participants can reflect on the communities that they know and the factors in those communities that contribute to or prevent obstetric fistula.

**Session Time (total):** 30 minutes

## SESSION 2

### Training Steps

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#### **PART A: COMMUNITY FACTORS**

**Time:** 30 minutes

#### **Activity: Presentation and Discussion (Review) (30 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to understand the *community factors related to obstetric fistula*.
3. Ask the participants what questions they have about the session objectives.
4. Ask the participants to describe the traditional and cultural factors that contribute to obstetric fistula that were presented in Module 1, Session 3. Record the factors on a sheet of flipchart paper.
5. Summarise the activity, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handouts 1-E and 1-F as a reference. Stress that nurses and midwives need to consider community factors when they are contributing to the design of IEC programmes and materials.

## **SESSION 3**

### **Information, Education, and Communication for Behaviour Change**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Define commonly used terms, including *information, education, and communication* (IEC) and *behaviour change communication* (BCC)
- Describe how IEC supports clients' rights
- Discuss the factors that affect a person's willingness and ability to adopt healthy behaviours
- Describe the responsibilities of nurses and midwives in providing IEC about obstetric fistula
- Describe how to effectively select and use IEC materials related to obstetric fistula
- Identify issues to consider when preparing a group health education session about the prevention of obstetric fistula

#### **POINTS TO REMEMBER**

- Information, education, and communication can help prevent fistula and protect the rights of women affected by fistula.
- Nurses and midwives play important roles in the IEC component of fistula care services.

#### **Training Methods**

- Presentation
- Reading
- Discussion
- Pair exercise
- Small-group work

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Part B, Activity 1: Paper and pencil for each pair
- Participant Handout 4-B: Information, Education, and Communication: Definitions
- Participant Handout 4-C: How Information, Education, and Communication Support Clients' Rights
- Participant's Handout 4-D: Factors Affecting the Adoption of Healthy Behaviours
- Participant's Handout 4-E: Information, Education, and Communication about Obstetric Fistula: Responsibilities of Nurses and Midwives
- Participant Handout 4-F: Effective Use of Information, Education, and Communication Materials
- Participant Handout 4-G: Sifa's Community
- Participant Handout 4-H: Group Health Education Sessions: Preventing Obstetric Fistula
- Trainer's Resource 4-2: Group Health Education Sessions: Preventing Obstetric Fistula: Discussion Guide

### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 4-B, 4-C, 4-D, 4-E, 4-F, 4-G, and 4-H.
4. Duplicate Participant Handouts 4-B, 4-C, 4-D, 4-E, 4-F, 4-G, and 4-H for the participants.

#### **TRAINING TIP**

Participants who have experience with conducting IEC campaigns, developing IEC materials, or serving as health educators can be valuable resources for this session.

**Session Time (total):** 2 hours, 25 minutes

## SESSION 3

### Training Steps

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#### **PART A: INTRODUCTION TO IEC AND BCC**

**Time:** 1 hour

##### **Activity 1: Presentation and Reading (Review) (20 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to review *basic concepts of information, education, and communication (IEC) and behaviour change communication (BCC)*.
3. Ask the participants what questions they have about the session objectives.
4. Distribute Participant Handout 4-B; ask the participants to spend a few moments reading the definitions. Explain that these are commonly used terms and that some of them overlap. Stress the definitions of IEC and BCC. Ask if anyone has questions or comments about the definitions.
5. Emphasise that the focus of all IEC efforts is improved health and healthy behaviours.

##### **Activity 2: Discussion (20 minutes)**

1. Ask the group to list the seven clients' rights, referring to the flipchart used in Session 1 as needed.
2. Ask the group how IEC about obstetric fistula supports clients' rights.
3. Summarise the activity, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handout 4-C as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

##### **Activity 3: Discussion and Presentation (20 minutes)**

1. Ask the group, "Can IEC on its own result in healthy behaviours?" The correct response is no. If someone says yes, ask him or her to think about other factors that are necessary before a person can adopt a healthy behaviour. Ask the group to describe some of those factors.
2. Summarise the activity, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handout 4-D as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

#### **PART B: IEC AND BCC FOR FISTULA CARE CLIENTS**

**Time:** 40 minutes

##### **Activity 1: Pair Exercise (20 minutes)**

1. Place the participants in pairs. Be sure each pair has paper and pencil to record their work. Ask the pairs to take turns describing the responsibilities of nurses and midwives in providing information and education about obstetric fistula. Give each pair five minutes to work.
2. Convene the large group. Ask each person to call out a responsibility and to avoid repeating what has already been said.

3. Summarise the activity, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handout 4-E as a reference. Ask the participants if they have any questions. At the end of the session, distribute copies of the handout to the group.

**Activity 2: Discussion and Presentation (20 minutes)**

1. If there are experienced nurses and midwives in the group, ask them to describe how to choose IEC materials, how to select materials for clients who cannot read or who can read only at a low level, and how to use IEC materials when working with clients. Record their ideas on a piece of flipchart paper. Add any ideas from Participant Handout 4-F that have not been mentioned.
2. If there are no experienced participants, present the ideas on the handout yourself.
3. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

**PART C: CONDUCTING GROUP EDUCATION SESSIONS: PREVENTING OBSTETRIC FISTULA**

**Time:** 45 minutes

**Activity: Small-Group Work and Discussion (45 minutes)**

1. Divide the participants into groups of three to five. Give each group copies of Participant Handouts 4-G and 4-H. Tell the participants that they are responsible for designing and conducting a group education session for local market leaders in Sifa's community. The purpose of the session is prevention of obstetric fistula. Ask each group to read Participant Handout 4-G and to answer the questions posed on Participant Handout 4-H. Give each group 20 minutes to work.
2. Convene the large group. Ask the participants to describe the ideas that their groups generated. Trainer's Resource 4-2 provides a discussion guide.
3. Provide constructive feedback to the participants. Emphasise that assessment of the local situation and audience is an essential first step in developing IEC strategies, plans, and activities. Emphasise likewise that some market leaders in Sifa's community may be women of childbearing age, so the information provided during the group session will have personal meaning for them.

## SESSION 4

### Community Involvement and Mobilisation

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Define *community involvement*, *community sensitisation*, and *community mobilisation*
- Identify the leadership structure in their own communities, including the leadership for fistula prevention and treatment
- Identify resources available for prevention and management of obstetric fistula in the community
- Explain strategies that communities can use to help sustain fistula prevention and management services

#### POINTS TO REMEMBER

- Communities play a key role in the prevention and management of fistula and the reintegration of women affected by fistula.
- Community leaders can promote changes that can help prevent and manage fistula and promote the reintegration of women affected by fistula.
- Communities can provide a variety of resources to support fistula care services.

#### Training Methods

- Presentation
- Discussion
- Small-group work

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 4-I: Definitions: Community Sensitisation, Involvement, and Mobilisation
- Participant Handout 4-J: Community Leadership Structures
- Participant Handout 4-K: Community Resources

#### Advance Preparation

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 4-I, 4-J, and 4-K.
4. Duplicate Participant Handouts 4-I, 4-J, and 4-K for the participants.

#### Training Tips

Participants who have experience in community involvement can be valuable resources for this session.

*Beyond Repair: Involving Communities in Fistula Prevention and Reintegration* describes how a community in Guinea is working to prevent fistula and help women reintegrate into society. This technical brief is available on the Fistula Care web site ([www.fistulacare.org](http://www.fistulacare.org)). It may make a useful handout or discussion topic.

**Session Time (total):** 1 hour, 10 minutes

## SESSION 4

### Training Steps

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#### COMMUNITY INVOLVEMENT AND MOBILISATION

**Time:** 1 hour, 10 minutes

##### **Activity 1: Presentation and Discussion (Review) (20 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explore *how communities can play a role in the prevention and management of obstetric fistula*.
3. Emphasise that *family members are part of the community and play an important role in preventing fistula and in referring women for care*.
4. Ask the participants what questions they have about the session objectives.
5. Ask the participants to define *community sensitisation, community involvement, and community mobilisation*.
6. Distribute Participant Handout 4-I and compare the definitions on the handout to the definitions given by the participants.
7. Emphasise that communities play an important role in the prevention and treatment of obstetric fistula and in the reintegration of women affected by fistula into their communities.
8. Remind the participants of the group education session they designed in Session 3, Part C, of this module. Such sessions are often the beginning of community involvement work.

##### **Activity 2: Discussion and Presentation (20 minutes)**

1. Ask the participants to describe different types of leadership structures in their communities. List their responses on a piece of flipchart paper.
2. Distribute Participant Handout 4-J and briefly summarise it for the group.
3. Emphasise that fistula care programmes must work with a variety of leadership structures in the community to help prevent fistula, to reach women who need repair services, and to help women affected by fistula reintegrate into the community.

##### **Activity 3: Presentation and Small-Group Work (30 minutes)**

1. Distribute copies of Participant Handout 4-K and present the types of community resources described on it.
2. Divide the group into small groups, one for each category listed on Participant Handout 4-K. Have the participants in each group provide examples from their communities for the category, describing how communities can help support and sustain fistula care services and women affected by fistula. Give each group 10 minutes to work.
3. Convene the large group. Ask the participants to provide examples from their group discussions.
4. Summarise the session, recognising the groups' contributions. Respond to any questions that the participants have.

## SESSION 5

### Advocacy

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Define *advocacy*
- Describe the steps in advocacy
- Explain the importance of advocacy for fistula prevention, management, and reintegration
- Describe local advocacy challenges to fistula prevention, management, and reintegration and how to overcome them

#### POINTS TO REMEMBER

- Advocacy is important for fistula care because it can influence decision making, policy development, community involvement, and programmatic sustainability.

#### Training Methods

- Presentation
- Discussion
- Brainstorm
- Pair exercise

#### Materials/Equipment

- Paper and pencil for each participant
- Flipchart paper, easel, markers and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 4-L: Defining Advocacy
- Participant Handout 4-M: Steps in Advocacy
- Participant Handout 4-N: Why Advocacy Is Especially Important for Obstetric Fistula

#### Advance Preparation

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 4-L, 4-M, and 4-N.
4. Duplicate Participant Handouts 4-L, 4-M, and 4-N for the participants.
5. Part A, Activity 2: Write the steps of advocacy from Participant Handout 4-M on a sheet of flipchart paper. List only the steps; do not include the accompanying text.

#### TRAINING TIPS

Participants who have experience with advocacy efforts can be valuable resources for this session.

The United Nations Population Fund (UNFPA) and Family Care International have produced *Living Testimony: Obstetric Fistula and Inequities in Maternal Health*, an advocacy booklet. To download the booklet in English or French, go to UNFPA's web site, [www.unfpa.org](http://www.unfpa.org).

**Session Time (total):** 1 hour, 15 minutes

## SESSION 5

### Training Steps

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#### **PART A: INTRODUCTION TO ADVOCACY**

**Time:** 30 minutes

##### **Activity 1: Presentation and Discussion (15 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explore *how advocacy plays a role in the prevention and management of obstetric fistula and the reintegration of affected women into their communities.*
3. Ask the participants what questions they have about the session objectives.
4. Ask each person to write the definition of *advocacy* in their own words on a piece of paper.
5. Ask volunteers to read their definitions to the group.
6. Capture highlights of the definitions on flipchart paper.
7. To summarise the activity, distribute Participant Handout 4-L, and ask one of the participants to read the definition on the handout.

##### **Activity 2: Presentation and Discussion (15 minutes)**

1. Display the steps of advocacy written on the flipchart. Describe the steps, using Participant Handout 4-M as a reference.
2. Ask the participants if they have ever worked on an advocacy effort. If any of them answer yes, have them describe their experiences.
3. Ask the participants if they have any questions about advocacy, and respond as needed.

#### **PART B: ADVOCACY FOR FISTULA PREVENTION, MANAGEMENT, AND REINTEGRATION**

**Time:** 45 minutes

##### **Activity 1: Discussion (15 minutes)**

1. Ask the participants why advocacy is especially important for fistula prevention, management, and reintegration.
2. Summarise the discussion, recognising the participants' contributions. Add any reasons that the participants did not mention, using Participant Handout 4-N as a reference. Ask the participants if they have any questions. At the end of the activity, distribute copies of the handout to the group.

##### **Activity 2: Brainstorm, Pair Exercise and Discussion (30 minutes)**

1. Ask the participants to brainstorm the challenges advocacy for fistula care might face. List the challenges on a piece of flipchart paper. Sample responses include:
  - Limited financial resources
  - Strong traditional practises
  - Opposition by community leaders
2. Divide the groups into pairs. Ask each pair to select one or two challenges from the list and describe what they would do to overcome the challenges. Give the pairs 10 minutes to work.
3. Convene the large group. Ask two to three pairs to report on their challenges and their responses. Be sure that the pairs report on different challenges and do not repeat one that has already been presented.

## SESSION 6

### Male Involvement

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Define *male involvement*
- Describe how men can be involved in the prevention and management of obstetric fistula
- Describe ways to create awareness among men about how traditional gender attitudes and practises contribute to obstetric fistula

#### POINTS TO REMEMBER

- Men play an important role in fistula prevention and management and in the reintegration of women affected by fistula into the community.
- Traditional gender attitudes and practises contribute to obstetric fistula.

#### Training Methods

- Presentation
- Discussion
- Small-group work

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 4-O: Male Involvement
- Participant Handout 4-P: How Traditional Gender Attitudes and Practises Contribute to Obstetric Fistula
- Participant Handout 4-Q: Creating Awareness among Men: How Traditional Gender Attitudes and Practises Contribute to Obstetric Fistula

#### Advance Preparation

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 4-O, 4-P, and 4-Q.
4. Duplicate Participant Handouts 4-O, 4-P, and 4-Q for the participants.
5. Part A, Activity 1: Write the definition of *male involvement* from Participant Handout 4-O on a piece of flipchart paper. Cover the sheet before it is shown during the activity.

#### TRAINING TIP

If a man in the community has been active in supporting fistula care services, consider asking him to present this session or to discuss his experiences with the participants.

**Session Time (total):** 1 hour, 10 minutes

## SESSION 6

### Training Steps

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#### **PART A: MALE INVOLVEMENT**

**Time:** 1 hour, 10 minutes

##### **Activity 1: Presentation and Discussion (10 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explore *how men can play a role in the prevention and management of obstetric fistula*.
3. Ask the participants what questions they have about the session objectives.
4. Ask the participants to give their own definitions of *male involvement*.
5. To summarise, display the definition of male involvement written on the flipchart paper.

##### **Activity 2: Small-Group Work (40 minutes)**

1. Divide the participants into three groups, with five to seven members per group. (If more than three groups are needed, assign each of them one of the three topics for this activity.) Have each group appoint a chairperson to lead the discussion and a presenter-notetaker. Allow 15 minutes for group work. Discussion topics are:
  - Group 1—how men can participate in fistula prevention, including involvement in their communities
  - Group 2—how men can participate in the management of clients with fistula, starting within the community
  - Group 3—how men can help women affected by fistula reintegrate into their communities
2. Convene the large group. Ask the presenter-notetaker for each group to summarise the group's discussion, taking no more than five minutes.
3. Summarise the activity, mentioning any points from Participant Handout 4-O not covered by the presenters.
4. Distribute copies of Participant Handout 4-O.

##### **Activity 3: Discussion (20 minutes)**

1. Ask the participants how traditional gender attitudes and practises contribute to obstetric fistula. Referring to Handout 4-P, add any points that the participants have not addressed.
2. Ask the participants how they can create awareness among men about these attitudes and practises in their communities.
3. Summarise the ideas, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handout 4-Q as a reference. Ask the participants if they have any questions. At the end of the session, distribute copies of Participants Handout 4-P and 4-Q to the group.

## **SESSION 7**

### **Networking with Partners and Stakeholders**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Define *networking*
- Describe how to use networking to support fistula prevention and management, and to help women affected by fistula reintegrate into their communities

#### **POINTS TO REMEMBER**

- Health professionals can use networking to support fistula prevention and management and to help women affected by fistula reintegrate into their communities.

#### **Training Methods**

- Presentation
- Discussion

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 4-R: Networking
- Participant Handout 4-S: Using Networking to Support Fistula Prevention, Management, and Reintegration
- Trainer's Resource 4-1: Module 4 Evaluation and Answer Key

#### **Advance Preparation**

1. Review the Training Steps.
2. Prepare a flipchart, a computer slide, or an overhead transparency listing the objectives for this session.
3. Review Participant Handouts 4-R and 4-S.
4. Duplicate Participant Handouts 4-R and 4-S for the participants.
5. Part A, Activity 1: Write the definition of *networking* from Participant Handout 4-R on flipchart paper. Cover the sheet before it is shown during the activity.

#### **TRAINING TIP**

If time allows, you may want to ask a person who has participated in networking activities related to obstetric fistula to speak to participants.

**Session Time (total):** 1 hour, 20 minutes

## SESSION 7

### Training Steps

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#### **PART A: NETWORKING WITH PARTNERS AND STAKEHOLDERS**

**Time:** 40 minutes

##### **Activity 1: Presentation and Discussion (10 minutes)**

1. Review the session objectives, using the prepared flipchart, computer slide, or overhead transparency.
2. Emphasise that the purpose of this session is to explore *how professional networking can play a role in the prevention and management of obstetric fistula and in the reintegration of affected women into their communities.*
3. Ask the participants what questions they have about the session objectives.
4. Ask the participants to give their own definitions of *networking*.
5. To summarise, display the definition written on flipchart paper and provide examples of networking from Participant Handout 4-R.

##### **Activity 2: Discussion (30 minutes)**

1. Ask the participants how they can use networking to support fistula prevention, management, and reintegration.
2. Summarise the activity, recognising the participants' contributions. Add any points that the participants have not addressed, using Participant Handout 4-S as a reference. Ask the participants if they have any questions. At the end of the session, distribute copies of Participant Handouts 4-R and 4-S to the group.

#### **PART B: MODULE 4 EVALUATION**

**Time:** 40 minutes

##### **Activity 1: Posttest (20 minutes)**

1. Distribute the Module 4 Evaluation (based on the questions provided in Trainer's Resource 4-1) to the participants and tell them they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

##### **Activity 2: Review/Debrief (20 minutes)**

1. Review the answers to the Module 4 Evaluation (using the Answer Key in Trainer's Resource 4-1).
2. Ask the participants what questions they have.

#### **TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.

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# **MODULE 4 RESOURCES**



## **PARTICIPANT HANDOUT 4-A**

### **Clients' Rights**

Women living with obstetric fistula, like all human beings, have rights that need to be respected. The needs of women living with fistula are unique because many of them:

- Feel shame and embarrassment because of their condition
- Are ostracised by their husbands, families, and communities

Hence, nurses, midwives, and all other health workers must be especially sensitive as they provide care to this marginalised group of women. Below is a list of the seven clients' rights and descriptions of how they relate to women living with fistula who present for care.

#### **1. The Client's Right to Information**

Women living with fistula have a right to all facts concerning fistula. Each woman should be informed about how the fistula developed, the causes, contributory factors, treatment, and management, including prevention.

*How to promote this right:* Nurses and midwives provide information to clients, family members, and the community about obstetric fistula, its causes, how it can be prevented and treated, and where services are available. They simplify technically complex information.

#### **2. The Client's Right to Informed Choice**

All women living with fistula have the right to receive correct information that will enable them to make informed decisions about care and about where, when, and how to receive care. Clients may need guidance, help, and support to make an informed choice.

*How to promote this right:* Nurses and midwives inform women living with fistula about the choices available to them (e.g., the advantages and disadvantages of not being treated, the advantages and disadvantages of being treated, issues to consider before another pregnancy). They simplify technically complex information.

#### **3. The Client's Right to Access to Services**

Women living with fistula have the right to fistula care services. They should be able to:

- Reach a fistula repair site when they recognise leaking of urine or faeces
- Receive repair services even if they lack the ability to pay for surgery, medication, or food
- Access services that help them reintegrate into society after repair and provide for themselves

*How to promote this right:* Nurses and midwives advocate for fistula care services within health care systems.

#### **4. The Client's Right to Safe Services**

All clients, regardless of colour, age, ethnicity, and marital or socioeconomic status, have the right to safe services. Fistula clients have the right to receive care from qualified skilled health workers in a safe environment, using safe equipment and materials. Safe services include:

- Correct use of service delivery guidelines, including informed consent procedures
- Quality assurance mechanisms within the facility

- Counselling and instructions for clients
- Timely recognition and management of complications

**How to promote this right:** Nurses and midwives correctly use and follow service delivery guidelines and quality assurance mechanisms; they inform their colleagues about these tools for safety. They counsel and instruct women affected by fistula about safety measures that the women can take themselves. Nurses and midwives recognise and manage complications, consulting with doctors according to local protocol. Nurses and midwives promote safety within the facilities where they work.

### **5. The Client's Right to Privacy and Confidentiality**

All clients have the right to privacy and confidentiality, including during counselling sessions, physical examinations, and clinical procedures. The client's sufferings and stories are her own; they cannot be shared with anyone, including her husband and family, unless she gives consent. This right also applies to the client's medical records and other personal information; information that identifies the client by name is shared with health care workers only when it is essential for her health and well-being.

**How to promote this right:** Nurses and midwives protect every woman's privacy and confidentiality. They share her personal information with other health care workers only when it is essential. They share information with the client's family members only when she gives her consent. Nurses and midwives promote privacy and confidentiality within the facilities where they work.

### **6. The Client's Right to Dignity, Comfort, and Expression of Opinion**

Women living with fistula are affected both physically and psychologically; hence, they need professional support, consideration, and respect. They have a right:

- To be treated with dignity at all times
- To be as comfortable as possible
- To express their views freely

**How to promote this right:** Nurses and midwives treat all clients at all times with dignity and respect. They ensure that clients are as comfortable as possible. They encourage clients to express their views freely, even when those views differ from the opinions of family members and service providers.

### **7. The Client's Right to Continuity of Care**

Because of their condition, women living with obstetric fistula require continuity of care at health care facilities, at home, and in the community. All clients have a right to continuity of services, supplies, referrals, and follow-up to maintain their health.

**How to promote this right:** Nurses and midwives ensure continuity of care across the health care system. They work to establish referral networks. Nurses and midwives help clients to reintegrate into the community. They remind clients of follow-up appointments and tell them where they can procure other reproductive health services as the need arises.

### **The United Nations and Clients' Rights**

The United Nations has supported clients' rights in a number of ways. Three documents are especially relevant to obstetric fistula:

- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)
- The Programme of Action from the International Conference on Population and Development (ICPD) (1994)
- The Platform for Action from the Fourth World Conference on Women, Beijing (1995)

### **References**

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: A curriculum*. New York: EngenderHealth/The ACQUIRE Project.

EngenderHealth. 2003. *COPE handbook: A process for improving quality in health services*. New York.

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

Kenya Ministry of Health, Department of Reproductive Health. 2006. *Reproductive health curriculum for service providers*. Nairobi.

## **PARTICIPANT HANDOUT 4-B**

### **Information, Education, and Communication: Definitions**

**Behaviour change communication:** A process that motivates people to adopt healthy behaviours and lifestyles.

**Communication:** The use of spoken language, written language, and nonverbal signs to convey meaning between parties.

**Communication channel:** A means of communication with an individual or target audience; includes mass media, print media, interpersonal contacts, and indigenous media.

**Health communication:** The crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities.

**Health education:** A multidisciplinary practise concerned with designing, implementing, and evaluating educational programmes that enable individuals, families, groups, organisations, and communities to play active roles in achieving, protecting, and sustaining health.

**Health information:** All information related to health, the content of which is communicated through various channels to inform various populations about health issues.

**Information, education, and communication (IEC):** An approach that attempts to change or reinforce a set of behaviours in a target audience regarding a specific health problem. It is a package of planned interventions that combine informational, educational, and motivational processes. IEC aims at achieving measurable behaviour and attitude changes or reinforcement within specific audiences, based on a study of their needs and perceptions.

#### **Sources**

Department of Reproductive Health and Research, World Health Organization. 2001. *Information, education, and communication: Lessons from the past; perspectives for the future*. Geneva.

Salem, R.M., Bernstein, J., Sullivan, T.M., and Lande, R. 2008. Communication for better health. *Population Reports*. Series J, No. 56. Baltimore, MD: INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

## **PARTICIPANT HANDOUT 4-C**

### **How Information, Education, and Communication Support Clients' Rights**

Information, education, and communication (IEC) help women living with obstetric fistula know their rights to quality health care.

#### **1. The Client's Right to Information**

IEC provides women, families, and communities with information about obstetric fistula. It provides easily understandable information to use when making decisions about the prevention and management of obstetric fistula.

#### **2. The Client's Right to Informed Choice**

IEC helps women living with obstetric fistula understand the choices available to them and the potential consequences of those choices.

#### **3. The Client's Right to Access to Services**

IEC provides information about where to obtain fistula care services.

#### **4. The Client's Right to Safe Services**

IEC helps to empower women, families, and communities to know what constitutes safe fistula services and to demand them. It helps women to understand instructions regarding antenatal care, labour and delivery, and fistula repair. IEC helps women to know what they can do to ensure their own safety during the recovery period after repair surgery and during future pregnancies.

#### **5. The Client's Right to Privacy and Confidentiality**

IEC tells clients, families, and communities that they have the right to privacy and confidentiality when seeking and receiving fistula care services.

#### **6. The Client's Right to Dignity, Comfort, and Expression of Opinion**

IEC tells clients, families, and communities that they have the right to dignity and comfort and the right to have their opinions sought and heard.

#### **7. The Client's Right to Continuity of Care**

IEC tells clients, families, and communities:

- Where to access services
- That continuity of care has health benefits
- That they have the right to expect that their health information will be readily available to providers, including when staff members change

## **PARTICIPANT HANDOUT 4-D**

### **Factors Affecting the Adoption of Healthy Behaviours**

Many factors can affect whether a person adopts healthy behaviours and the consistency with which he or she maintains them. A person is more likely to adopt and maintain healthy behaviours when the following circumstances pertain:

- The person intends to perform the behaviour.
- External constraints or barriers to the behaviour are minimal or can be overcome.
- The person possesses the necessary skills to perform the behaviour.
- The person has a positive attitude about the behaviour, and the person has a positive emotional reaction towards the behaviour.
- The person believes that important people support the behaviour.
- The behaviour suits how the person sees himself or herself.
- The person feels capable of performing the behaviour.
- The person performs the behaviour and enjoys a good result, making her or him likely to try the behaviour again.

The first three factors are generally considered necessary and sufficient to perform any behaviour. The remaining factors influence the strength and direction of the person's intention.

#### **Reference**

Salem, R.M., Bernstein, J., Sullivan, T.M., and Lande, R. 2008. Communication for better health. *Population Reports*. Series J, No. 56. Baltimore, MD: INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

## **PARTICIPANT HANDOUT 4-E**

### **Information, Education, and Communication about Obstetric Fistula: Responsibilities of Nurses and Midwives**

Nurses and midwives are responsible for doing all of the following in their effort to inform and educate individuals, families, and communities about obstetric fistula:

- Use information, education, and communication (IEC) to promote, maintain, and improve the health of women at risk for fistula or affected by it.
- Provide accurate, balanced information to women, their families, and their communities about obstetric fistula.
- Use IEC to promote freedom of choice and informed decisions for the individual woman.
- Use IEC to encourage women at risk for fistula or affected by it to participate in the provision of their own health care.
- Demonstrate respect for the attitudes, values, experiences, and beliefs of women, their families, and communities when conducting IEC activities.
- Include men as well as women in IEC activities.
- Actively listen to women, their families, and their communities, and elicit their opinions, desires, and preferences.
- Participate in strategic communication processes that address fistula prevention, management, and reintegration.
- Contribute to the development of appropriate messages about obstetric fistula for use in IEC materials and activities.
- Assist in the development of IEC materials.
- Obtain feedback from clients on the effectiveness of IEC materials and activities to ensure that the intended communication is correctly received.
- Tailor IEC efforts to the needs of women, their families, and their communities, taking into account their cultural and educational backgrounds.
- Select IEC materials and channels that are appropriate to the women served.
- Use simple, easily understood language with clients and in IEC materials, avoiding clinical terminology when possible (and if clinical terms are necessary, explaining them in simple language).
- Involve the community in IEC activities, such as testing messages and images, to ensure that intended communications are correctly received.
- Use peer educators and support groups as part of IEC activities, when appropriate.
- Effectively use IEC materials during health education and counselling.
- Ensure a reliable supply of materials to maintain uninterrupted availability.

#### **References**

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## **PARTICIPANT HANDOUT 4-F**

### **Effective Use of IEC Materials**

#### **Choosing Materials for Clients**

- Choose materials that are balanced and accurate.
- Choose materials that suit the needs of your audience.
- Choose materials that are appropriate to the client's state of mind and decision-making stage.
- Choose materials that clearly identify what behaviours clients will need to undertake and that make behaviour change seem possible.
- Consider the culture and educational level of your audience—the people shown in the materials should dress, talk, and act in ways that the audience can relate to.
- Ensure that language is simple, easily understandable, and conversational and that the tone is friendly. (Sentences should be relatively short. Avoid materials that have long, dense blocks of text. Subheads can make material easier to read.)
- Communicate messages that contain as few medical and technical terms as possible, and if such terms are used, be sure that they are explained clearly.
- Avoid materials that present information in all capital letters.
- Ensure that all visuals (illustrations, photographs, graphics, etc.) reinforce the intended message and contain captions, when appropriate.
- If anatomical drawings are used, be sure that they are as simple as possible, as clients need to understand how the drawings relate to their own bodies.
- Avoid materials that reinforce inequitable gender roles or stereotypes.
- Use materials that have been tested with your audience or with similar audiences.
- Ask clients to read the materials and then tell you what the materials say.

#### **For Clients Who Cannot Read or Who Can Read Only at a Low Level**

Choose materials that:

- Stress simple pictures, with limited text
- Present only three or four main points
- Use headings and summaries to show organisation and provide repetition
- Stress what the client needs to do
- Have been tested with audiences who do not read or with low-literacy audiences

In addition, see if someone in the client's family or community can help her understand printed material. She can then take the material home and still be able to find useful information in it.

Other approaches include:

- Using several communication channels (for instance, an illustrated flipchart and a demonstration)
- Talking a client through printed materials, making it clear how your spoken words relate to the illustrations

### Using Materials with Individual Clients

- Before beginning the educational session, be sure that you have the client's attention.
- Assess what the client already knows about the topic. Do not spend time on information she already knows.
- State the key points without delay, at the beginning of the session.
- Do not feel obligated to read every word of a printed material to the client. Ask her questions so you can tailor the session to her needs and desires and what she already knows. Use printed materials to reinforce your oral communication.
- Remember that people can usually take in only two or three important pieces of information in a brief time. Receiving too much information causes stress. If a woman is fearful or anxious, she will take longer to assimilate information.
- Take extra time to explain new words and concepts.
- Relate new information in the materials to something familiar to the client. For instance, vesicovaginal fistula affects the vagina, the birth canal through which babies typically pass during delivery and the route through which menstrual blood flows. Knowing these facts about the vagina may help women better understand vesicovaginal fistula.
- Ask the client to restate new and important information in her own words.
- When reviewing printed material with the client:
  - Ask her to describe what she needs to do to care for herself at home or in the hospital.
  - Ask her to think about any problems she may have taking actions related to the IEC materials.
  - At the end of the session, summarise key points.

### References

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- Upadhyay, U. D. 2001. Informed choice in family planning: Helping people decide. *Population Reports*, series J, no. 50. Baltimore, MD: Center for Communication Programs, Johns Hopkins University Bloomberg School of Public Health.

## **PARTICIPANT HANDOUT 4-G**

### **Sifa's Community**

Sifa is a young woman who has obstetric fistula. She has been abandoned by her family and community and has made her way to the capital city of her country in the hopes of having fistula surgery. Sifa tells the health professionals at the hospital about her community.

In the area where Sifa's family lives, girls marry very young, sometimes as young as age 12. Marriages are arranged among the families. Most girls are illiterate and have never gone to school.

Women in the community who have obstetric fistula are often turned out of their homes. Their husbands and families often abandon them. Some people in the community do not believe that fistula can be repaired by surgery. They believe it is God's will when a woman has fistula.

Women receive little antenatal care and usually deliver at home without skilled care. They must travel 50 km to receive fistula treatment services. Women and their families must pay for transportation to reach the treatment facility.

## **PARTICIPANT HANDOUT 4-H**

### **Group Health Education Sessions: Preventing Obstetric Fistula**

You and your staff decide to hold health education sessions in Sifa's community to raise awareness about and create understanding of obstetric fistula, its causes, and how it can be prevented. Your goal is to encourage market leaders to develop plans for actively preventing fistula and to help women and families living with fistula to access treatment services.

You will conduct an educational session for market leaders. Answer the following questions to help you prepare an effective health education session for this group.

1. **Knowledge of fistula:** Based on what you have been able to learn, market leaders know little about obstetric fistula and how it develops. How will this factor affect the content of the educational session you design?
2. **Education and literacy:** Market leaders have varying levels of education. Their level of literacy ranges from low to medium. What will you do to take this factor into account?
3. **Myths and misunderstandings:** Some community members believe that obstetric fistula is God's will and that the condition cannot be treated. How will this affect the content of the educational session?
4. **Community customs:** Which community customs might prevent market leaders from taking action to prevent fistula?
5. **Access to services:** What barriers does the community face that make it hard to prevent obstetric fistula and to help women access fistula treatment services?
6. **Taking action:** What might market leaders do to prevent fistula?
7. **Your credentials:** What credentials and qualifications will make you a credible presenter to the market leaders? Who else might join you in the presentation to increase your credibility?

## **PARTICIPANT HANDOUT 4-I**

### **Definitions: Community Sensitisation, Involvement, and Mobilisation**

#### **Community Sensitisation**

Making the community aware of a health problem and helping the community to identify and address its needs associated with the problem.

#### **Community Involvement**

Actively involving community members in the planning, operation, and control of health care programmes. Community involvement enhances, promotes ownership of, and sustains health programmes. The community can contribute to all aspects of a programme, including assessment, planning, decision making, implementation, monitoring, and evaluation.

#### **Community Mobilisation**

Working with community leaders and community groups to stimulate or precipitate action related to a health issue.

#### **References**

Coordinating Assembly of Non-Governmental Organizations. 2006. *Non-governmental development practitioners' community development handbook*. Mbabane, Swaziland

Howard-Grabman, L., and Sentro, G. 2003. *How to mobilize communities for health and social change*. Health Communication Partnership and Center for Communication Programs, Johns Hopkins University.

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## **PARTICIPANT HANDOUT 4-J**

### **Community Leadership Structures**

**Formal leadership structures** include local administrative bodies and other local institutions that operate according to defined policies and procedures. Examples include government agencies. Health programmes are usually implemented with the involvement of formal leadership structures because resources are often channeled through their offices or their participation is needed to facilitate acquisition of resources.

**Informal leadership** structures include people in the community who are highly respected or who have considerable power. Examples include men or women in the community whom people consult for guidance or advice.

**Religious leadership structures** may be formal or informal, and they include the leaders affiliated with all the various religions practised in a given community. It is important to respect all of the different religions, as they influence the health-seeking behaviours of individuals and their families.

**Development and health committees**, which are examples of formal leadership structures, are the custodians of health and health-related issues within communities. Because communities often have confidence in these committees, programmes that work closely with them are often more likely to succeed.

#### **References**

Coordinating Assembly of Non-Governmental Organizations. 2006. *Non-governmental development practitioners' community development handbook*. Mbabane, Swaziland.

Howard-Grabman, L., and Sentro, G. 2003. *How to mobilize communities for health and social change*. Health Communication Partnership and Center for Communication Programs, Johns Hopkins University.

Kenya: Ministry of Health, Department of Reproductive Health. 2006. *National reproductive health instructional manual for service providers*. Nairobi.

## **PARTICIPANT HANDOUT 4-K**

### **Community Resources**

#### **Human Resources**

Influential people within a community can help bring about change. In addition, community residents can assume ownership of a fistula awareness, care, and prevention programme and increase the likelihood of its sustainability.

#### **Material Resources**

Fistula care services require a range of physical resources. Examples include:

- Hospital equipment and supplies
- Vehicles to transport women who need health services
- Educational posters and brochures
- Food and shelter for women who are awaiting repair surgery or recovering from it

#### **Financial Resources**

Sources of funds include local, regional, and national government agencies, nongovernmental organisations, religious organisations, businesses, and individuals.

#### **Volunteer Time**

Community members can perform some programmatic activities at no cost. Examples include:

- Transporting women to health care facilities (if volunteers use their own vehicles, it may be necessary to compensate them for fuel)
- Speaking to community groups and political leaders
- Providing support and care for women affected by obstetric fistula to help them reintegrate into society

#### **References**

Coordinating Assembly of Non-Governmental Organizations. 2006. *Non-governmental development practitioners' community development handbook*. Mbabane, Swaziland.

Kenya: Ministry of Health, Department of Reproductive Health. 2006. *National reproductive health instructional manual for service providers*. Nairobi.

## **PARTICIPANT HANDOUT 4-L**

### **Defining Advocacy**

**Advocacy** is a set of actions undertaken by a group of committed individuals or organisations to introduce, change, or obtain support for specific policies, programmes, legislation, issues, or actions.

#### **Why is advocacy important?**

Advocacy can influence decision making, policy development, community involvement, and programme sustainability.

## **PARTICIPANT HANDOUT 4-M**

### **Steps in Advocacy**

#### **Analyzing**

Advocates clearly identify the problems and identify possible solutions. They identify the stakeholders associated with the needed changes.

#### **Developing a Strategy**

Advocates identify the target audiences, including key decision makers, and set goals and objectives. Goals and objectives are specific, measurable, achievable, realistic, and linked to clear deadlines. Advocates plan advocacy activities, develop messages, and identify communication channels best suited to the target audiences. They prepare an implementation plan and budget.

#### **Mobilising**

Advocacy requires building alliances with stakeholders, both individuals and organisations. Advocates work with supporters who can provide resources and help implement activities.

#### **Implementing**

Advocates implement the strategy, in partnership with alliance members.

#### **Monitoring and Evaluating**

Monitoring and evaluation is continuous. Advocates gather information to measure progress and make necessary adjustments to facilitate achievement of objectives.

#### **Ensuring Continuity**

Advocacy is an ongoing process. Advocates develop long-term goals, hold functioning coalitions together, and adapt to changing situations.

#### **References**

Population Communication Services, Center for Communication Programs, Johns Hopkins School of Public Health. 1999. *"A" frame for advocacy*. Baltimore.

World Health Organization. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva.

## **PARTICIPANT HANDOUT 4-N**

### **Why Advocacy Is Especially Important for Obstetric Fistula**

Traditional practises that contribute to obstetric fistula are well established in many communities, and sustained advocacy efforts at many levels will be required to overcome them.

**Fistula is preventable!** If it is to be prevented, women need ongoing support from both their families and their communities. Examples of such support include access to antenatal care, delivery by skilled health care personnel, early decision making when a woman is in prolonged or obstructed labour, and transportation to health care services. Advocacy efforts can help develop and sustain what is needed to prevent obstetric fistula within the family, the community, and the health care system.

Women affected by fistula are often isolated and stigmatised. Sustained advocacy efforts can help provide the support women need to reintegrate into their communities.

Competition for health care funding is intense. Advocacy for maternity care and fistula care services can help generate the funds needed for these critical health initiatives.

## **PARTICIPANT HANDOUT 4-0**

### **Male Involvement**

**Definition of male involvement:** The process of incorporating male participation into programmes aimed at preventing obstetric fistula and delivering care to affected girls and women.

#### **The Role of Males in Fistula Care Programmes**

Men can contribute to the effective prevention and care of obstetric fistula in many important ways, including by:

- Preventing early marriage and childbirth by delaying marriage of young girls (In many communities, men are often responsible for decisions regarding marriage and the timing of childbirth.)
- Encouraging the use of family planning methods to prevent early childbearing and promoting the healthy spacing of pregnancies
- Facilitating access to emergency obstetric care (Men often decide when women seek health care. Effectively targeted fistula awareness programmes can educate men about the risk factors for obstetric fistula. They can encourage men to listen to women when they say they need to go to a health care facility and to create a savings plan for emergency transport and care.)
- Supporting women living with fistula by helping them access information and treatment as soon as possible
- Helping women affected by fistula reintegrate into their communities (Society often views clients with fistula as unclean.)
- Preventing secondary fistula by abstaining from sex for the recommended time following repair and by using family planning to prevent pregnancy for at least one year after repair surgery
- Preventing harmful traditional practises (Men can influence change in harmful traditional practises that contribute to occurrence of fistula. Examples of such practises include compelling or allowing women to go through labour alone or without a skilled birth attendant and female genital cutting.)
- Serving as peer educators for other men
- Helping the fistula care programme monitor and evaluate its activities and develop strategies for sustainability

## **Participant Handout 4-P**

### **How Traditional Gender Attitudes and Practises Contribute to Obstetric Fistula**

Because women lack or have limited economic power, they often have difficulty accessing health care services.

Women lack or have limited power to make their own decisions regarding their reproductive health.

Decisions about when to start having children, where to give birth, and even when to seek health care for prolonged or obstructed labour often lie with the husband, other family members (e.g., the mother-in-law or the brother-in-law), the village chief, or a religious leader.

When a woman develops obstetric fistula, her husband often divorces her immediately. His family may also reject her, leaving her isolated and with no means of support. The woman may be treated as if she were the cause of her condition, when often she has in fact developed fistula as a result of abiding by social expectations imposed upon her.

Traditional attitudes and practises may make it difficult for women affected by fistula to reintegrate into their communities. For example, community members may not believe that a woman has been successfully treated for fistula and continue to consider her an outcast, or a woman may lack the knowledge and skills needed to generate income to support herself.

## **PARTICIPANT HANDOUT 4-Q**

### **Creating Awareness among Men: How Traditional Gender Attitudes and Practises Contribute to Obstetric Fistula**

Begin by creating awareness among men about the physical causes of obstetric fistula and the contributing social factors. Then consider the following activities:

- Ask a respected leader to discuss traditional gender practises with men and to lead discussions about how to make changes that will prevent fistula.
- Ask a man whose wife has been affected by fistula to talk about how fistula repair has improved life for their family.
- Ask a man who has changed traditional gender practises to talk with other men about why he has changed; what benefits he has gained from the changes; what the results of the changes have been for himself, his wife, and his family; and why he is committed to maintaining the changes.
- Ask a man who has encouraged his wife to seek antenatal care and safe delivery to tell other men why he did so and how he was able to create and maintain an emergency fund for birth.
- Develop a brochure or DVD with men from the community describing how and why they are changing traditional gender practises and the challenges and benefits of the changes.
- Develop short plays or skits with men in the community that describe how traditional gender practises harm women and their families.
- Work with radio broadcasters to interview men who are changing traditional practises that are harmful to women and families.

## **PARTICIPANT HANDOUT 4-R**

### **Networking**

**Definition of networking:** The exchange of information or services among individuals, groups, or institutions; specifically, the cultivation of productive relationships for business purposes.

Networking offers opportunities to:

1. Update practise information
2. Share innovations and results of initiatives
3. Exchange ideas
4. Find opportunities to collaborate on defining and developing best practises and on advocating for change
5. Gain support for changes in practises, management, and organisation of health services

#### **Examples of Networking**

1. Attending professional meetings, conferences, or conventions
2. Visiting with colleagues within the health facility where you work or from other health care institutions
3. Engaging in conversation with other health professionals
4. Reconnecting with former colleagues
5. Talking with former teachers or professors
6. Communicating with influential community leaders who you know personally

## **PARTICIPANT HANDOUT 4-S**

### **Using Networking to Support Fistula Prevention, Management, and Reintegration**

Make presentations about obstetric fistula at professional meetings, conferences, and conventions. Ask audiences to support fistula care initiatives. List specific things that audience members might be able to do, depending upon their positions, roles, and responsibilities.

Make presentations about obstetric fistula within the health facility where you work. Ask your audiences to support fistula care initiatives. List specific things that staff members of the facility might be able to do (e.g., action planning with input from community stakeholders and representatives of the health system).

Contact former colleagues, teachers, and professors and ask them to support fistula care initiatives. List specific things that they might be able to do within their professional fields.

Contact community leaders that you know and ask them to support fistula care initiatives. Encourage them to develop action plans that address prevention, access to treatment services, and reintegration.

Ask personal and professional contacts to (a) facilitate the reintegration of women affected by fistula into their communities and (b) identify resources that help women build their skills and generate income.

## **TRAINER'S RESOURCE 4-I**

### **Evaluation and Answer Key for Module 4**

#### **TRAINING TIP**

Based on the sessions and content covered, select 10 to 15 relevant questions from this list for the Module 4 Pretest and Posttest. The correct answers are shown below in **boldface** and the source of the correct answer is shown in [brackets].

1. List the seven clients' rights.
  - a. **Information**
  - b. **Informed choice**
  - c. **Access to services**
  - d. **Safe services**
  - e. **Privacy and confidentiality**
  - f. **Dignity, comfort, and expression of opinion**
  - g. **Continuity of care**[Participant Handout 4-A]
2. Proper use of service delivery guidelines is an example of which clients' right?
  - a. The client's right to information
  - b. The client's right to access to services
  - c. **The client's right to safe services**[Participant Handout 4-A]
3. A woman's medical history can be shared at any time with her husband.
  - a. True
  - b. **False**[Participant Handout 4-A]
4. Early marriage and childbirth are examples of traditional practises that contribute to obstetric fistula.
  - a. **True**
  - b. False[Participant Handout 1-F]
5. What is the purpose of behaviour change communication?

**To motivate people to adopt healthy behaviours and lifestyles**

[Participant Handout 4-B]
6. Name at least three factors that affect a person's willingness and ability to adapt healthy behaviours.

[Participant Handout 4-D provides the list of possible answers.]
7. Name at least three ways in which nurses and midwives can inform and educate women and communities about obstetric fistula.

[Participant Handout 4-E provides a list of possible responses.]

8. Anatomical diagrams in IEC materials should be as detailed as possible.
  - a. True
  - b. False**[Participant Handout 4-F]
9. Messages in IEC materials should contain as few medical and technical terms as possible.
  - a. True**
  - b. False[Participant Handout 4-F]
10. Describe at least three things that a nurse or midwife can do when using IEC materials with clients who cannot read about obstetric fistula.  
[Participant Handout 4-F provides a list of possible responses.]
11. Identify at least three issues to consider when preparing a group health education session about the prevention of obstetric fistula.  
[Participant Handout 4-H provides a list of possible issues.]
12. Define community involvement.  
**Actively involving community members in the planning, operation, and control of health care programmes.**  
[Participant Handout 4-I]
13. Explain the difference between formal and informal leadership structures.  
**Formal leadership structures operate according to defined policies and procedures. Informal leadership structures do not.**  
[Participant Handout 4-J]
14. Describe at least one way in which volunteers can contribute to the prevention and management of obstetric fistula.  
Possible answers include:
  - a. Transporting women to health care facilities**
  - b. Speaking to community groups and political leaders**
  - c. Providing support and care for women affected by obstetric fistula to help them reintegrate into society**[Participant Handout 4-K]
15. Why is advocacy important?  
**It can influence decision making, policy development, community involvement, and programme sustainability.**  
[Participant Handout 4-L]
16. Traditional practises that contribute to obstetric fistula are well-established; therefore, sustained advocacy is needed at many levels to oppose them.
  - a. True**
  - b. False[Participant Handout 4-N]

17. Men have little role to play in the practise of family planning.

a. True

**b. False**

[Participant Handout 4-O]

18. A man whose wife has been affected by obstetric fistula can be an effective spokesperson for the prevention and management of this condition.

**a. True**

b. False

[Participant Handout 4-Q]

19. Which of the following activities are examples of networking?

√ Attending professional meetings of nurses and midwives

√ Giving a talk on obstetric fistula to the husbands of women affected by obstetric fistula

√ Talking about obstetric fistula with former nursing school professors

√ Giving a talk on obstetric fistula to colleagues where you work

[Participant Handout 4-R]

## **TRAINER'S RESOURCE 4-2**

### **Group Health Education Sessions: Preventing Obstetric Fistula: Discussion Guide**

1. **Knowledge of fistula:** Based on what you have been able to learn, the market leaders know little about obstetric fistula and how it develops. How will this affect the content of the educational session?

*Content will need to be basic. Questions to be addressed include: What is obstetric fistula? What causes it? How do social factors play a role? How is it treated? What must a woman do after treatment?*

2. **Education and literacy:** The market leaders have varying levels of education. Literacy among them ranges from low to medium. What will you do to take into account the group's literacy level?

*Presenters need to use simple layperson's language and avoid medical jargon. Simple anatomical drawings may be appropriate. Presenters may want to use stories or ask questions that the group can relate to personally (e.g., What if this had happened to you or your wife?).*

3. **Myths and misunderstandings:** Some community members believe that obstetric fistula is God's will and that the condition cannot be treated. How will this affect the content of the educational session?

*Presenters will need to correct any myths and misunderstandings. The market leaders may or may not share these beliefs, but they need to be aware that these exist in the community. Presenters may want to ask women who have been treated and rebuilt their lives to share their stories with the group. Family members of such women may also be appropriate speakers.*

4. **Community customs:** Which community customs might prevent the market leaders from taking action to prevent fistula?

*Girls marry young and have little education. Some members of the community believe that it is acceptable to abandon women living with obstetric fistula. These long-established customs may be difficult to overcome and the market leaders may be reluctant to challenge them.*

5. **Access to services:** What barriers does the community face that make it hard to prevent obstetric fistula and to help women access fistula treatment services?

*Women receive little antenatal care and usually deliver at home without skilled care. The treatment facility is far away and transportation is costly.*

6. **Taking action:** As leaders in the community market, what might these participants do to prevent fistula?

*Participants may want to reach out to other community leaders, such as religious leaders and heads of women's and men's organisations. They may want to develop an action plan*

*focusing on areas such as traditional practises, transportation barriers, and access to antenatal care.*

7. **Your credentials:** What credentials and qualifications will make you a credible presenter to local opinion leaders? Who else might join you in the presentation to increase your credibility?

*The following qualifications are likely to increase the participants' credibility:*

- *Having medical credentials*
- *Being well informed about obstetric fistula*
- *Being culturally competent (i.e., familiar with the local culture and able to speak the local language) in regard to this particular community*
- *Being recognised and respected by community leaders*
- *Being associated with a respected health facility*

*Other presenters might include a doctor who provides fistula care services, a respected market leader, or a woman or family from the community who has been affected by obstetric fistula.*



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# MODULE 5: COUNSELLING CLIENTS WITH OBSTETRIC FISTULA

## Introduction

Counselling is an integral part of comprehensive obstetric fistula care services. As such, nurses and midwives need to be able to provide counselling related to fistula prevention and management, and the reintegration of fistula clients. This module provides a general introduction to counselling, describes a counselling framework (REDI), and gives an overview of the role of nurses and midwives in counselling during all phases of fistula care.

### TRAINING TIP

As indicated above, this module provides a **general introduction to the subject of counselling** and gives an **overview of the role of nurses and midwives in counselling related to fistula care**. Effective counselling—including counselling clients with fistula—requires a range of knowledge, skills, and experience that are beyond the scope of this module. Nurses and midwives will need additional course work and/or training in counselling. Participants who will be working at facilities that treat large numbers of clients with fistula should consider completing EngenderHealth’s *Counseling the Obstetric Fistula Client: A Training Curriculum*.

## Prerequisites

- Successful completion of modules 1, 2, 3, and 4 of this curriculum (or equivalent knowledge and experience)

## Module Objectives

Upon completion of this module, the participants will be able to:

- Define *counselling*
- Explain the difference between *counselling* and *informing, providing guidance, and advising*
- Compare and contrast individual, joint, and group counselling
- Explain the REDI counselling framework
- Discuss the importance of offering counselling about fistula
- Describe the role of nurses and midwives in counselling related to fistula prevention
- Describe the role of nurses and midwives in counselling related to fistula management
- Describe the role of nurses and midwives in counselling related to reintegration of clients with fistula
- Demonstrate the use of the REDI counselling framework in a fistula care–related role play

### Overview of Module Content

Sessions/Parts	Total time
1. Introduction to Counselling	1 hour, 30 minutes
A. What Is Counselling?	50 minutes
B. Individual, Joint, and Group Counselling	40 minutes
2. Introduction to the REDI Counselling Framework	35 minutes
3. Overview of Fistula-Related Counselling	3 hours, 35 minutes
A. Fistula-Related Counselling	30 minutes
B. Counselling for Fistula Prevention	40 minutes
C. Fistula Management Counselling	1 hour, 5 minutes
D. Reintegration Counselling for Clients with Fistula	40 minutes
E. Module 5 Evaluation	40 minutes
<b>Total time</b>	<b>5 hours, 40 minutes</b>

### Evaluation

- Trainer’s Resource 5-1: Module 5 Evaluation and Answer Key

## SESSION I

### Introduction to Counselling

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Define *counselling*
- Explain the difference between *counselling* and *informing*, *providing guidance*, and *advising*
- Compare and contrast individual, joint, and group counselling

#### POINTS TO REMEMBER

- Counselling is two-way communication between a client and a health care staff member for the purpose of confirming or facilitating a decision by the client or helping the client address problems or concerns.
- The counselling process:
  - Focuses on helping individuals make decisions and manage the emotions associated with their situation
  - Goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices
  - Includes a discussion of feelings and concerns, because they are relevant to the client's choices
- The role of the counsellor is to *facilitate* decision making—not to make decisions on behalf of the clients.
- Staff who provide counselling must be nonjudgmental and extremely sensitive to and respectful of the client's emotions and feelings in order to adapt the session to her specific needs. Counsellors should be knowledgeable, well-trained, and able to give accurate information. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity. Critical elements of all good counselling include the ability of the counsellor to elicit and listen to the client's needs, concerns, and questions, and to inform, educate, and reassure her, using language and terms that she understands.
- Informing is *giving or imparting knowledge of a fact or circumstance*. A synonym is *telling*.
- Guidance is *the act or function of guiding*, which, in turn, is defined as *exerting influence or control over something or someone*. A synonym is *direction*.
- Advising is *offering an opinion or suggestion as worth following*. A synonym is *recommending*.
- Nurses and midwives may perform counselling in an individual (one-on-one) setting, a joint setting (with a partner or family member), or a group setting.
- Individual counselling involves a one-to-one helping relationship in which the counsellor works with the client to enable her to make an informed decision regarding a problem or situation. The privacy of the individual setting can help to put the client at ease when discussing personal concerns with the counsellor.
- Joint counselling is a helping relationship in which the counsellor works with the client in conjunction with a partner or family member to make an informed decision regarding a problem or situation. Joint counselling focuses on the issues and needs of a single client in situations in which decisions also may affect the other person. The joint setting can help to promote communication between the client and her partner or family member.
- Group counselling involves a helping relationship in which the counsellor works with a group of clients to address a problem or situation that affects all the members of the group. It enables one counsellor to help a number of clients who share a common problem to deal with the reality of their situation and assist the individual members in identifying realistic goals and making informed decisions.
- Regardless of the type of counselling, it is essential to respect the client's privacy and confidentiality. The client must always have the option to receive individual counselling without anyone else present.

## Training Methods

- Presentation
- Lecture
- Small-group exercise

## Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 5-A: What is Counselling?
- Participant Handout 5-B: Informing, Guidance, and Advising
- Participant Handout 5-C: Individual, Joint, and Group Counselling
- Trainer's Resource 5-1: Module 5 Evaluation and Answer Key

## Advance Preparation

1. Review the Training Steps.
2. Review Participant Handouts 5-A, 5-B, and 5-C.
3. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Definition of counselling (from Participant Handout 5-A)
  - Characteristics of counselling (from Participant Handout 5-A)
  - Counselling tasks that health care staff are responsible for (from Participant Handout 5-A)
  - Definitions of informing, guidance, and advising (from Participant Handout 5-B)
  - Descriptions of individual counselling, joint counselling, and group counselling (from Participant Handout 5-C)
  - Phases and steps of REDI (from Participant Handout 5-D)
4. Write the headings “Informing,” “Providing Guidance,” and “Advising” at the top of three sheets of flipchart paper.  
*Note: Keep these pages covered until Step 14 of Part A, Activity 2.*
5. Duplicate Participant Handouts 5-A, 5-B, and 5-C for the participants.

### TRAINING TIP

If you wish to do a pretest for Module 5, select approximately 20 relevant questions from Trainer's Resource 5-1 (based on the sessions and content that you will be covering) to create the test. The pretest will add about 20 minutes to the length of Session 1. The correct answers are shown in **boldface**.

**Session Time (total):** 1 hour, 30 minutes

## SESSION I

### Training Steps

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#### PART A: WHAT IS COUNSELLING?

**Time:** 50 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Explain that counselling is an integral part of obstetric fistula care services.
2. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
3. Emphasise that the purpose of this session is to provide a *general introduction to counselling*.
4. Ask the participants what questions they have about the session objectives.

##### **Activity 2: Lecture and Discussion (45 minutes)**

1. Facilitate a brief discussion by asking the participants the following questions:
  - “What training have you had on counselling?”
  - “What kinds of counselling have you done with clients?”
2. Write the participants’ responses on a piece of flipchart paper.

#### TRAINING TIP

This initial discussion will allow you to assess the participants’ level of knowledge regarding counselling. If they have had some counselling training or experience, you can make the remainder of this activity more interactive (asking questions, asking for examples, etc.); if they have little or no counselling training or experience, give a lecture to present the information for the remainder of this activity.

3. Distribute Participant Handout 5-A
4. Discuss the definitions of counselling, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 5-A).
5. Describe the characteristics of counselling (based on Participant Handout 5-A).
6. Emphasise that the role of the counsellor is to *facilitate* decision making—not to make decisions on behalf of the clients.
7. Have the participants read “The World Health Organization (WHO) on Counselling” in the handout.
8. Facilitate a brief discussion of the WHO statements by asking the participants, “What did you find most significant or important?”
9. Write the participant responses on a piece of flipchart paper. Possible answers could include:
  - Being nonjudgmental
  - Being aware of the need for privacy and confidentiality
  - Using written and pictorial support materials

If not mentioned, emphasise the following statement:

- *Critical elements of all good counselling include the ability of the counsellor to elicit and listen to the client’s needs, concerns, and questions, and to inform, educate, and reassure, using language and terms that the client understands.*

10. List the counselling tasks that health care staff are responsible for, using a prepared flipchart, computer slide, or overhead transparency (based on Participant Handout 5-A).
11. Distribute Participant Handout 5-B.
12. Explain the definitions of informing, guidance, and advising, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 5-B).
13. Reveal the three prepared flipchart pages labeled “Informing,” “Providing Guidance,” and “Advising” (Advance Preparation, Step 4).
14. Direct the participants to review the definition of counselling on Participant Handout 5-A.
15. Ask the participants, “How does *informing* differ from *counselling*?”
16. Write the participants’ responses on the “Informing” flipchart. Possible answers could include:
  - *Informing* involves one-way communication; *counselling* involves two-way communication.
  - *Informing* only requires giving facts; *counselling* involves enabling clients to apply information and make informed choices.
  - *Informing* does not typically address feelings and concerns; *counselling* does address them, because they are relevant to the client’s choices.
17. Ask the participants, “How does providing guidance differ from counselling?”
18. Write the participants’ responses on the “Providing Guidance” flipchart. Possible answers could include:
  - Providing guidance involves one-way communication; counselling involves two-way communication.
  - Providing guidance is not collaborative—the person providing guidance is trying to influence or direct the client; counselling involves enabling clients to make their own, informed choices.
19. Ask the participants, “How does advising differ from counselling?”
20. Write the participants’ responses on the “Advising” flipchart. Possible answers could include:
  - *Advising* involves one-way communication; *counselling* involves two-way communication.
  - *Advising* is not collaborative—the advisor is suggesting what the client should do; *counselling* involves enabling clients to make their own informed choices.
21. Emphasise the following points about counselling:
  - It is an *interactive* process.
  - Counsellors must be *nonjudgmental* and *nonmanipulative*.
  - The goal is to *enable clients to make their own, informed choices*.
22. Ask the participants what questions they have about the definition of counselling.

## **PART B: INDIVIDUAL, JOINT, AND GROUP COUNSELLING**

**Time:** 40 minutes

### **Activity 1: Lecture and Discussion (10 minutes)**

1. Direct the participants to briefly review the counselling tasks listed on Participant Handout 5-A.
2. Explain that nurses and midwives may perform these counselling tasks in an individual (one-on-one) setting, a joint setting (with a partner or family member), or a group setting.

3. Distribute Participant Handout 5-C.
4. Describe individual counselling, joint counselling, and group counselling, based on the information in Participant Handout 5-C.
5. Emphasise that, regardless of the type of counselling, it is essential to respect the client's privacy and confidentiality; the client must always have the option to receive individual counselling without anyone else present.
6. Ask the participants what questions they have about the three types of counselling.

**Activity 2: Small Group Exercise (30 minutes)**

1. Divide the participants into three groups.
2. Give each group several sheets of flipchart paper and markers.
3. Assign the first group to identify examples of health care–related situations in which individual counselling would be most appropriate; assign the second group to identify examples of health care–related situations in which joint counselling would be most appropriate; assign the last group to identify examples of health care–related situations in which group counselling would be most appropriate.
4. Give the groups about 10 minutes to complete the assignment; have each group write its answers on the flipcharts and select a presenter.
  - A. Have the first group present examples of health care–related situations in which individual counselling would be especially appropriate. These could include:
    - Counselling a victim of domestic violence
    - Counselling a single adult about a medical procedure or treatment
    - Counselling a client about an emergency medical procedure or treatment when no family members are available
    - Whenever the client specifically requests individual counselling
  - B. Have the second group present examples of health care–related situations in which joint counselling would be especially appropriate. These could include:
    - Counselling a married couple about family planning
    - Counselling a married person about a medical procedure or treatment (with permission to have the spouse present)
    - Counselling a child about a medical procedure or treatment (with a parent or family member present)
    - Counselling HIV-discordant couples (i.e., couples in which one person is HIV-positive and the other HIV-negative)
    - Whenever the client specifically requests that another person be present
  - C. Have the third group present examples of health care–related situations in which group counselling would be especially appropriate. These could include:
    - Counselling young women about antenatal nutrition
    - Counselling young adults about prevention of sexually transmitted infections
    - Counselling women who have recently had fistula repair operations
    - Counselling people being treated for alcohol or drug abuse
    - Counselling women about preventing mother-to-child transmission of HIV during antenatal care
5. Ask the participants what questions they have about the situations in which the three types of counselling are most appropriate.

## SESSION 2

### Introduction to the REDI Counselling Framework

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Explain the REDI counselling framework

#### POINTS TO REMEMBER

- REDI is an acronym that stands for the four phases of a reproductive health counselling framework. The four phases are:
  - **R**apport building
  - **E**xploration
  - **D**ecision making
  - **I**mplementing the decision
- The REDI counselling framework:
  - Emphasises the client's right and responsibility for making decisions and carrying them out
  - Provides guidelines to help the counsellor and client consider the client's circumstances and social context
  - Identifies the challenges a client may face in carrying out his or her decision
  - Helps clients build skills to address those challenges
- Emphasise the following four key points about the REDI framework:
  - A framework is an aid—a means to an end, not the end in itself.
  - The REDI framework provides a structure and guidance for talking with clients so that providers do not miss important steps in the counselling process.
  - Counselling should always be client-centred; too often, providers focus more on following the steps than on listening to the client and responding to what he or she is saying.
  - The essential task of counselling is to understand what the client needs and then help him or her meet those needs as efficiently as possible.
- The steps in **Phase 1—Rapport Building** are:
  - Greet the client with respect.
  - Make introductions.
  - Assure the client's confidentiality and privacy.
  - Explain the need to discuss sensitive and personal issues candidly.
- The steps in **Phase 2—Exploration** are:
  - Explore in depth the client's reason for the visit. (This information will help determine the client's counselling needs and the focus of the counselling session.)
  - Explore the client's current situation and, if relevant, past experience.
  - Explore the client's social context, circumstances, and relationships.
  - Identify and discuss the client's issue(s) and/or concern(s).
  - Provide and clarify information as needed and correct any misconceptions.
- The steps in **Phase 3—Decision Making** are:
  - Identify the decision(s) the client needs to confirm or make.
  - Explore relevant options for each decision.
  - Help the client weigh the benefits, disadvantages, and consequences of each option, providing information needed to fill any remaining knowledge gaps.
  - Encourage the client to make his or her own realistic decision(s).
- The steps in **Phase 4—Implementing the Decision** are:
  - Assist the client in making a concrete and specific plan for carrying out the decision(s).
  - Identify barriers that the client might face in implementing his or her decision.
  - Develop strategies to overcome the barriers.
  - Make a plan for follow-up and/or provide referrals as needed.

### **Training Methods**

- Presentation
- Lecture
- Large-group discussion

### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 5-D: The REDI Counselling Framework

### **Advance Preparation**

1. Review the Training Steps.
2. Review Participant Handout 5-D.
3. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objective for this session
  - Definition of REDI (from Participant Handout 5-D)
  - Phases and steps of REDI (from Participant Handout 5-D)
  - Duplicate Participant Handout 5-D for the participants.

**Session Time (total):** 35 minutes

## SESSION 2

### Training Steps

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#### **Activity 1: Presentation (5 minutes)**

1. Review the session objective, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Explain that this session will give participants a *basic counselling framework*—a short series of phases and steps—that nurses and midwives can apply in a number of health care-related situations, including, but not limited to, fistula care.
3. Ask the participants what questions they have about the session objectives.

#### **Activity 2: Lecture (10 minutes)**

##### **TRAINING TIP**

If, during Session 1, you determined that the participants have had some counselling training or experience, you can start this activity by asking, “Are you familiar with the REDI framework, often used in family planning counselling?” If the participants do have experience with REDI, you can make the remainder of this activity more interactive (by asking questions, asking for examples, etc.); if not, give a lecture presenting the information for the remainder of this activity.

1. Define the acronym “REDI,” using a prepared flipchart, computer slide, or overhead transparency (based on Participant Handout 5-D).
2. Discuss the following points about the REDI counselling framework (based on information in Participant Handout 5-D). Note that REDI:
  - Emphasises the client’s right and responsibility for making decisions and carrying them out
  - Provides guidelines to help the counsellor and client consider the client’s circumstances and social context
  - Identifies the challenges a client may face in carrying out his or her decision
  - Helps the client build skills to address those challenges
3. Emphasise the following key points about the REDI framework:
  - A framework is an aid—a means to an end, *not* the end in itself.
  - The REDI framework provides a structure and guidance for talking with clients, so that providers do not miss important steps in the counselling process.
  - Counselling should be client-centred; too often, providers focus more on following the steps than on listening to the client and responding to what he or she is saying.
  - The essential task of counselling is to understand the client’s needs and then help him or her meet those needs as efficiently as possible.
4. Distribute Participant Handout 5-D.
5. Review the phases and steps of REDI using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 5-D).
6. Indicate that the next activity will give the participants a chance to discuss the REDI framework in greater detail.

#### **Activity 3: Large Group Discussion (20 minutes)**

1. Give the participants approximately five minutes to read through Participant Handout 5-D.
2. Facilitate a brief discussion by asking the participants, “How does the REDI framework ensure that the counselling is client-centred?”

3. Write the participants' responses on a piece of flipchart paper. Possible answers could include:
  - The REDI framework starts with and is focused on the client's individual circumstances. Each counselling session is then tailored to the specific needs of the individual client, taking into consideration his or her specific circumstances, needs, and desires.
  - The REDI framework treats the client as a whole person with different and interrelated needs and circumstances. It helps providers explore and address clients' needs and problems in an integrated way.
  - REDI also takes into consideration whether the client will be able to implement his or her decision(s). REDI helps providers identify potential barriers and develop strategies to overcome them. Therefore, the Implementing the Decision phase of REDI evolves differently based on each client's unique set of needs and circumstances.
4. Facilitate a brief discussion by asking the participants, "Why does the REDI framework address clients' social context and personal circumstances?"
5. Write the participants' responses on a piece of flipchart paper. Possible answers could include:
  - Clients need to make realistic decisions that they can carry out successfully and safely.
  - Examining the social context helps clients to understand the potential outcomes of their decisions.
  - It is important that counsellors and clients understand who has the decision-making power and who else influences the decisions (i.e., partners, friends, family members).
  - It is also important to understand what economic pressures might affect the client's decisions.
6. Facilitate a brief discussion by asking the participants, "How does the REDI framework help to ensure a client's informed and voluntary decision making?"
7. Write their responses on a piece of flipchart paper. Possible answers could include:
  - REDI helps the provider tailor the information to the client's needs and circumstances, so the client can make realistic decisions after having considered his or her life circumstances
  - The framework reminds the client to weigh options and consider their implications and helps the client anticipate potential barriers to the implementation of his or her decision and develop strategies to overcome them.
  - The framework guides providers in helping clients to better understand their options, thus enabling clients to make informed decisions.
  - The framework also helps to ensure that the provider checks to see whether social pressure (i.e., from partners, family members, or the community) may be influencing the client and makes sure that the decision the client makes is voluntary and free of coercion.
8. Ask the participants what questions they have about the REDI counselling framework.

## SESSION 3

### Overview of Fistula-Related Counselling

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Explain the importance of offering counselling about fistula
- Describe the role of nurses and midwives in counselling related to fistula prevention
- Describe the role of nurses and midwives in counselling related to fistula management
- Describe the role of nurses and midwives in counselling related to reintegration of clients with fistula
- Demonstrate the use of the REDI counselling framework in a fistula care-related role play

#### POINTS TO REMEMBER

- Counselling is an integral part of obstetric fistula care services.
- The special counselling needs of obstetric fistula clients fall into three general categories:
  - Information/education
  - Emotional support
  - Clinical management
- Counselling skills and steps should **always** be part of nurses' and midwives' interactions with obstetric fistula clients.
- Fistula care comprises three elements: prevention, management, and reintegration. Each of these elements has a set of counselling competencies (i.e., skills and actions) involving individual, joint, or group counselling.
- Counselling for obstetric fistula *prevention* falls into three types, based on when it occurs:
  - Preconception counselling
  - Antenatal counselling
  - Postnatal counselling
- Counselling related to the *management* of obstetric fistula falls into four types, based on when it occurs:
  - Preoperative counselling
  - Intraoperative counselling
  - Postoperative counselling
  - Discharge counselling
- Counselling related to the *reintegration* of obstetric fistula clients falls into three types, based on the situation that it addresses:
  - Counselling on physical therapy/physiotherapy
  - Counselling on community/family reentry
  - Counselling on livelihood

#### Training Methods

- Presentation
- Lecture/discussion
- Demonstration
- Small-group role plays
- Large-group discussion
- Posttest
- Review/debrief

## Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 5-E: Fistula-Related Counselling
- Participant Handout 5-F: Counselling for Fistula Prevention
- Participant Handout 5-G: Fistula Management Counselling
- Participant Handout 5-H: Reintegration Counselling for Fistula Clients
- Trainer’s Resource 5-1: Module 5 Evaluation and Answer Key
- Trainer’s Resource 5-2: Counselling Demonstration/Role Play Checklist
- Trainer’s Resource 5-3: Demonstration/Role Play Scenario 1—Prevention
- Trainer’s Resource 5-4: Demonstration/Role Play Scenario 2—Management
- Trainer’s Resource 5-5: Demonstration/Role Play Scenario 3—Reintegration
- Module 3 Participant Handouts:
  - Participant Handout 3-O: Informed Consent for Fistula Repair
  - Participant Handout 3-R: Preoperative Care and Preparation of Fistula Repair Surgery Clients
  - Participant Handout 3-X: Postoperative Care of Fistula Repair Surgery Clients
  - Participant Handout 3-Y: Fistula Repair Surgery: Postoperative Complications
  - Participant Handout 3-BB: Fistula Repair Surgery: The Discharge Plan and Follow Up

## Advance Preparation

1. Review the Training Steps.
2. Review Participant Handouts 5-E, 5-F, 5-G, and 5-H.
3. Review Trainer’s Resources 5-1, 5-2, 5-3, 5-4, and 5-5.
4. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Characteristics of the counselling process (from Participant Handout 5-A)
  - Information/education counselling needs of fistula clients (from Participant Handout 5-E)
  - Emotional support counselling needs of fistula clients (from Participant Handout 5-E)
  - Clinical management counselling needs of fistula clients (from Participant Handout 5-E)
  - Competencies for preconception counselling (from Participant Handout 5-F)
  - Competencies for antenatal counselling (from Participant Handout 5-F)
  - Competencies for postnatal counselling (from Participant Handout 5-F)
  - Competencies for preoperative counselling (from Participant Handout 5-G)
  - Competencies for intraoperative counselling (from Participant Handout 5-G)
  - Competencies for postoperative counselling (from Participant Handout 5-G)
  - Competencies for discharge counselling (from Participant Handout 5-G)
  - Competencies for counselling on physical therapy/physiotherapy (from Participant Handout 5-H)
  - Competencies for counselling on community/family reentry (from Participant Handout 5-H)
  - Competencies for counselling on livelihood (from Participant Handout 5-H)
5. Duplicate Participant Handouts 5-E, 5-F, 5-G, and 5-H for the participants.
6. Prepare the Module 5 Evaluation (based on Trainer’s Resource 5-1).

**TRAINING TIP**

Based on the sessions and content covered, select approximately 20 relevant questions from Trainer's Resource 5-1 for the Module 5 Posttest. The correct answers are shown in **boldface**, and the source of the correct answer is shown in [brackets].

7. Make three copies for each participant of the Counselling Demonstration/Role Play Checklist (from Trainer's Resource 5-2)
8. Make one copy of Trainer's Resource 5-3: Demonstration/Role Play Scenario 1—Prevention
9. Make copies of Trainer's Resource 5-4: Demonstration/Role Play Scenario 2—Management and Trainer's Resource 5-5: Demonstration/Role Play Scenario 3—Reintegration
10. Make copies of the following Module 3 Participant Handouts for role play preparation:
  - Participant Handout 3-O: Informed Consent for Fistula Repair
  - Participant Handout 3-R: Preoperative Care and Preparation of Fistula Repair Surgery Clients
  - Participant Handout 3-X: Postoperative Care of Fistula Repair Surgery Clients
  - Participant Handout 3-Y: Fistula Repair Surgery: Postoperative Complications
  - Participant Handout 3-BB: Fistula Repair Surgery: The Discharge Plan and Follow-Up

**TRAINING TIP**

Because Session 3 is 3 hours, 35 minutes in length, it may not be practical to conduct the entire session on a single day. If you need to split the session, we suggest conducting Part A (Fistula-Related Counselling) and Part B (Counselling for Fistula Prevention) on one day and Part C (Fistula Management Counselling), Part D (Reintegration Counselling for Clients with Fistula), and Part E (Module 5 Evaluation) on another day; be sure also to schedule a break before Part E.

**Session Time (total):** 3 hours, 35 minutes

## SESSION 3

### Training Steps

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#### **PART A: FISTULA-RELATED COUNSELLING**

**Time:** 30 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Emphasise that the purpose of this session is to give *an overview of the role of nurses and midwives in counselling during all phases of fistula care*.
3. Explain that, to truly be effective counsellors, nurses and midwives will need additional course work and/or training in counselling. Participants who will be working at facilities that treat large numbers of clients with fistula should consider completing EngenderHealth's *Counseling the Obstetric Fistula Client: A Training Curriculum*.
4. Ask the participants what questions they have about the session objectives.

##### **Activity 2: Lecture and Discussion (25 minutes)**

1. Remind the participants of the characteristics of the counselling process (listed on Participant Handout 5-A) that were discussed in Session 1, using a prepared flipchart, a computer slide, or an overhead transparency:
  - Counselling focuses on helping individuals make decisions and manage the emotions associated with their situation.
  - Counselling goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices.
  - Counselling includes a discussion of feelings and concerns—because they are relevant to the client's choices.
2. Remind the participants that, in Session 1, we stated that counselling is an integral part of obstetric fistula care services.
3. Ask the participants, "Why is it important to integrate counselling into obstetric fistula care services?"
4. Write the participants' responses on a piece of flipchart paper. Possible answers could include:
  - Women with fistula experience social isolation and other emotionally devastating effects.
  - Women with fistula need to make informed decisions about their treatment.
  - Preconception and antenatal counselling can help to prevent obstetric fistula.
  - Women who have had fistula repair operations need to understand postoperative and discharge-related information to ensure a successful recovery.
5. Explain that the special counselling needs of obstetric fistula clients fall into three general categories:
  - Information/education
  - Emotional support
  - Clinical management
6. Distribute Participant Handout 5-E.

7. Discuss the information and education counselling needs of obstetric fistula clients (based on Participant Handout 5-E), using a prepared flipchart, a computer slide, or an overhead transparency.
8. Discuss the emotional support counselling needs of obstetric fistula clients (based on Participant Handout 5-E), using a prepared flipchart, a computer slide, or an overhead transparency.
9. Discuss the clinical management counselling needs of obstetric fistula clients (based on Participant Handout 5-E), using a prepared flipchart, a computer slide, or an overhead transparency.
10. Emphasise that counselling skills and steps should *always* be part of nurses' and midwives' interactions with obstetric fistula clients.
11. Discuss the following points:
  - Fistula care comprises three elements: prevention, management, and reintegration.
  - Each of these elements has a set of counselling competencies (i.e, skills and actions) involving individual, joint, or group counselling.
  - Most of the remainder of this session will deal with the sets of competencies for each of these three elements.
12. Ask the participants what general questions they have about the counselling needs of obstetric fistula clients.

#### **TRAINING TIP**

At this point, participants may have questions that will be addressed later in the session. If they do, acknowledge their concerns and write them on a "Parking Lot" flipchart. Indicate that, after completing this module, their questions should be answered. At the end of Part D of this session, you will need to validate that you have answered their questions and that the participants understand the counselling competencies for each of the three elements of fistula care.

## **PART B: COUNSELLING FOR FISTULA PREVENTION**

**Time:** 40 minutes

### **Activity 1: Presentation (10 minutes)**

1. Explain that counselling for obstetric fistula prevention falls into three types, based on when it occurs:
  - Preconception counselling
  - Antenatal counselling
  - Postnatal counselling
2. Distribute Participant Handout 5-F.
3. Discuss the competencies for preconception counselling (based on Participant Handout 5-F), using a prepared flipchart, a computer slide, or an overhead transparency.
4. Discuss the competencies for antenatal counselling (based on Participant Handout 5-F), using a prepared flipchart, a computer slide, or an overhead transparency.
5. Discuss the competencies for postnatal counselling (based on Participant Handout 5-F), using a prepared flipchart, a computer slide, or an overhead transparency.
6. Explain the following points about counselling for fistula prevention:
  - The primary counselling need that it addresses is information/education.
  - It can involve individual, joint, and/or group counselling.

7. Ask the participants what questions they have about the competencies related to counselling for obstetric fistula prevention.

### **Activity 2: Demonstration (30 minutes)**

1. Explain that you are going to give a demonstration of fistula prevention counselling, and specifically, of postnatal counselling.
2. Ask for a volunteer to play the role of a client; give the volunteer a copy of Trainer's Resource 5-3 (Demonstration/Role Play Scenario 1—Prevention) and have the volunteer review the scenario for two or three minutes.
3. Distribute copies of the Counselling Demonstration/Role Play Checklist (based on Trainer's Resource 5-2) to the other participants and direct them to refer to it during the demonstration, to check off the counselling steps as they are performed, and to write down any comments about what was or was not effective.
4. Indicate that, to save time, this demonstration will be a condensed version of the counselling process and will not address information on optimal nutrition for woman and infant, which should always be covered in a comprehensive postnatal counselling session.

#### **TRAINING TIP**

When preparing for this demonstration, be sure to review both the REDI framework and any family planning educational materials used at your facility.

5. Working with the volunteer, role-play the postnatal counselling process.
  - Provide information on the healthy timing and spacing of pregnancies and the family planning options available to the client.
  - Follow the phases and steps of REDI framework as closely as possible.
  - Try to keep the role play to no more than 10 to 15 minutes.
6. Ask the participants (including the volunteer "client") for feedback about the role play, including:
  - What worked well?
  - What could be improved?
7. Ask the participants what questions they have about counselling for obstetric fistula prevention.

## **PART C: FISTULA MANAGEMENT COUNSELLING**

**Time:** 1 hour, 5 minutes

### **Activity 1: Presentation (20 minutes)**

1. Explain that counselling related to the management of obstetric fistula falls into four types, based on when it occurs:
  - Preoperative counselling
  - Intraoperative counselling
  - Postoperative counselling
  - Discharge counselling
2. Distribute Participant Handout 5-G.
3. Discuss the competencies for preoperative counselling (based on Participant Handout 5-G), using a prepared flipchart, a computer slide, or an overhead transparency.

4. Discuss the competencies for intraoperative counselling (based on Participant Handout 5-G), using a prepared flipchart, a computer slide, or an overhead transparency.
5. Discuss the competencies for postoperative counselling (based on Participant Handout 5-G), using a prepared flipchart, a computer slide, or an overhead transparency.
6. Discuss the competencies for discharge counselling (based on Participant Handout 5-G), using a prepared flipchart, a computer slide, or an overhead transparency.
7. Explain the following points about counselling related to the management of fistula:
  - It addresses all three counselling needs—information/education, emotional support, and clinical management.
  - It can involve individual and joint counselling; at some large fistula care centres it could also involve group counselling.
8. Ask the participants what questions they have about the competencies related to fistula management counselling.

### **Activity 2: Small Group Role Plays (35 minutes)**

1. Explain that the participants are going to have an opportunity to practise counselling related to the management of obstetric fistula, and specifically, of preoperative counselling.
2. Divide the participants into groups of three and assign each member of each group a role as the client, the counsellor, and the observer.

#### **TRAINING TIP**

If the group does not divide evenly by three, then you will either have:

- ⊙ One group of four (with two observers) or
- ⊙ One group of two (with you taking the role of the observer)

3. Give each group:
  - A copy of Trainer's Resource 5-4 (Demonstration/Role Play Scenario 2—Management) for the client
  - Two copies of the Counselling Demonstration/Role Play Checklist (based on Trainer's Resource 5-2) for the counsellor and the observer
4. Give the counsellors and clients three or four minutes to prepare.
5. Have the clients review the first scenario on the page.
6. Have the counsellors review the preoperative counselling portion of Participant Handout 5-G.
7. Have the counsellors review the following handouts from Module 3:
  - Participant Handout 3-O—Informed Consent for Fistula Repair
  - Participant Handout 3-R—Preoperative Care and Preparation of Fistula Repair Surgery Clients
  - Participant Handout 3-X—Postoperative Care of Fistula Repair Surgery Clients
  - Participant Handout 3-Y—Fistula Repair Surgery: Postoperative Complications
8. Tell the counsellors and observers to refer to the checklist during the demonstration:
  - The counsellors can use it to remind themselves of the REDI framework phases and steps.
  - The observers can check off the counselling steps as they are performed and write down comments about what was or was not effective.

9. Indicate that, to save time, this role play will be a condensed version of the counselling process; the counsellors should limit the information they provide to two or three priority subjects. A real preoperative counselling session would cover all subjects relevant to the client's situation.
10. Have the groups role-play the preoperative counselling process.
11. Have the groups wrap up the role plays after about 10 to 12 minutes.
12. Have the groups repeat the process (steps 4 through 11 above), using the second scenario on the page, and shifting roles as follows:
  - The counsellor will become the observer.
  - The client will become the counsellor.
  - The observer will become the client.

### **Activity 3: Large Group Discussion (10 minutes)**

1. Ask the participants for feedback about the role plays, including:
  - How did the clients feel?
  - Were technical issues explained using simple language?
  - What worked well?
  - What could be improved?
2. Ask the participants what questions they have about fistula management counselling.

## **PART D: REINTEGRATION COUNSELLING FOR CLIENTS WITH FISTULA**

**Time:** 40 minutes

### **Activity 1: Presentation (10 minutes)**

1. Explain that counselling related to the reintegration of obstetric fistula clients falls into three types, based on the situation that it addresses:
  - Counselling on physical therapy/physiotherapy
  - Counselling on community/family reentry
  - Counselling on livelihood
2. Distribute Participant Handout 5-H.
3. Discuss the competencies for counselling on physical therapy/physiotherapy (based on Participant Handout 5-H), using a prepared flipchart, a computer slide, or an overhead transparency.
4. Discuss the competencies for counselling on community/family reentry (based on Participant Handout 5-H), using a prepared flipchart, a computer slide, or an overhead transparency.
5. Discuss the competencies for counselling on livelihood (based on Participant Handout 5-H), using a prepared flipchart, a computer slide, or an overhead transparency.
6. Explain the following points about counselling related to the reintegration of obstetric fistula clients:
  - The primary counselling need that it addresses is emotional support; it may also address information/education.
  - It can involve individual, joint, and/or group counselling.
7. Ask the participants what questions they have about the competencies for counselling related to the reintegration of obstetric fistula clients.

### **Activity 2: Small Group Role Plays (20 minutes)**

1. Explain that the participants are going to have an opportunity to practise counselling related to the management of obstetric fistula, and specifically, counselling on community/family reentry.
2. Have the participants reform into the same groups they used for the previous role plays; for this role play, the group members will shift roles as follows:
  - The counsellor will become the observer.
  - The client will become the counselor.
  - The observer will become the client.
3. Give each group:
  - A copy of Trainer’s Resource 5-5: Demonstration/Role Play Scenario 3—Reintegration for the client
  - Two copies of the Counselling Demonstration/Role Play Checklist (based on Trainer’s Resource 5-2) for the counsellor and the observer
4. Give the counsellors and clients three or four minutes to prepare.
  - Have the clients review the scenario.
  - Have the counsellors review the counselling on community/family reentry portion of Participant Handout 5-H.
  - Have the counsellors review Module 3 Participant Handout 3-BB: Fistula Repair Surgery: The Discharge Plan and Follow-Up.
5. Tell the counsellors and observers to refer to the checklist during the demonstration:
  - The counsellors can use it to remind themselves of the REDI framework phases and steps.
  - The observers can check off the counselling steps as they are performed and write down comments about what was or was not effective.
6. Indicate that, to save time, this role play will be a condensed version of the counselling process; the counsellors should limit the information they provide to two or three priority subjects. A real community/family reentry counselling session would cover all subjects relevant to the client’s situation.
7. Have the groups role-play the community/family re-entry counselling process.
8. Have the groups wrap up the role plays after about 10 to 12 minutes.

### **Activity 3: Large Group Discussion (10 minutes)**

1. Ask the participants for feedback about the role play, including:
  - How did the clients feel?
  - Were technical issues explained using simple language?
  - What worked well?
  - What could be improved?
2. Ask the participants what questions they have about reintegration counselling for fistula clients.

#### **TRAINING TIP**

If, during Part A of this session, participants raised questions or concerns that you set aside and wrote down on a “Parking Lot” flipchart, you now need to validate that you have addressed them. Briefly review the “Parking Lot” questions and confirm with the participants that they have been answered satisfactorily.

**PART E: Module 5 Evaluation**

**Time:** 40 minutes

**Activity 1: Posttest (20 minutes)**

1. Distribute the Module 5 Evaluation (based on the questions provided in Trainer's Resource 5-1) to the participants and tell them they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

**Activity 2: Review/Debrief (20 minutes)**

1. Review the answers to the Module 5 Evaluation (using the Answer Key in Trainer's Resource 5-1).
2. Ask the participants what questions they have.

**TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.



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# **MODULE 5**

# **RESOURCES**



## PARTICIPANT HANDOUT 5-A

### What Is Counselling?

#### Definition of Counselling

Here are two definitions of *counselling* in a health care context:

- “Counselling is two-way communication between a client and a health care staff member for the purpose of confirming or facilitating a decision by the client or helping the client address problems or concerns.”

*Source:* The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Participant handbook*. New York: EngenderHealth/The ACQUIRE Project.

- Counselling is “use of an interactive helping process focusing on the needs, problems, or feelings of the client and significant others to enhance or support coping, problem solving, and interpersonal relationships.”

*Source:* Elsevier, 2003.

#### Characteristics of Counselling

The counselling process:

- Focuses on helping individuals make decisions and manage the emotions associated with their situation
- Goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices
- Includes a discussion of feelings and concerns because these are relevant to the client’s choices

Counselling always involves two-way communication between the client and the provider, in which each spends time talking, listening, and asking questions.

The role of the counsellor is to *facilitate* decision making—*not* to make decisions on behalf of the clients.

Counselling **is**:

- Client-centred
- Collaborative
- Respectful

#### The World Health Organization (WHO) on Counselling

“Counselling... can be provided by a variety of staff members, including nurses, midwives, physicians, social workers or nurse aides. [*Note:* This list of providers will vary, depending upon the country.] Volunteers have been used successfully in some situations. A professional counsellor is not necessary; however, training in counselling techniques should be provided for any staff functioning as counsellors.”

“Staff who provide counselling must be nonjudgmental, extremely sensitive to and respectful of the woman’s emotions and feelings, in order to adapt the session to the woman’s specific needs. Counsellors should be knowledgeable, well trained, and able to give accurate

information. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity... Critical elements of all good counselling include the ability of the counsellor to elicit and listen to a woman's needs, concerns, and questions, and to inform, educate, and reassure, using language and terms that the woman understands... It is also useful to augment verbal explanations with written and pictorial materials to reinforce what has been said in the counselling sessions.”

*Source:* WHO, 1995.

### **Counselling Tasks**

When providing counselling, health care staff are responsible for:

- Helping clients to assess their own needs for services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their own voluntary and informed decisions by helping them weigh their options
- Helping clients explore possible barriers to the implementation of their decisions, helping them develop the strategies and skills needed to overcome those barriers, and helping them carry out their decisions
- Answering questions and addressing concerns and making sure clients understand all the information they have received

### **References**

The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Participant handbook*. New York: EngenderHealth/The ACQUIRE Project.

Elsevier, Inc. 2003. *Miller-Keane encyclopedia and dictionary of medicine, nursing, and allied health*, 7th ed. Saunders.

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

World Health Organization (WHO). 1995. Information and counselling for the patient. In *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva.

## **PARTICIPANT HANDOUT 5-B**

### **Informing, Guidance, and Advising**

#### **Informing**

Informing is “giving or imparting knowledge of a fact or circumstance.” A synonym is *telling*.

#### **Guidance**

Guidance is “the act or function of guiding,” which, in turn, is defined as “exerting influence or control over” something or someone. A synonym is *direction*.

#### **Advising**

Advising is “offering an opinion or suggestion as worth following.” A synonym is *recommending*.

#### **References**

Houghton Mifflin Company. 2009. *The American heritage dictionary of the English language*, 4th ed. New York.

Random House, Inc. 2011. *Random House dictionary*. New York.

## **PARTICIPANT HANDOUT 5-C**

### **Individual, Joint, and Group Counselling**

Nurses and midwives may perform counselling in an individual (one-on-one) setting, a joint setting (with a partner or family member), or a group setting.

#### **Individual Counselling**

Individual counselling is a one-to-one helping relationship in which the counsellor works with the client to enable him or her to make an informed decision regarding a problem or situation. By definition, it focuses on the specific issues and needs of a single client. The privacy of the individual setting can help to put the client at ease when discussing personal concerns with the counsellor. It also aids the client in making his or her own voluntary and informed decisions without undue influence from partners, family members, or peers.

#### **Joint Counselling**

Joint counselling is a helping relationship in which the counsellor works with the client, in conjunction with a partner or family member, to make an informed decision regarding a problem or situation. It focuses on the issues and needs of a single client when decisions also may affect the other person. The joint setting can help to promote communication between the client and his or her partner or family member. However, it is crucial that the client voluntarily allows the other person to participate in the counselling; the client must always have the option to receive individual counselling without the partner or family member present.

#### **Group Counselling**

Group counselling is a helping relationship in which the counsellor works with a group of clients to address a problem or situation that affects all the members of the group. It enables one counsellor to help a number of clients who share a common problem to deal with the reality of their situation and assist the individual members in identifying realistic goals and making informed decisions. The group setting provides an opportunity for clients to both receive help and help each other; it allows the members to receive genuine support, honest feedback, and useful alternatives from peers.

At the start of group counselling, the counsellor clarifies the purpose of the group, explains his or her role, and discusses the role of each member and how the member is going to benefit from participating in the group. The counsellor also explains the group's ground rules, emphasizing the need to respect members' privacy and confidentiality and the importance of freely expressing their thoughts and feelings. As with joint counselling, it is crucial that the client voluntarily participate in the group; the client must always have the option to receive individual counselling without other group members present.

## **PARTICIPANT HANDOUT 5-D**

### **The REDI Counselling Framework**

#### **REDI**

REDI is an acronym that stands for the four phases of a reproductive health counselling framework. The four phases are:

- **R**apport building
- **E**xploration
- **D**ecision making
- **I**mplementing the decision

The REDI counselling framework:

- Emphasises the client's right and responsibility for making decisions and carrying them out
- Provides guidelines to help the counsellor and client consider the client's circumstances and social context
- Identifies the challenges a client may face in carrying out his or her decisions
- Helps clients build skills to address those challenges

A framework is an aid—a means to an end, *not* the end in itself. Counselling should be client-centred. The REDI framework provides a structure and guidance for talking with clients, so that providers do not miss important steps in the counselling process. However, too often providers focus more on following the steps than on listening to the client and responding to what he or she is saying. The essential task of counselling is to understand what the client needs and then help him or her meet those needs as efficiently as possible.

It is important to personalise counselling sessions by exploring each client's individual situation. Understanding and exploring the social context of decisions is critical in helping clients accurately assess their situation and make well-considered, appropriate decisions. Social context encompasses the people (partners, family members, friends, and community members) and the factors that influence a client's decisions, including the client's power to make autonomous decisions. Consideration of the client's social context also includes anticipating the ramifications of decisions for the client's social network.

## **Phases and Steps of REDI**

### **Phase 1: Rapport Building**

1. Greet the client with respect.
2. Make introductions.
3. Assure the client's confidentiality and privacy.
4. Explain the need to discuss sensitive and personal issues candidly.

### **Phase 2: Exploration**

1. Explore in depth the client's reason for the visit. (This information will help determine the client's counselling needs and the focus of the counselling session.)
2. Explore the client's current situation and, if relevant, past experience.
3. Explore the client's social context, circumstances, and relationships.
4. Identify and discuss the client's issue(s) and/or concern(s).
5. Provide and clarify information as needed and correct any misconceptions.

### **Phase 3: Decision Making**

1. Identify the decision(s) the client needs to confirm or make.
2. Explore relevant options for each decision.
3. Help the client weigh the benefits, disadvantages, and consequences of each option (provide information to fill any remaining knowledge gaps).
4. Encourage the client to make his or her own realistic decision(s).

### **Phase 4: Implementing the Decision**

1. Assist the client in making a concrete and specific plan for carrying out the decision(s).
2. Identify barriers that the client might face in implementing his or her decision.
3. Develop strategies to overcome the barriers.
4. Make a plan for follow-up and/or provide referrals, as needed.

*Adapted from:* ACQUIRE Project, 2008.

### **References**

The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Participant handbook*. New York: EngenderHealth/The ACQUIRE Project.

## PARTICIPANT HANDOUT 5-E

### Fistula-Related Counselling

The special counselling needs of obstetric fistula clients fall into three general categories:

- Information/education
- Emotional support
- Clinical management

#### **Information/Education**

Up-to-date information and education about fistula and related care should be shared by providers in language that the client will understand and using simple, clear messages. A fistula client will need information in order to:

- Understand what caused her condition (to dispel any myths or misperceptions) so that she can participate in the management of her condition
- Understand the type of fistula she has and the degree and extent of her injury, preferably with the help of a diagram
- Understand the scope of treatment and its success rates, risks, and benefits
- Know about the availability of fistula repair
- Understand the possible outcomes of treatment
- Understand her own role in managing her condition
- Have clear preoperative and postoperative instructions
- Understand the importance of her own personal hygiene
- Become involved in client-support groups within the facility
- Be exposed to fistula success stories
- Understand possible preoperative and postoperative complications
- Understand the issues in reproductive health and sexual rights (including family planning) that might affect her
- Understand that she should avoid reproductive tract infections, including sexually transmitted infections
- Understand her fertility potential after treatment
- Understand her family planning options
- Understand options if repair either is not possible or has been unsuccessful
- Understand how to care for herself after surgery, including how to maintain good nutrition, how to cook her own food, and how to ensure good personal hygiene
- Understand the importance of antenatal care in the prevention of fistula, as well as how and where to go for care
- Understand how to care for herself and where to go for care during any subsequent childbirth (e.g., the need for her next delivery to be a cesarean section performed in a health facility)
- Use her own knowledge and experience in bringing other fistula clients to facilities
- Contact community organisations that work with women with fistulas and tap into income-generating activities and educational opportunities

## Emotional Support

Counsellors will need to ensure that a fistula client:

- Feels welcome at the facility
- Has her privacy and confidentiality maintained
- Feels comfortable with staff and other clients at the facility
- Feels comfortable discussing feelings, concerns, questions, and needs
- Feels empowered
- Has her fears dispelled
- Has her feelings, concerns, questions, and needs addressed
- Has adequate support (emotional, physical, and material) before and after repair, regardless of the surgical outcome
- Understands that she is not the only one with this condition
- Has coping skills to manage depression or other emotional consequences of fistula

## Clinical Management

Health systems should ensure that fistula clients have:

- Easy access to health services
- Access to quality treatment/surgical repair for fistula, with no delays
- Care that is provided with empathy and love
- Well-trained and competent service providers
- Quality nursing care
- Confidence that they will be treated with respect, that their confidentiality and privacy will be maintained, and that they will be treated as partners in their care and treatment
- Quality care to address comorbid conditions both preoperatively and postoperatively (e.g., physiotherapy if necessary, special diet in preparation for surgery, etc.)
- Access to client-support groups within a given facility
- Access to community self-help organisations, where available
- Access to quality follow-up services after discharge
- Access to quality emergency obstetric care services (before and after successful repair)
- Access to other sexual and reproductive health services after repair, including family planning services, antenatal care for future pregnancies, and cesarean section services in a hospital

*Adapted from:* The ACQUIRE Project & EngenderHealth, 2005.

## References

The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 and 30, 2005, Kampala, Uganda*. New York.

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## **PARTICIPANT HANDOUT 5-F**

### **Counselling for Fistula Prevention**

Counselling for obstetric fistula prevention falls into three types, based on when it occurs:

- Preconception counselling
- Antenatal counselling
- Postnatal counselling

#### **Preconception Counselling**

The competencies (i.e., skills and actions) for preconception counselling include:

- Explaining the causes of fistula
- Explaining how to prevent fistula through girl-child nutrition, delay of early childbearing, nutrition, and use of family planning
- Engaging partners and/or others influencing decision making in the family

#### **Antenatal Counselling**

The competencies for antenatal counselling include:

- Providing information on understanding danger signs during pregnancy and knowing when to go to the hospital, accessing timely hospital services during labour, and making a birth preparedness plan (including making plans and setting aside funds for transportation)
- Engaging partners and/or others influencing decision making in the family about the risk for long labour and delaying health care and about the importance of delivery being performed by a trained provider

#### **Postnatal Counselling**

The competencies for postnatal counselling include:

- Providing information on the healthy timing and spacing of pregnancies and the family planning options available
- Providing information on optimal nutrition for the new mother and her infant—particularly the nutritional needs of the girl infant/child

#### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## **PARTICIPANT HANDOUT 5-G**

### **Fistula Management Counselling**

Counselling related to the management of obstetric fistula falls into four types, based on when it occurs:

- Preoperative counselling
- Intraoperative counselling
- Postoperative counselling
- Discharge counselling

#### **Preoperative Counselling**

The competencies (i.e., skills and actions) for preoperative counselling include:

- Assessing the client's ability to give and receive information, and exploring the client's needs and feelings
- Providing information on the initial assessment, possible treatment options, potential outcomes, and on possible side effects, complications, and risks
- Linking the client with social support groups and/or resources within the facility
- Maintaining emotional support through verbal and nonverbal communication, using techniques to minimise fear and anxiety
- Providing information on the client's expected postoperative role in self-care, catheter care, mobility, nutrition, pain management, complications and danger signs, physiotherapy, period of sexual abstinence, future childbearing, family planning needs, and the need for close antenatal care and cesarean delivery for subsequent pregnancy(ies)

*Note:* Sometimes, due to limited availability of fistula repair services, the client must wait at home until her repair surgery can be scheduled and/or performed. While specific preoperative counselling instructions for the client will vary, depending upon her condition, the resources she has at home, and local medical protocols, those instructions typically include information about how to care for the fistula, the need to take sitz baths, and the importance of good nutrition.

#### **Intraoperative Counselling**

The competencies for intraoperative counselling include:

- Protecting the client's privacy and ensuring her respect and dignity
- Providing reassurance and comfort before administration of anaesthesia
- Providing information about the anaesthesia to be used, its risks, and the management of pain

#### **Postoperative Counselling**

The competencies for postoperative counselling include:

- Maintaining emotional support and monitoring pain management needs during the immediate recovery period
- Providing information as indicated related to outcome of surgery, self-care, catheter care, mobility, nutrition, pain management, complications and danger signs, physiotherapy, period of sexual abstinence, future childbearing, family planning needs, need for close antenatal care, and the need for cesarean delivery for subsequent pregnancy(ies)

- Engaging partners and/or others influencing decision making in the family about the recovery needs of the client, about the need for rest, follow-up at the facility, sexual abstinence, and use of family planning for delay of desired pregnancy until healing is complete, and about support for the client to receive close antenatal care and cesarean delivery for subsequent pregnancy(ies)

### **Discharge Counselling**

The competencies for discharge counselling include:

- Assessing the client's feelings, questions, and concerns regarding the recovery phase and the future
- Providing discharge information according to the postoperative management plan, and information on healthy nutrition, sexual abstinence, avoidance of reproductive tract infections (including sexually transmitted infections), delaying pregnancy, and management of stress incontinence
- Reinforcing the importance of information discussed during postoperative counselling regarding sexual abstinence, family planning, the need for antenatal care, and the need for cesarean delivery for subsequent pregnancy(ies)
- Scheduling a follow-up visit within three months of surgery and emphasising the importance of the client's coming in to the facility even if she feels well
- Assessing additional psychosocial needs and linking the client with additional counselling services or referral for additional services and with community organisations that support women with fistula repair

### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## **PARTICIPANT HANDOUT 5-H**

### **Reintegration Counselling for Fistula Clients**

Counselling related to the reintegration of obstetric fistula clients falls into three types, based on the situation that it addresses:

- Counselling on physical therapy/physiotherapy
- Counselling on community/family reentry
- Counselling on livelihood

#### **Counselling on Physical Therapy/Physiotherapy**

The competencies (i.e., skills and actions) for counselling on physical therapy/physiotherapy include:

- Exploring the client's feelings about her physiotherapy progress and progress to independence

#### **Counselling on Community/Family Reentry**

The competencies for counselling on community/family reentry include:

- Exploring the client's feelings about her acceptance and functioning within the family and/or community
- Linking the client with community and/or social services that address her changing needs

#### **Counselling on Livelihood**

The competencies for counselling on livelihood include:

- Linking the client with skills-building for income-generation opportunities and management of her resources

*Note:* In cases where surgery was not successful, based on the client's condition, counselling related to reintegration should also provide information on why the surgery was not a success; possible future procedures and options; complications and/or infections; personal hygiene and nutrition; management of incontinence; and the need to delay pregnancy until after a future procedure.

#### **References**

Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## TRAINER'S RESOURCE 5-I

### Module 5 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select approximately 20 relevant questions for the Module 5 Pretest and/or Posttest. The correct answers are shown below in **boldface** and the source of the correct answer is shown in [brackets].

1. Counselling is two-way communication between a client and a health care staff member for the purpose of \_\_\_\_\_.
  - a. Confirming a decision by the client
  - b. Facilitating a decision by the client
  - c. Helping the client address problems or concerns
  - d. All of the above**[Participant Handout 5-A]
  
2. Counselling is “use of an interactive helping process focusing on the needs, problems, or feelings of \_\_\_\_\_ to enhance or support coping, problem solving, and interpersonal relationships.”
  - a. The client
  - b. Significant others
  - c. Both A and B**
  - d. None of the above[Participant Handout 5-A]
  
3. The counselling process goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices.
  - a. True**
  - b. False[Participant Handout 5-A]
  
4. The counselling process includes a discussion of the client’s feelings because \_\_\_\_\_.
  - a. Feelings are the best basis for decision making
  - b. They are relevant to the client’s choices**
  - c. Both A and B
  - d. None of the above[Participant Handout 5-A]
  
5. The role of the counsellor is to make decisions on behalf of the clients.
  - a. True
  - b. False**[Participant Handout 5-A]

The role of the counsellor is to *facilitate* decision making—not to make decisions on behalf of the clients.

6. Counselling always involves two-way communication between the client and the provider, in which each spends time \_\_\_\_\_.
- Talking
  - Listening
  - Asking questions
  - All of the above**
- [Participant Handout 5-A]
7. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity.
- True**
  - False
- [Participant Handout 5-A]
8. Which of the following words is defined as “giving or imparting knowledge of a fact or circumstance?”
- Informing**
  - Guidance
  - Advising
  - None of the above
- [Participant Handout 5-B]
9. A synonym for guidance is *recommending*.
- True
  - False**
- [Participant Handout 5-B]  
A synonym for guidance is *direction*.
10. Advising is \_\_\_\_\_.
- Exerting influence or control over something or someone
  - Offering an opinion or suggestion as worth following**
  - Telling
  - None of the above
- [Participant Handout 5-B]
11. \_\_\_\_\_ is a helping relationship in which the counsellor works with the client, in conjunction with a partner or family member, to make an informed decision regarding a problem or situation.
- Individual counselling
  - Joint counselling**
  - Group counselling
  - All of the above
- [Participant Handout 5-C]
12. The privacy of the individual setting \_\_\_\_\_.
- Can help to put the client at ease when discussing personal concerns
  - Aids the client in making his or her own voluntary and informed decisions without undue influence from partners, family members, or peers
  - Both A and B**
  - None of the above
- [Participant Handout 5-C]

13. Which of the following is true of group counselling?
- a. It enables one counsellor to help a number of clients who share a common problem
  - b. It provides an opportunity for clients to both receive help and help each other
  - c. It allows the members to receive genuine support, honest feedback, and useful alternatives from peers.

**d. All of the above**

[Participant Handout 5-C]

14. Regardless of the type of counselling, it is essential to respect the client’s privacy and confidentiality; the client must always have the option to receive individual counselling without anyone else present.

**a. True**

b. False

[Participant Handout 5-C]

15. In which of the following situations might joint counselling be especially appropriate?

**a. Counselling a married couple about family planning**

b. Counselling a single adult about a medical procedure or treatment

c. Counselling women who have recently had fistula repair operations

d. All of the above

[Session 1, Part B, Activity 2]

16. What does the acronym REDI stand for?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**R**apport building

**E**xploration

**D**ecision making

**I**mplementing the decision

[Participant Handout 5-D]

17. The REDI counselling framework:

a. Emphasises the client’s right and responsibility for making decisions and carrying them out

b. Provides guidelines to help the counsellor and client consider the client’s circumstances and social context

c. Identifies the challenges a client may face in carrying out his or her decision

**d. All of the above**

[Participant Handout 5-D]

18. The REDI framework is an aid—a means to an end, *not* the end in itself.

**a. True**

b. False

[Participant Handout 5-D]

19. The social context of a client's decisions can include:
- The people (partners, family members, friends, and community members) and the factors that influence a client's decisions
  - The client's power to make autonomous decisions
  - Anticipating the ramifications of decisions for the client's social network
  - All of the above**
- [Participant Handout 5-D]
20. Which of the following is *not* a step in Phase 1 of the REDI framework?
- Greeting the client with respect
  - Assuring confidentiality and privacy
  - Making a plan for follow-up and/or providing referrals, as needed**
  - Explaining the need to discuss sensitive and personal issues candidly
- [Participant Handout 5-D]
21. During which phase of the REDI framework would a counsellor provide and clarify information, as needed, and correct any misconceptions?
- Phase 1
  - Phase 2**
  - Phase 3
  - Phase 4
- [Participant Handout 5-D]
22. The special counselling needs of obstetric fistula clients fall into which of the following general categories?
- Information/education
  - Emotional support
  - Clinical management
  - All of the above**
- [Participant Handout 5-E]
23. If time permits, counselling skills and steps may be incorporated into nurses' and midwives' interactions with obstetric fistula clients.
- True
  - False**
- [Session 3, Part A, Activity 2]  
Counselling skills and steps should *always* be part of nurses' and midwives' interactions with obstetric fistula clients.
24. The primary counselling need that counselling related to *fistula prevention* addresses is:
- Information/education.**
  - Emotional support
  - Clinical management
  - All of the above
- [Session 3, Part B, Activity 1]

25. One of the competencies for \_\_\_\_\_ counselling is providing information on understanding danger signs during pregnancy and when to go to the hospital.
- Preconception
  - Antenatal**
  - Postnatal
  - None of the above
- [Participant Handout 5-F]
26. One of the competencies for preoperative counselling is \_\_\_\_\_:
- Providing information on the initial assessment, possible treatment options, potential outcomes, and possible side effects, complications, and risks**
  - Providing reassurance and comfort before administration of anaesthesia
  - Engaging partners and/or others influencing decision making in the family about the recovery needs of the client
  - All of the above
- [Participant Handout 5-G]
27. As part of postoperative counselling, nurses and midwives maintain emotional support and monitor pain management needs during the immediate recovery period.
- True**
  - False
- [Participant Handout 5-G]
28. During discharge counselling, the client needs to schedule a follow-up visit within \_\_\_\_\_ of surgery.
- One month
  - Three months**
  - Six months
  - None of the above
- [Participant Handout 5-G]
29. Counselling related to the reintegration of obstetric fistula clients includes which of the following?
- Counselling on physical therapy/physiotherapy
  - Counselling on community/family reentry
  - Counselling on livelihood
  - All of the above**
- [Participant Handout 5-H]
30. Counselling related to the reintegration of obstetric fistula clients only involves group counselling (unless the client requests individual counselling).
- True
  - False**
- [Session 3, Part D, Activity 1]  
Counselling related to the reintegration of obstetric fistula clients can involve individual, joint, and/or group counselling.

## **TRAINER'S RESOURCE 5-2**

### **Counselling Demonstration/Role Play Checklist**

#### **Phase 1: Rapport Building**

- Greet the client with respect.
- Make introductions.
- Assure the client's confidentiality and privacy.
- Explain the need to discuss sensitive and personal issues candidly.

Comments: \_\_\_\_\_

#### **Phase 2: Exploration**

- Explore in depth the client's reason for the visit. (This information will help determine the client's counselling needs and the focus of the counselling session.)
- Explore the client's current situation and, if relevant, past experience.
- Explore the client's social context, circumstances, and relationships.
- Identify and discuss the client's issue(s) and/or concern(s).
- Provide and clarify information as needed and correct any misconceptions.

Comments: \_\_\_\_\_

#### **Phase 3: Decision Making**

- Identify the decision(s) that the client needs to confirm or make.
- Explore relevant options for each decision.
- Help the client weigh the benefits, disadvantages, and consequences of each option (providing information to fill any remaining knowledge gaps).
- Encourage the client to make his or her own realistic decision(s).

Comments: \_\_\_\_\_

#### **Phase 4: Implementing the Decision**

- Assist the client in making a concrete and specific plan for carrying out his or her decision(s).
- Identify barriers that the client might face in implementing his or her decision.
- Develop strategies to overcome the barriers.
- Make a plan for follow-up and/or provide referrals as needed.

Comments: \_\_\_\_\_

*Adapted from:* The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Participant handbook.* New York: EngenderHealth/The ACQUIRE Project.

## **TRAINER'S RESOURCE 5-3**

### **Demonstration/Role Play Scenario 1—Prevention**

**Client Name:** Ayodele

**Client Age:** 18

**Client Situation:**

- Ayodele delivered her first child a week ago by cesarean section and has returned to the facility to have her stitches removed.
- She is breastfeeding the child.
- She has not used any form of contraception in the past but is considering it now.
- Ayodele has previously attended a group educational session on family planning methods. She doubts that her husband would want to use a condom, so she is leaning towards using the contraceptive pill.

*Adapted from:* The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Participant handbook*. New York: EngenderHealth/The ACQUIRE Project.

## **TRAINER'S RESOURCE 5-4**

### **Demonstration/Role Play Scenario 2—Management**

#### **Scenario 1**

**Client Name:** Naneye

**Client Age:** 15

**Client Situation:**

- Naneye was married at age 13 and became pregnant two years later.
- Her pregnancy proceeded well. She was not sick until labour. Her family and her husband were with her during labour. She was in labour for four days, and on the fourth day she was taken to a health centre. At the health centre, she delivered a dead baby.
- Soon after the delivery, she noticed that she was leaking urine. The providers at the health centre determined that she had a vesicovaginal fistula and referred her immediately to a specialised hospital in the capital city. Her husband borrowed some money and took her to the hospital, where the doctors will evaluate and perform surgery on her fistula.
- All through presurgical assessment, Naneye's husband has visited her regularly and is eagerly waiting for her to have her surgery and return home. They hope to have children sometime soon after Naneye is healed.

*Adapted from:* A personal story provided by the Addis Ababa Fistula Hospital, as quoted in EngenderHealth/ The ACQUIRE Project, 2008.

#### **Scenario 2**

**Client Name:** Tigest

**Client Age:** 16

**Client Situation:**

- Tigest was married at 12. She is not literate and has never been to school.
- At age 14, Tigest gave birth to a stillborn baby girl after four days of labouring at home, assisted by a traditional birth attendant (TBA). When she began leaking urine after birth, the TBA told her that it was most likely because she had received a curse from God.
- Tigest's husband finds her dirty, and although he has not divorced her, he does not let her stay in the house. Her family will not take her back, and Tigest has no income and depends on her husband for livelihood, so she must stay with her husband, even though he will not allow her to reside in the house.
- Tigest hears that doctors in a hospital in the capital city might be able to help heal her. Her husband and family tell her that no doctors can help her because God obviously did not hear and reply to her prayers during labour. So she decides to take a risk and run away from her husband and go to the capital city by any means she can find. At times, she has to prostitute herself to get money.
- When Tigest arrives at the hospital, she is told that funds are available to help her pay for the necessary surgery, which the doctors believe will be relatively uncomplicated.

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## **TRAINER'S RESOURCE 5-5**

### **Demonstration/Role Play Scenario 3—Reintegration**

**Client Name:** Aberesh

**Client Age:** 22

**Client Situation:**

- At the age of 18, Aberesh was married to an older man in a remote rural village. Aberesh has never gone to school and does not know how to read and write.
- She became pregnant immediately after getting married. The pregnancy was difficult. Labour was obstructed and Aberesh was unable to deliver.
- On the third day of labour, her relatives decided to seek help. They sold a goat and paid men to carry Aberesh on a stretcher for six hours to the nearest hospital. By the time she arrived, it was too late to save the baby; her son was stillborn.
- Aberesh was so weak and exhausted from the ordeal that she could not get out of bed. It took another four weeks before she could walk by herself again.
- Two days after giving birth, she began to leak urine from a vesicovaginal fistula. Nothing would stop the flow.
- Her husband sent her back to her mother's house to recover.
- A doctor in the hospital told her relatives about the possibility for repair at a hospital in the capital city. Once again, her family rallied to support her and raised money for bus fare to the capital city. At the fistula hospital, her repair surgery was uncomplicated, and she recovered completely.
- She plans to return to her parent's home and hopes that, ultimately, she can go back to live with her husband.

*Adapted from:* A personal story provided by the Addis Ababa Fistula Hospital, as quoted by EngenderHealth/The ACQUIRE Project, 2008.



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# MODULE 6: USING DATA TO INFORM DECISION MAKING WITHIN FISTULA CARE SERVICES

## Introduction

Besides playing a crucial role in the delivery of fistula care services to clients, nurses and midwives are key to the collection and management of fistula care data and information systems. This module is designed to increase the ability of nurses and midwives to use such data to inform decision making at both the client and facility levels within fistula prevention, treatment, and reintegration services.

## Prerequisites

- Successful completion of modules 1, 2, and 3 of this curriculum (or equivalent knowledge and experience)
- Basic knowledge of client record keeping
- Successful completion of a course in nursing or midwifery research

## Module Objectives

Upon completion of this module, the participants will be able to:

- Define key monitoring and evaluation terms
- Describe the reasons for monitoring and evaluation
- Distinguish client monitoring from monitoring of services
- Correctly identify the data sources of key monitoring indicators for fistula care services
- Discuss the nursing- and midwifery-related implications of key monitoring indicators for fistula care services
- State the role of nurses and midwives in the fistula care information system
- Describe six dimensions of data quality
- Identify common data errors in client records
- Describe an enabling environment that assures that quality data are part of routine practise
- Define *evidence-based practise*
- Differentiate between quantitative and qualitative research
- Describe potential uses of research findings in the provision of fistula services
- Discuss the roles of nurses and midwives in fistula care research
- Describe appropriate strategies for displaying, presenting, and disseminating data for different target audiences
- Present fistula service monitoring and evaluation data effectively in a classroom exercise

## Overview of Module Content

Sessions/Parts	Total time
1. Introduction to Data for Decision Making	55 minutes
A. What Is Data-Based Decision Making?	55 minutes
2. Collection and Management of Routine Fistula Care Data	1 hour, 10 minutes
A. Client Monitoring and Monitoring of Services	25 minutes
B. Indicators for Monitoring Fistula Care Services	35 minutes
C. Fistula Care Data Success Story	10 minutes
3. Assuring the Quality of Routinely Collected Fistula Care Data	1 hour, 55 minutes
A. Dimensions of Data Quality	25 minutes
B. Recognising Common Data Errors	1 hour, 15 minutes
C. The Role of Nurses and Midwives in Ensuring Data Quality	15 minutes
4. Using Research to Improve Fistula Care Services	1 hour, 20 minutes
A. Sources of Knowledge	15 minutes
B. Common Research Methods	1 hour, 5 minutes
5. Displaying, Presenting, and Disseminating Data to Maximise Their Use to Inform Decision Making	2 hours, 40 minutes
A. Displaying Data	30 minutes
B. Interpreting Data	20 minutes
C. Presenting and Disseminating Data	1 hour, 10 minutes
D. Module 6 Evaluation	40 minutes
<b>Total time</b>	<b>8 hours</b>

## Evaluation

- Trainer's Resource 6-1: Module 6 Evaluation and Answer Key

## SESSION I

### Introduction to Data for Decision Making

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Define key monitoring and evaluation terms
- Describe the reasons for monitoring and evaluation

#### POINTS TO REMEMBER

- Nurses and midwives play a key role in the collection of fistula care data and in the management of fistula care information systems.
- Capturing data related to fistula care services is important because, in general, these services are relatively new and thus there is a lack of historical data.
- Using data for decision making is a process that consists of: (a) obtaining, analysing, and interpreting data; (b) making decisions based on such data; and (c) taking actions based on such data to strengthen the delivery of services.
- Monitoring continuously tracks performance against what was planned by collecting and analysing data on predetermined indicators. It provides continuous information on whether progress is being made towards objectives through record keeping and regular reporting systems. The performance information generated from monitoring enhances learning from experience and improves decision making.
- Evaluation is a periodic, in-depth analysis of performance. It relies on data generated through monitoring activities but can also include information obtained from other sources (e.g., studies, research, in-depth interviews, focus group discussions, surveys, etc.). Evaluation commonly aims to determine the relevance, validity of design, efficiency, effectiveness, and impact of activities or services.
- The reasons for monitoring and evaluation of services include:
  - Reviewing progress
  - Adjusting plans
  - Identifying opportunities for improvement
  - Identifying best practises
  - Informing and communicating with stakeholders
  - Supporting advocacy and resource mobilisation
- Monitoring and evaluation are done to *inform decision making* and to *improve services*. They are *not* undertaken to punish staff for weak performance.

#### Training Methods

- Presentation
- Lecture/discussion
- Group discussion

#### Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 6-A: Monitoring and Evaluation Terms
- Trainer’s Resource 6-1: Module 6 Evaluation and Answer Key
- Trainer’s Resource 6-2: Examples of Monitoring and Evaluation Terms in Nursing and Midwifery

### **Advance Preparation**

1. Review the Training Steps.
2. Review Participant Handout 6-A.
3. Review Trainer's Resource 6-1.
4. Review Trainer's Resource 6-2.
5. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Definition of "using data for decision making" (from Participant Handout 6-A)
6. Duplicate Participant Handout 6-A for the participants.

#### **TRAINING TIP**

If you wish to do a pretest for Module 6, select approximately 20 relevant questions from Trainer's Resource 6-1 (based on the sessions and content that you will be covering) to create the test. The pretest will add about 20 minutes to the length of Session 1. The correct answers are shown in **boldface**.

**Session Time:** 55 minutes

## SESSION I

### Training Steps

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#### **PART A: WHAT IS DATA-BASED DECISION MAKING?**

**Time:** 55 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Explain that nurses and midwives play a key role in the collection and management of fistula care data and information systems.
3. Indicate that this module is designed to increase the ability of nurses and midwives to use such data to inform decision making at both the client and facility levels within fistula prevention, treatment, and reintegration services.
4. Emphasise the importance of capturing data related to fistula care services, because, in general, these services are relatively new and thus historical data are lacking.
5. Explain that, while this module focuses on data related to obstetric fistula services, this information can be applied in many areas in their health facilities and jobs.
6. Ask the participants what questions they have about the session objectives.

#### **TRAINING TIP**

Depending upon the participants' level of knowledge and experience, they may have basic questions—for instance, “What do you mean by ‘use data to inform decision making at both the client and facility levels?’” If so, acknowledge their concerns and write them on a “Parking Lot” flipchart. Indicate that, after completing all of the sessions in this module, their questions should be answered. At the end of the module, you will need to validate that you have answered their questions and that the participants understand these terms and concepts.

##### **Activity 2: Lecture and Discussion (35 minutes)**

1. Distribute copies of Participant Handout 6-A.
2. Explain the definition of *using data for decision making* (from Participant Handout 6-A), using a prepared flipchart, a computer slide, or an overhead transparency.
3. Facilitate a brief discussion of the three steps in the process of using data for decision making by asking the participants the following questions:
  - What does obtaining data entail?  
*Possible response:* Details about the collecting, processing, and managing of data.
  - What is the difference between analysing and interpreting data?  
*Possible response:* Analysing data involves organising and sifting the data to find important results. Interpreting data involves answering the question “What does the information from the analysis tell us?”
  - Why is it important to highlight both *making decisions* and *taking action*?  
*Possible response:* No other part of the process of collecting and analyzing data for decision making matters if no actions are taken as a result of the data-based decisions.
4. Discuss the monitoring and evaluation (M&E) terms listed on Participant Handout 6-A, as follows:
  - Read the definition of the first term on Participant Handout 6-A.

- Ask the participants to give a nursing or midwifery example for each term. Provide an example if the participants cannot think of one (refer to Trainer’s Resource 6-2 for a list of examples).
  - Repeat the process until you have defined and discussed all of the M&E terms listed on the handout.
5. Ask the participants what questions they have about the M&E terms.

**Activity 3: Group Discussion (15 minutes)**

1. Facilitate a group discussion by asking the participants, “What are some of the reasons that we monitor and evaluate services?”
2. Write the participants’ responses on a piece of flipchart paper. Answers might include:
  - **Reviewing progress:** M&E enables us to determine if the service is achieving its goals and having the desired outcomes and impact.
  - **Adjusting plans:** M&E yields information about what has or has not been accomplished and what efforts have and have not been effective; we can use this information to make decisions about what needs to change in our plans and implementation strategies.
  - **Identifying opportunities for improvement:** M&E can help us to identify areas of inadequate or ineffective performance and recognise potential issues or constraints before they become crises.
  - **Identifying best practises:** M&E also can help point out areas of superior performance, including highly effective procedures and practises that can be used to enhance service delivery.
  - **Informing and communicating with stakeholders:** M&E provides information for feedback to local representatives, including beneficiaries (such as women who have received fistula repair services). Discussing M&E information with stakeholders can help us identify effective strategies for serving different groups of people.
  - **Supporting advocacy and resource mobilisation:** M&E provides credible information about achievements, challenges, and potential solutions that advocates can use to mobilise greater commitment and financial support for services.
3. Add and discuss any of the reasons listed above that have not been mentioned by the participants.
4. Emphasise that M&E is done to inform decision making and to improve services. It is *not* undertaken to punish staff for weak performance.
5. Ask participants what questions they have about the reasons for M&E.

## SESSION 2

### Collection and Management of Routine Fistula Care Data

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Distinguish client monitoring from monitoring of services
- Correctly identify the data sources of key monitoring indicators for fistula care services
- Discuss the nursing- and midwifery-related implications of key monitoring indicators for fistula care services
- State the role of nurses and midwives in the fistula care information system

#### POINTS TO REMEMBER

- *Client monitoring* is the routine collection, compilation, and analysis of data on individual clients over time and across service delivery points, using information collected on paper forms and/or entered into a computer.
- *Monitoring of services* is the routine reporting and tracking of key information about a service, and particularly the comparison of actual to intended outcomes. Monitoring of services requires many types of information (e.g., demographic, medical, psychosocial, financial, etc.), including aggregated client data.
- The primary data sources of key monitoring indicators for fistula care services are the client register and the client record.
- Monitoring indicators for fistula repair services include:
  - Number of women arriving and seeking fistula repair
  - Number of women requiring fistula surgery
  - Number of women receiving fistula repair services
  - Type of fistula repair surgery
  - Number of repairs for urinary-only clients and urinary-and-RVF clients
  - Number of women discharged who had urinary-only repairs
  - Number of women discharged who had urinary-and-RVF repairs
  - Number of women discharged who had RVF-only repairs
  - Number of fistula repair clients discharged during the quarter
  - Number of women who had repair surgery but were not discharged during the quarter
  - Outcome of urinary-only and urinary-and-RVF cases discharged this quarter
  - Outcome of RVF-only cases discharged this quarter
  - Number of women discharged this quarter who experienced complications
- Nurses and midwives play an important role in both client monitoring and monitoring of services:
  - Nurses and midwives are responsible for client monitoring; they are a key source of client data.
  - Monitoring of services *depends* on client monitoring data.

#### Training Methods

- Presentation
- Lecture and discussion
- Story and discussion

## Materials/Equipment

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 6-B: Data Collection at Different Levels of the Health Care System
- Participant Handout 6-C: Sample Fistula Care Indicators
- [Optional] Trainer's Resource 6-3: Fistula Care Data Success Stories

## Advance Preparation

1. Review the Training Steps.
2. Review Participant Handouts 6-B and 6-C.
3. Determine whether you will tell a personal recollection or use one of the stories from Trainer's Resource 6-3 during Part D, Activity 2. If you choose a personal recollection, outline the key elements of the client's story. Otherwise, review the success story in Trainer's Resource 6-3.
4. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Definitions of *client monitoring* and *monitoring of services* (from Participant Handout 6-B)
  - A diagram showing data collection at different levels of the health care system (from Participant Handout 6-B)
  - Fistula care indicators (from Participant Handout 6-C)
5. Duplicate Participant Handouts 6-B and 6-C for the participants.

### TRAINING TIPS

The material in this session has the potential to be dry and abstract. To facilitate this session successfully, you will need to focus on:

- ☉ Making sure the participants stay engaged by keeping them busy, asking them open-ended questions, etc.
- ☉ Making the content relevant to them by emphasising the role of nurses and midwives as a key source of client data.

**Session Time (total):** 1 hour, 10 minutes

## SESSION 2

### Training Steps

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#### **PART A: CLIENT MONITORING AND MONITORING OF SERVICES**

**Time:** 25 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Ask the participants what questions they have about the session objectives.

##### **Activity 2: Lecture/Discussion (20 minutes)**

1. Ask the participants how and where they record data for individual clients. Desired responses include:
  - Client register
  - Client record
2. Indicate that recording data when managing clients with fistula also uses the client register and client record.
3. Define and differentiate *client monitoring* and *monitoring of services*, using a prepared flipchart, a computer slide, or an overhead transparency based on Participant Handout 6-B.
4. Distribute Participant Handout 6-B.
5. Using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-B), explain that the diagram on the handout shows how different levels of a health care system collect data.
  - Some data elements used to monitor the care and well-being of individual clients are compiled and used at the facility level as service statistics. For example, the hourly/daily postoperative observations of individual fistula clients by nurses (such as the client's "drinking, draining, and dry" regime) is aggregated at the facility level as "number of clients discharged dry."
  - Client information is used to monitor progress at the facility level and, ultimately, at other levels of the system. For instance, monthly reports from one facility will be aggregated with monthly reports from other facilities in the same district to produce a district quarterly report.
6. Facilitate a discussion, asking the group when, where, and how often client monitoring data elements are recorded, collected, and/or compiled. Responses may include:
  - When: at admission, preoperatively, intraoperatively, postoperatively, at discharge
  - Where recorded/collected: client record, maternity register, and operating theatre register.
  - Where compiled: summary report
  - How often: compiled monthly, quarterly, and annually

#### **TRAINING TIP**

Some participants may be experienced nurses or midwives who have used data elements for client monitoring. If this is the case, ask them to describe how they have used such elements in their day-to-day work. Potential responses could include:

- ☉ Monitoring the client's physical condition to determine her health status or her need for a nursing or medical intervention
- ☉ Deciding how to treat the client

7. Ask the participants to name some important data elements that nurses and midwives would monitor and record for fistula care clients.
8. Write their responses on a piece of flipchart paper. Potential responses could include:
  - Vital signs
  - Liquid/fluid intake (rate of IV fluid flow and or amounts drunk by client) per day
  - Liquid output/urine (amount and colour)
  - Drugs (dose and frequency) given per day
  - Cleanliness of repair/fistula site
9. Emphasise that nurses and midwives play an important role both in monitoring clients and in monitoring services.
  - Nurses and midwives are responsible for client monitoring—they are a key source of client data.
  - Monitoring of services *depends* on client monitoring data.
10. Ask the participants what questions they have about client monitoring and the monitoring of services.

#### TRAINING TIP

Keep the prepared flipchart, computer slide, or overhead transparency showing how different levels of a health care system collect data (based on Participant Handout 6-B). You can use it again in the presentation about the impact of data errors in Session 3, Part B, Activity 1.

## PART B: INDICATORS FOR MONITORING FISTULA CARE SERVICES

**Time:** 35 minutes

### Activity 1: Lecture and Discussion (35 minutes)

1. Facilitate a brief discussion by asking the participants, “If you were in charge of delivering fistula care services at a facility, what information would you need to know to determine how effective those services were?”
2. Write the participants’ responses on a piece of flipchart paper.
3. Explain that, following discussions with managers of fistula care services in East and West Africa and Asia, 13 indicators have been used in 14 countries to establish and strengthen fistula prevention, repair, and reintegration programmes. These are provided for illustrative purposes and can serve to monitor progress as well as to consider improvements in the quality of care based on an analysis of the indicators.
4. Distribute copies of Participant Handout 6-C, which defines and explains the indicators.

#### TRAINING TIP

Use a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-C) when describing the 13 indicators (steps 5 through 13, below). For the indicators to be legible, you will need several pages/slides/ transparencies; group the indicators to align with the training steps.

5. Describe indicators 1 to 3 (demand for fistula repair services).
6. Facilitate a brief discussion by asking the participants:
  - Which of these three indicators is likely to yield the largest number?  
Answer: Indicator 1 (women arriving and seeking fistula repair)

- What if indicator 2 (women needing surgery) is very small compared with indicator 1? What might that tell us?  
Answers: Perhaps health care workers have problems recording cases. Perhaps workers at lower-level facilities or community members do not understand what kinds of cases to refer for repair, so that women arriving for fistula repair may not actually have a fistula or the fistulas they have may be inoperable.
  - What if indicator 3 (women having surgery) is much lower than indicator 2 (women needing surgery)? What could this indicate?  
Answers: There may be a backlog of cases; if so, facility management and/or staff need to look for possible reasons (e.g., no surgeon, lack of supplies, no routine repair services there, and only periodic “camp” opportunities for repair).
7. Describe indicators 4 (type of repair surgery) and 5 (number of repairs per client), including the subindicators.
  8. Describe indicators 6 to 9 (number of women discharged).
  9. Facilitate a brief discussion by asking the participants:
    - Which previous indicators do indicators 6 (urinary-only fistula), 7 (urinary and rectovaginal fistula), and 8 (RVF only) correspond to?  
Answers: Indicators 4.1, 4.2, and 4.3.
    - Can the total number of women discharged (indicator 9) be larger than the total number who had surgery (indicator 3)?  
Answer: Yes, if some women who had surgery during the last reporting period were not discharged in the same quarter they had surgery.
    - Can the total number of women discharged (indicator 9) be smaller than the number who had surgery (indicator 3)?  
Answer: Yes, not every woman who has surgery is discharged in the same quarter.
  10. Describe indicator 10 (number of women not discharged this quarter).
  11. Explain that indicator 10 is usually equal to the difference between indicator 3 (number having surgery) and indicator 9 (total discharged). Sometimes, however, the number of those discharged is larger than this difference. For instance, a client may need to remain in hospital for a long period because she needs additional surgery. The number not discharged informs managers about bed capacity.
  12. Describe indicators 11 and 12 (outcome of surgery), including the subindicators.
  13. Describe indicator 13 (complications), including the subindicators.
  14. Explain that the indicators on Participant Handout 6-C focus only on fistula repair service delivery, but other indicators can also be useful for monitoring and evaluating fistula care services. Examples include:
    - Number of staff members trained, by type of training and cadre
    - Number of community outreach activities carried out relating to fistula prevention
    - Number of persons reached with information about fistula prevention
    - Percentage of all labours for which partographs were completed correctly and managed according to protocol
    - Percentage of all births by caesarean
    - Percentage of all caesarean births that were a result of prolonged or obstructed labour
  15. Ask the participants, “What other sources of data might provide useful information?” Responses may include:
    - Sexual and reproductive health (SRH) service statistics
    - Census data
    - Client interviews
    - Focus group discussions
    - Population-based surveys such as the Demographic and Health Surveys

16. Add and discuss any of the sources of data listed above, if not mentioned by the participants.
17. Ask the participants, “What role do nurses and midwives play in relation to the indicators we’ve just discussed?”  
Answers:
  - Nurses and midwives are responsible for client monitoring and are responsible for documenting client data.
  - Service monitoring depends on client monitoring data and its accurate documentation.
18. Emphasise the critical importance of that role.
19. Ask the participants what questions they have about the fistula care indicators for monitoring services.

### **PART C: FISTULA CARE DATA SUCCESS STORY**

**Time:** 10 minutes

#### **Activity 1: Story/Discussion (10 minutes)**

1. Tell a success story, a situation that demonstrates the importance of nurses and midwives in collecting fistula care data (either a personal recollection or one of the success stories from Trainer’s Resource 6-3).
2. Ask the participants to describe their reactions to the story; how did it make them feel?
3. Summarise the participants’ comments; draw out from the participants what they see as important roles nurses and midwives should be play in collecting fistula care data.

## **SESSION 3**

### **Assuring the Quality of Routinely Collected Fistula Care Data**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Describe six dimensions of data quality
- Identify common data errors in client records
- Describe an enabling environment that assures that quality data are part of routine practise

#### **POINTS TO REMEMBER**

- Six dimensions—desirable attributes—of client care data quality include:
  - Accuracy
  - Reliability
  - Completeness
  - Legibility
  - Timeliness
  - Accessibility
- Some of the most frequent data collection errors include:
  - Mathematical errors
  - Logical impossibilities
  - Numbers out of the normal/expected range
  - Missing data
  - Transcription errors
- Examples of transcription errors include:
  - Transposition
  - Extra or missing zeros
  - False zeros
  - Illegible writing
  - Miscopied data
- All health care institutions have a responsibility to collect accurate and complete data in client records and to use that information to monitor and improve the care of clients.
- Health care systems must have standardised procedures for identifying and cleaning errors in all data sources.
- Nurses and midwives play an important role in accurately recording data and in checking for and correcting errors.
- All staff who record data must understand data definitions and regularly check their own work; if they have any questions, they should ask their supervisors.

#### **Training Methods**

- Presentation
- Lecture and discussion
- Small-group exercise
- Group discussion
- Brainstorming and discussion

### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 6-D: Dimensions of Data Quality
- Participant Handout 6-E: Common Data Collection Errors
- Participant Handout 6-F: Assessing Data Quality Exercise
- Trainer’s Resource 6-4: Assessing Data Quality Exercise—Answer Key

### **Advance Preparation**

1. Review the Training Steps.
2. Review Participant Handouts 6-D, 6-E, and 6-F.
3. Review Trainer’s Resource 6-4.
4. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Six dimensions of data quality (from Participant Handout 6-D)
  - Common data collection errors (from Participant Handout 6-E)
5. Duplicate Participant Handouts 6-D, 6-E, and 6-F for the participants.

**Session Time (total):** 1 hour, 55 minutes

## SESSION 3

### Training Steps

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#### PART A: DIMENSIONS OF DATA QUALITY

**Time:** 25 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Ask the participants what questions they have about the session objectives.

##### **Activity 2: Lecture and Discussion (20 minutes)**

1. Ask the participants, “What do people mean when they say that something is *high quality*?” Responses are likely to reflect the participants’ subjective opinions about what *quality* means.
2. Explain that *high quality* reflects adherence to defined standards of excellence.

#### TRAINING TIP

The focus of this activity is **data quality**. However, if the participants are familiar with COPE or facilitative supervision, you have the option to use this as an opportunity to (briefly) reinforce the three fundamentals of care for quality services:

- ⊙ Ensuring informed and voluntary decision making
- ⊙ Assuring safety for clinical techniques and procedures
- ⊙ Providing a mechanism for ongoing quality assurance and management

Just be sure to quickly transition back to the dimensions of data quality.

3. Explain that, for data, there are a number of dimensions—desirable attributes—that define data quality. In this session we will focus on six dimension of data quality.
4. Distribute copies of Participant Handout 6-D.
5. Describe each of the dimensions of data quality, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-F).
6. Ask the participants to suggest a positive and a negative example for each dimension. Sample responses include:
  - **Accuracy**  
*Positive example:* The client’s identification details are correct and uniquely identify the client.  
*Negative example:* A medical problem unrelated to surgery is recorded as a surgical complication.
  - **Reliability**  
*Positive example:* The diagnosis recorded on the front sheet of the hospital medical record is consistent with the diagnosis recorded in the progress notes and other relevant parts of the medical record.  
*Negative example:* The client’s name is spelled differently on different forms within the medical record.

- **Completeness**  
*Positive example:* All nursing notes, including nursing plan, progress notes, blood pressure, temperature and other charts and forms are fully completed, signed, and dated.  
*Negative example:* The medical record is missing required documentation.
  - **Legibility**  
*Positive example:* All handwritten notes in the client chart are clear and concise, and use standard abbreviations.  
*Negative example:* Doctors' notations are undecipherable and include nonstandard symbols.
  - **Timeliness**  
*Positive example:* The client's past medical history, a history of the present illness or problem as detailed by the client, and results of physical examination are recorded at the first attendance at a health care facility or admission to hospital.  
*Negative example:* Clinical information is not documented when it is observed, leading to omissions or mismanagement.
  - **Accessibility**  
*Positive example:* A client's records are available for doctors and nurses at all times.  
*Negative example:* Statistical reports are not available when the government needs the information to make budgetary decisions; client records cannot be located for doctors to review clients' progress and make informed medical decisions.
7. Ask the participants what questions they have about the dimensions of data quality.

## **PART B: RECOGNISING COMMON DATA ERRORS**

**Time:** 1 hour, 15 minutes

### **Activity 1: Presentation (10 minutes)**

1. Remind the participants about data collection at the different levels of the health care system (discussed in Session 2 of this module). Client-level data are collected and compiled into facility-level data; facility-level data are collected and compiled into district-level data, etc.

#### **TRAINING TIP**

To illustrate step 1, you can reuse the prepared flipchart, computer slide, or overhead transparency showing how different levels of a health care system collect data (based on Participant Handout 6-B), from Session 2, Part A, Activity 2.

2. Explain the following points:
  - The client record and client register are the foundation upon which the rest of health care system's information is built.
  - Errors at the client level undermine the integrity of data for the whole health care system.
3. Emphasise that while all six dimensions of data quality are important, accuracy is *critically important*.
4. Explain that two steps can help to ensure the accuracy of data:
  - Being aware of common types of data errors
  - Identifying those errors and correcting them
5. Distribute copies of Participant Handout 6-E to the participants.
6. Describe the common types of data collection errors, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-E).
7. Ask the participants what questions they have about common data collection errors.

**Activity 2: Lecture/Discussion (20 minutes)**

1. Ask the participants to describe different types of client records. Possible responses include:
  - Client file
  - Outpatient department (OPD) card
  - Inpatient register
  - Admission record
  - Temperature chart
  - Urinary output record
  - Operating theatre list or register
  - Maternity delivery register
2. Remind the participants about the partograph, covered in Module 2.
  - This internationally standardised tool records labour monitoring graphically so that timely action can be taken if labour does not progress according to normal parameters.
  - Because it is used to monitor the course of labour, the partograph should be filled out during labour, *not* after labour and delivery are over.
  - The partograph should be part of the individual client record for every woman who delivers at a facility.
3. Explain that there are no international standards for many parts of the client record (although there are internationally accepted guidelines for the medical information to be collected for each service or procedure). Examples of data for which there are no standards include:
  - Demographic data (e.g., name, address, date of birth, sex)
  - Information about pregnancy
  - Information about the client’s reproductive health history
  - The client’s antenatal record
  - The postpartum record
  - Information about caesarean delivery
  - Information about anaesthesia
4. Remind the participants that Module 3 has a prototype of a “standard” client record.
5. Explain that some client variables are captured first (or only) in registers. Registers in use in fistula care facilities might include:
  - Ward register
  - Operating theatre register
  - Ward supply/order book
6. Explain that some countries give women a record to keep. This document (sometimes called a passport) helps to transfer information about the client when she receives maternal health services from various facilities.
7. Ask the participants if they have ever seen such documents.
8. Ask the participants to think about all the types of client records and information that have been discussed. Based on their experience:
  - What do they think of the quality of data in such records?
  - What types of errors have they seen or heard about?
9. Explain that all health care institutions have a responsibility to collect accurate and complete data in client records and to use that information to monitor and improve the care of clients.
10. Emphasise that nurses and midwives play an important role in assuring the quality of data.
11. Ask the participants what questions they have about the different types of client records.

### **Activity 3: Small Group Exercise and Group Discussion (45 minutes)**

1. Set up this small group exercise as follows:
  - Divide the participants into four groups.
  - Distribute copies of Participant Handout 6-F, which includes the instructions for the exercise and the sample client record and register that will be examined.
  - Review the exercise instructions on Participant Handout 6-F.
  - Assign groups 1 and 2 to review Example 1 (Mabel Solo) and groups 3 and 4 to review Example 2 (Mercy Kastor).
  - Give each group a sheet of flipchart paper and a marker.
2. Give the groups 15 minutes to complete the assignment.
3. Have Group 1 present the errors it has identified.
4. Have Group 2 briefly present the errors it has identified, highlighting any differences.
5. If necessary, point out any errors that the groups have missed (based on Trainer's Resource 6-3).
6. Have Group 3 present the errors it has identified.
7. Have Group 4 briefly present the errors it has identified, highlighting any differences.
8. If necessary, point out any errors that the groups have missed (based on Trainer's Resource 6-3).
9. Facilitate a group discussion of data quality and data verification issues by asking the following questions:
  - What can you do to check that data are being recorded reliably?
  - How can you be sure that data are being transferred accurately from the registers?
10. Emphasise the following points:
  - Health care systems must have standardised procedures for identifying and eliminating errors in all data sources.
  - Nurses and midwives play an important role in checking for and correcting errors.
  - All staff who record data must understand data definitions and regularly check their own work; if they have any questions, they should ask their supervisors.
11. Ask the participants what questions they have about this exercise in assessing data quality.

## **PART C: THE ROLE OF NURSES AND MIDWIVES IN ENSURING DATA QUALITY**

**Time:** 15 minutes

### **Activity 1: Brainstorming and Discussion (15 minutes)**

1. Remind the participants that, throughout this session, we have emphasised the important role that nurses and midwives play in ensuring data quality.
2. Ask the participants to think about their own health care facility, the environment in which they work.
3. Ask the participants, "What do you need in order to ensure data quality as a routine part of your practise? What elements need to be present in your environment to make that possible?"
4. Facilitate a short brainstorming session and write the participants' responses on a piece of flipchart paper. Responses can include:
  - Well-designed, standardised forms and records
  - Established data quality policies, standards and guidelines

- Adequate record-keeping systems and/or technology
- Education and training of staff on the importance of accurate data collection
- Commitment to and valuing of data quality among administration, supervisors, etc.
- Support from doctors (timely completion of medical records, clear handwriting on forms, eliminating the use of nonstandard abbreviations, etc.)
- An effective quality-review committee
- Established data verification procedures
- Teamwork (all staff members doing their part; everyone committed to data quality)

#### **TRAINING TIP**

It is likely that participants will identify many elements that, while valid, are beyond their control. The success of this activity depends on empowering them to see what *they themselves* can do to assure that quality data are part of their routine practise.

5. Ask the participants, “Which of these elements do you have the most control over?”
6. Write the participants’ responses on a piece of flipchart paper. Responses can include:
  - Teamwork
  - Doing their part (good data entry)
  - Being committed to data quality
7. Ask the participants, “What conclusion do you draw from this?” Ideally, they will say they understand that ensuring data quality starts with nurses and midwives, who must always be aware of its importance and remain committed to it.
8. Emphasise that at many facilities it is the nurse in charge of the fistula ward, maternity ward, or obstetrics-gynecology department who will compile data and give it to the doctor(s). Individual clients’ records and registers are usually kept by nurses, who send them to the records department when the client is discharged.

## **SESSION 4**

### **Using Research to Improve Fistula Care Services**

#### **Session Learning Objectives**

Upon completion of this session, the participants will be able to:

- Define *evidence-based practise* (EBP)
- Differentiate quantitative and qualitative research
- Describe potential uses of research findings in the provision of fistula services
- Discuss the roles of nurses and midwives in fistula care research

#### **POINTS TO REMEMBER**

- *Evidence-based practice, or EBP*, refers to the use of research and scientific studies as a basis for determining best practises in a particular field. In nursing and midwifery, EBP involves the conscientious integration of the best research evidence with clinical expertise and client values and needs in the delivery of quality, cost-effective health care (Burns and Grove, 2008).
- *Research* is diligent, systematic inquiry or investigation to validate and refine existing knowledge and generate new knowledge (Burns and Grove, 2008). In nursing and midwifery, the overriding purpose of research is improving outcomes (Cluett and Bluff, 2006).
- Research methods can be divided into two broad categories, based on the types of findings they produce: numerical (quantitative research) and descriptive (qualitative research).
- *Quantitative research* is research based on traditional scientific methods; it generates numerical data and usually seeks to establish causal relationships between two or more variables, using statistical methods to test the strength and significance of the relationships (*A Dictionary of Nursing*, 2008).
- Quantitative research involves statistical analysis of data from records and reports; it can also include the use of methods such as surveys, questionnaires, and structured interviews.
- *Qualitative research* is research that seeks to provide understanding of human experience, perceptions, motivations, intentions, and behaviours based on description and observation and using a naturalistic interpretative approach to a subject and its contextual setting (*A Dictionary of Nursing*, 2008).
- Qualitative research methods include unstructured interviews, focus group discussions, direct observation, case studies, and photographic documentation.

#### **Training Methods**

- Presentation
- Group discussion
- Lecture and discussion
- Homework assignment
- Small-group exercise

#### **Materials/Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 6-G: Evidence-Based Practise and Research
- Participant Handout 6-H: Fistula Care–Related Research Homework Assignment
- Trainer’s Resource 6-5: Fistula Care–Related Research

### Advance Preparation

1. Review the training steps.
2. Review Participant Handouts 6-G and 6-H.
3. Review Trainer's Resource 6-5.
4. Identify fistula care-related research articles (based on Trainer's Resource 6-5) for the homework reading assignment.

#### TRAINING TIP

For the homework reading assignment, you have two options depending upon the resources available:

- ☉ Provide the participants with the titles of and URLs for the articles and have them access their assigned article online
- ☉ Download the articles, make copies of them, and distribute them to the participants.

5. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Definition of evidence-based practise (from Participant Handout 6-G)
  - Definition of research and information about categories of research methods (from Participant Handout 6-G)
  - Homework reading assignment instructions (from Participant Handout 6-H)
6. Duplicate Participant Handouts 6-G and 6-H for the participants.

**Session Time:** 1 hour, 20 minutes

## SESSION 4

### Training Steps

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#### **PART A: SOURCES OF KNOWLEDGE**

**Time:** 15 minutes

#### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Ask the participants what questions they have about the session objectives.

#### **Activity 2: Group Discussion (10 minutes)**

1. Ask the participants, “What are some of the sources of knowledge that nurses and midwives commonly use to make decisions in their practise?”

#### **TRAINING TIPS**

- ⊙ For in-service training, ask participants to think about the sources they used on a recent day at work.
- ⊙ For preservice training, ask participants to think of sources they used during their clinical, surgical, and ob-gyn rotations.

Write their responses on a piece of flipchart paper. Sample responses could include (Rees, 2003):

- Tradition: “We’ve always done it that way.”
  - Authority/policy: “I was told to do it that way.”
  - Education/training: “I was taught/learnt to do it that way.”
  - Personal experience: “I’ve found it usually works/does not work.”
  - Trial and error: “I tried several other ways first.”
  - Role modelling: “I’ve seen others do it this way.”
  - Intuition: “It feels right this way.”
  - Research: “Research I read suggested this is the best method.”
2. Facilitate a brief discussion of the pros and cons of the sources the participants have mentioned. Sample responses could include:
    - Tradition: pro—familiarity; con—rigidity, stifles improved decision making
    - Authority/policy: pro—compliance with policy; con—no personal accountability
    - Education/training: pro—thorough knowledge of learned procedure; con—depends on quality and recentness of training
    - Personal experience: pro—experience-based; con—risky, potentially inconsistent
    - Trial and error: pro—experience-based; con—risky, potentially inconsistent
    - Role modelling: pro—experience-based; con—risky, potentially inconsistent
    - Intuition: pro—builds self-confidence; con—no tangible basis for decisions
    - Research: pro—evidence-based; con—depends on quality and recentness of research
  3. Explain that Part B of this session will focus on using research for decision making.

## PART B: COMMON RESEARCH METHODS

**Time:** 1 hour, 5 minutes

### **Activity 1: Lecture and Discussion, and Homework Assignment (20 minutes)**

1. Remind the participants that research provides an *evidence-based* source of knowledge for decision making.
2. Ask the participants to define *evidence-based practise*.
3. Distribute copies of Participant Handout 6-G.
4. Review the definition of *evidence-based practise*, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-G).
5. Emphasise that it is important to use evidence-based practises in nursing and midwifery care whenever possible.
6. Indicate that we lack evidence for much medical practise (both for fistula care and for other types of medical care). Some practise is based on scientific principles, while other practise is based on custom, experience, or observation, not on evidence. It is unrealistic to think we will ever have evidence for everything in practise.
7. Review the definition of research and the information about qualitative and quantitative research and research to improve the quality of care, using a prepared flipchart, a computer slide, or an overhead transparency (based on Participant Handout 6-G).
8. Tell the participants that research on fistula and fistula care is limited and that those working in fistula care may take part in research studies such as case studies or clinical trials.
9. Ask the participants, “What function might nurses and midwives fulfill as participants or supporting agents of research activities?” Possible responses might include: collecting data; recording service statistics; recording personal and service data.
10. Describe a current clinical trial comparing the effectiveness of seven-day postsurgery catheterisation versus 14-day postsurgery catheterisation. Nurses and midwives will be monitoring clients enrolled in the study and working with surgeons to complete data collection forms.
11. Indicate that nursing and midwifery research is the subject of many books and courses, while this session only provides a very brief, high-level overview.
12. Ask the participants what questions they have about evidence-based practise and research.
13. Divide the participants into groups (see Training Tip below).

#### **TRAINING TIP**

Using Trainer’s Resource 6-5, identify several fistula care-related research articles for the participants to read as a homework assignment.

- If there are eight or fewer participants, select two articles.
- If there are nine to 12 participants, select three articles
- If there are more than 12 participants, select four articles.

14. Distribute copies of Participant Handout 6-H and give each group its homework reading assignment. As stated in the Advance Preparation Training Tip, either:
  - Provide the participants with the titles and URLs for the articles and have them access their assigned article online
  - Download the articles, make copies of them, and distribute them to the participants

**Activity 2: Small Group Exercise (45 minutes)**

1. Have the participants meet in their groups (assigned in the previous activity).
2. Give each group a flipchart pad and a marker.
3. Explain that each of the groups will have approximately 20 minutes to:
  - Review their answers to the discussion questions in Participant Handout 6-H
  - Prepare a short action plan describing how to apply the research finding to fistula care services at their facility
  - Assign a presenter to give a brief presentation (four to five minutes long) summarising the research, the answers to the discussion questions, and the group's action plan
4. After approximately 20 minutes, ask the small groups to bring their work to a close.
5. Have the first group give its presentation.
6. Solicit two or three feedback comments from the other groups.
7. Repeat the process for the remaining groups.
8. Ask the participants what questions they have about the potential uses of research findings in the provision of fistula services.

## SESSION 5

### Displaying, Presenting, and Disseminating Data to Maximise Their Use to Inform Decision Making

#### Session Learning Objectives

Upon completion of this session, the participants will be able to:

- Describe appropriate strategies for displaying, presenting, and disseminating data for different target audiences
- Present fistula service monitoring and evaluation data effectively in a classroom exercise

#### POINTS TO REMEMBER

- Once data have been collected, it is important to display these data in a way that effectively conveys their meaning. Effective ways to display data include:
  - Lists
  - Tables
  - Graphs
- *Lists* are best when they are short. The human brain has difficulty processing long lists.
- Bullets or numbers can make lists easier to follow and understand. Numbered lists work better for presenting sequential data.
- A useful way to organise list data is *ranking*—listing items in a meaningful order.
- *Tables* display data in an ordered grid arrangement of horizontal rows and vertical columns.
- The top row of a table, often called the *header*, does not display data; it identifies the column contents.
- The table format makes it easy to compare data.
- *Graphs* make the most visual impact of these three ways of presenting data.
- Common types of graphs include:
  - Bar and column graphs
  - Stacked and 100%-stacked bar and column graphs
  - Line graphs
  - Pie graphs
- To be effective, graphs should be limited to making only one or two major points.
- Although it may take more time to make them, tables or graphs can be just as effective when they are drawn on paper with pencils, pens, or markers as when they are printed or generated on a computer.
- A key reason for displaying data is to make it easier to interpret the data. *Interpreting data* is the process of determining, clarifying, or explaining the meaning of information in order to draw conclusions based on it.
- While data may *suggest* a conclusion, deeper investigation may be needed to *validate* that conclusion.
- Participants may need to present and disseminate data for decision making in three situations:
  - When determining what decisions need to be made
  - When talking with people affected by those decisions
  - When talking with the people or organisations who need to make (or have input into) those decisions
- Two important steps when preparing to present and disseminate data are:
  - Audience analysis
  - Message development

### **POINTS TO REMEMBER (continued)**

- Audience analysis involves identifying your audience(s) and analysing their informational needs.
  - Consider the audience’s level of technical and clinical knowledge, as well as their interests and motivations, to determine how best to communicate with them.
  - Anticipate their questions and concerns so that you can be prepared with answers.
  - Offer solutions for any problems that you present.
- When developing your message, prioritise the information to share with your audience(s) and avoid presenting nonessential information.
  - For most presentations, select only the three to five most important points.
  - Identify possible actions for the audience(s) to take.
  - Avoid presenting only negative information. Too much negative information can create a sense of helplessness.
- If feasible, use several formats for elaborating your points, including:
  - Numerical data, presented in lists or tables
  - Visual data, presented in graphs
  - Narrative formats (e.g., stories, reports, two-page information sheets)

### **Training Methods**

- Presentation
- Lecture/brainstorming/discussion
- Small-group exercise
- Large-group exercise
- Posttest
- Review/debrief

### **Materials and Equipment**

- Flipchart paper, easel, markers, and tape
- [Optional] Laptop computer and LCD projector (or overhead projector and transparencies)
- Participant Handout 6-I: Displaying Data—Lists
- Participant Handout 6-J: Displaying Data—Tables
- Participant Handout 6-K: Displaying Data—Graphs
- Participant Handout 6-L: Presenting and Disseminating Data
- Participant Handout 6-M: Presenting and Disseminating Data Exercise
- Trainer’s Resource 6-1: Module 6 Evaluation and Answer Key
- Trainer’s Resource 6-6: Table and Graph for Session 5 Prepared Flipcharts

### **Advance Preparation**

1. Review the training steps.
2. Review Participant Handouts 6-I, 6-J, 6-K, 6-L, and 6-M.
3. Review Trainer’s Resources 6-6 and 6-1.
4. Prepare flipcharts, computer slides, or overhead transparencies of the following:
  - Objectives for this session
  - Lists (key points from Participant Handout 6-I)
  - Tables (key points from Participant Handout 6-J)
  - Graphs (key points from Participant Handout 6-K)
  - Audience analysis, message development, and formats for presenting data (key points from Participant Handout 6-L)

5. Prepare two flipchart pages for Part A, Activity 2 (based on Trainer’s Resource 6-6):
  - A table displaying data about Women Seeking Care, Women Needing Repair, and Women Receiving Care, by Quarter—2008
  - A line graph displaying data about Surgery Repair Order Among Women Receiving Surgery, by Quarter—2009

*Note:* Keep these pages covered until step 8 of Part A, Activity 2.

6. Prepare a flipchart page for Part B, Activity 1 (based on Trainer’s Resource 6-6).  
*Note:* Keep this page covered until Step 4 of Part B, Activity 1.
7. Duplicate Participant Handouts 6-I, 6-J, 6-K, 6-L, and 6-M for the participants.

#### **TRAINING TIP**

Based on the sessions and content covered, select approximately 20 relevant questions from Trainer’s Resource 6-1 for the Module 6 Posttest. The correct answers are shown in **boldface** and the source of the correct answer is shown in [brackets].

#### **TRAINING TIP**

Because Session 5 is 2 hours, 40 minutes in length, it may not be practical to conduct the entire session on a single day. If you need to split the session, we suggest conducting Part A (Displaying Data) and Part B (Interpreting Data) on one day and Part C (Presenting and Disseminating Data) and Part D (Module 6 Evaluation) on another day. If you do conduct all the sessions on a single day, be sure to schedule a break before and after Part C.

**Session Time:** 2 hours, 40 minutes

## SESSION 5

### Training Steps

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#### **PART A: DISPLAYING DATA**

**Time:** 30 minutes

##### **Activity 1: Presentation (5 minutes)**

1. Review the session objectives, using a prepared flipchart, a computer slide, or an overhead transparency.
2. Ask the participants what questions they have about the session objectives.

##### **Activity 2: Lecture and Discussion (25 minutes)**

1. Explain that, once you have collected data, it is important to display those data in a way that effectively conveys their meaning.
2. Ask the participants, “What are some effective ways to display data?”
3. Write the participants’ answers on a piece of flipchart paper. Desired responses include:
  - Lists
  - Tables
  - Graphs

#### **TRAINING TIP**

Use the participants’ responses to gauge their familiarity with how data can be displayed. If the participants are familiar with lists, tables, and graphs, you can make the remainder of this activity more interactive (e.g., asking them for examples of each type of display). If not, give a lecture to present the information for the remainder of this activity.

4. Discuss displaying data using lists, tables, and graphs, using prepared flipcharts, computer slides, or overhead transparencies based on the information on Participant Handouts 6-I, 6-J, and 6-K.
5. Distribute Participant Handouts 6-I, 6-J, and 6-K.
6. Ask the participants, “Do you need a computer to create a table or graph?”
7. Explain that people who do not have access to a computer sometimes hesitate to make tables or graphs by hand; however, tables and graphs can be just as effective when drawn on paper with pencils, pens, or markers.
8. Reveal the prepared flipcharts with handmade tables and graphs showing fistula data (Advanced Preparation, Step 5).
9. Emphasise that, while it may take a little more time to make graphs and tables by hand, they can convey information as effectively as computer-generated versions.
10. Ask the participants what questions they have about displaying data.

#### **PART B: INTERPRETING DATA**

**Time:** 20 minutes

##### **Activity 1: Lecture, Brainstorming, and Discussion (20 minutes)**

1. Explain that a key reason for displaying data is to help you to interpret those data.
2. Ask the participants, “What do we mean by *interpreting data*?”

3. Explain that interpreting data is the process of determining, clarifying, or explaining the meaning of information in order to draw conclusions based on it.
4. Display the prepared flipchart for this activity (Advanced Preparation, Step 6).
5. Discuss the data shown on the prepared flipchart. During the previous month:
  - Sixty percent of the clients who came to the health facility for fistula repair services came from community X.
  - Forty percent of the clients who came to the health facility for fistula repair services came from community Y.
6. Explain that one interpretation of the data might be that fistula is more prevalent in community X than in community Y.
7. Direct the participants to each write down as many possible interpretations as they can think of in three minutes.
8. Ask the participants to share their interpretations.
9. Write their responses on a piece of flipchart paper. Possible responses may include:
  - Community X is more aware of fistula repair services than community Y.
  - Community X has more women of childbearing age than community Y.
  - Transportation to the local health facility is more available in community X than in community Y.
  - A cultural value, belief, or myth in community Y prevents women from seeking fistula repairs services.
  - Negative experiences by a woman or family from community Y may have discouraged others in her community from using the repair services.
  - Community Y has different social norms that include delay of childbearing, education of women, and fewer barriers to accessing services, resulting in lower incidence of women with prolonged and obstructed labour and timely access to obstetrical services.
  - The referral system from community Y may not be reliably functional.
  - Community X may have more active community health personnel informing and directing families to the repair service site.
10. Point out that the participants have been able to draw several different conclusions from the same data.
11. Emphasise that, while data may suggest a conclusion, deeper investigation may be needed to validate that conclusion.
12. Ask the participants what questions they have about interpreting data.

### **PART C: PRESENTING AND DISSEMINATING DATA**

**Time:** 1 hour, 10 minutes

#### **Activity 1: Lecture and Discussion (15 minutes)**

1. Remind the participants that the focus of this session is *displaying, presenting, and disseminating data to maximise their use to inform decision making*, and specifically, decision making regarding fistula care services.
2. Ask the participants, “What are some situations in which *you* might need to present and disseminate data for decision making?”
3. Record their responses on a piece of flipchart paper. Possible responses could include:
  - Determining what decisions need to be made
  - Talking with people affected by those decisions
  - Talking with the people or organisations who need to make (or have input on) those decisions

4. Ask the participants for some examples of each situation.
5. Write the participants' responses on the applicable flipchart. Sample responses include:
  - Determining what decisions need to be made (services to be added, changed, or strengthened; training to be delivered; equipment to be purchased)
  - Talking with people affected by those decisions (medical, nursing, midwifery, counselling, or community health personnel; clients and their families)
  - Talking with the people or organisations who need to make (or have input on) those decisions (directors of the health care facility, supervisors of service units, community leaders/networks, women's, men's, youth groups; the national Ministry of Health, Education, Finance, or Youth; donors, international groups)
6. Explain that there are two important steps when preparing to present and disseminate data:
  - Audience analysis
  - Message development
7. Discuss the key points about audience analysis (from Participant Handout 6-L), using a prepared flipchart, a computer slide, or an overhead transparency.
8. Ask the participants, "What are some ways to determine how best to communicate with your audience?" Potential responses may include:
  - When talking to management or finance people, use statistical and monetary data.
  - When talking with clients, use personal stories.
9. Discuss the key points about message development (from Participant Handout 6-L), using a prepared flipchart, a computer slide, or an overhead transparency.

#### **TRAINING TIP**

If the participants have some familiarity with presenting data, make the discussion of message development more interactive, asking questions such as:

- ⊙ Why is it important to focus on only three to five points of information?
- ⊙ Why is it important to avoid presenting only negative information?

The answers to these questions are provided on Participant Handout 6-L.

10. Emphasise that being brief and clear are essential skills when presenting data.
11. Distribute copies of Participant Handout 6-L.
12. Describe the three formats for presenting data (numerical, visual, and narrative) listed at the bottom of the handout.
13. Ask the participants what questions they have about presenting and disseminating data.

#### **Activity 2: Small Group Exercise and Large Group Exercise (55 minutes)**

1. Remind the participants that in Session 2 of this module, they learned about 13 fistula repair indicators.
2. Explain that, in this exercise, they will be interpreting and presenting data related to those indicators.
3. Distribute copies of Participant Handout 6-M.
4. Divide the participants into three groups and assign indicator data to each group, as follows:
  - Group 1: women seeking care, needing repair, and receiving care, by quarter
  - Group 2: complications among fistula repair clients, 2008 and 2009
  - Group 3: outcome of fistula repair surgery at time of discharge, by type of fistula

5. Give each group a flipchart pad and a marker.
6. Explain that each of the groups will have approximately 30 minutes to:
  - Analyse and interpret their assigned data
  - Create a graph that effectively displays this data
  - Identify who would be interested in this data (the audience)
  - Analyse that audience
  - Select and develop two or three key messages
  - Prepare a brief (approximately three-minute-long) presentation that appropriately communicates those messages to that audience
  - Assign a presenter
7. After approximately 30 minutes, ask the groups to bring their work to a close.
8. Remind the participants that being brief is an essential skill when presenting data.
9. Conduct the large group exercise as follows:
  - Have Group 1 give its presentation
  - Solicit two or three feedback comments
  - Repeat the process for Groups 2 and 3.
10. Debrief the exercises, asking:
  - Was it hard to agree on an interpretation? Why or why not?
  - Was it hard to analyse your audience? Why or why not?
  - Was it hard to identify the two or three most important points? Why or why not?
  - Was it hard to keep the presentation short? Why or why not?
11. Ask the participants what additional questions they have about presenting and disseminating data.

#### **TRAINING TIP**

If, earlier in this module, participants raised questions or concerns that you set aside and wrote down on a “Parking Lot” flipchart, you now need to validate that you have addressed them. Briefly review the “Parking Lot” questions and confirm with the participants that they have been answered satisfactorily.

### **PART D: Module 6 Evaluation**

**Time:** 40 minutes

#### **Activity 1: Posttest (20 minutes)**

1. Distribute the Module 6 Evaluation (based on the questions provided in Trainer’s Resource 6-1) to the participants and tell them they have 20 minutes to take the test.
2. Collect the tests after 20 minutes.

#### **Activity 2: Review and Debrief (20 minutes)**

1. Review the answers to the Module 6 Evaluation (using the Answer Key in Trainer’s Resource 6-1).
2. Ask the participants what questions they have.

#### **TRAINING TIP**

If time permits, go around the room, asking participants to answer the posttest questions. If time is short, read the answers aloud.



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# **MODULE 6**

# **RESOURCES**



## **PARTICIPANT HANDOUT 6-A**

### **Monitoring and Evaluation Terms**

#### **Definition of Using Data for Decision Making**

Using data for decision making is a process that consists of:

1. Obtaining, analysing, and interpreting data
2. Making decisions based on such data
3. Taking actions based on such data to strengthen the delivery of services (Timmons & Egboh, 1992)

#### **Definitions of Monitoring and Evaluation**

**Monitoring** continuously tracks performance against what was planned by collecting and analysing data on predetermined indicators. It provides continuous information on whether progress is being made towards objectives through record keeping and regular reporting systems. The performance information generated from monitoring enhances learning from experience and improves decision making.

**Evaluation** is a periodic, in-depth analysis of performance. It relies on data generated through monitoring activities but can also include information obtained from other sources (e.g., studies, research, in-depth interviews, focus group discussions, surveys etc.). Evaluation commonly aims to determine the relevance, validity of design, efficiency, effectiveness, and impact of activities or services.

#### **Glossary of Key Monitoring and Evaluation Terms**

**Analysis:** The process of systematically applying statistical techniques and logic to interpret, compare, categorise, and summarise data collected in order to draw conclusions.

**Data:** Specific quantitative and qualitative information or facts (e.g., recorded observations in numeric or textual form), which can then be collected and analysed.

**Data collection:** Systematic gathering of information on predetermined indicators; collection methods include the review of records, surveys, or interviews.

**Data element:** A basic unit of information built on standard structures having a unique meaning and distinct units or values (e.g., client name, date of birth, weight, etc.).

**Impact:** The long-term or ultimate effect attributable to an activity or service, including changes—whether planned or unplanned, positive or negative, direct or indirect, primary or secondary—that an activity or service helped to bring about.

**Indicator:** A unit of quantitative or qualitative information providing a simple and reliable way to measure achievement, assess performance, or reflect changes connected to an activity or service.

**Input:** A financial, human, material, technological, or information resource needed to implement an activity or service (such as funding, personnel, facilities, equipment, and policies).

**Objective:** A statement defining a desired result that an activity or service seeks to achieve.

**Outcome:** The short- to medium-term result of an activity's or service's output; outcome represents a change that occurs between the completion of the output and the achievement of the impact.

**Output:** The immediate result of processes or activities (such as the number of individuals trained, services delivered, or supervisory visits conducted).

**Process:** An activity in which inputs are used in a specific way to achieve desired results (such as training, service delivery, or supervision).

**Qualitative data:** Information that is nonnumeric (words) and that describes attributes, characteristics, or behaviours that can be observed but not measured (e.g., religion, socioeconomic status, opinions, attitudes).

**Quantitative data:** Information that is numerical and can be counted (e.g., clients treated, procedures performed) or measured (e.g., weight, height).

**Record keeping:** A defined process for documenting information using appropriate tools (registers, client records). Accurate record keeping (either manual or computerised) helps facilitate client tracking and continuity of care and also provides data for reporting and monitoring.

### References

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: Trainer's manual*. New York: EngenderHealth.

Timmons, R., and Egboh, M., eds. 1992. Using service data: The tools for taking action, *The Family Planning Manager*, Vol. I, No. 2, Boston: Management Sciences for Health.

United Nations Population Fund. 2004. *Programme manager's planning monitoring and evaluation toolkit*. New York: United Nations Population Fund.

## PARTICIPANT HANDOUT 6-B

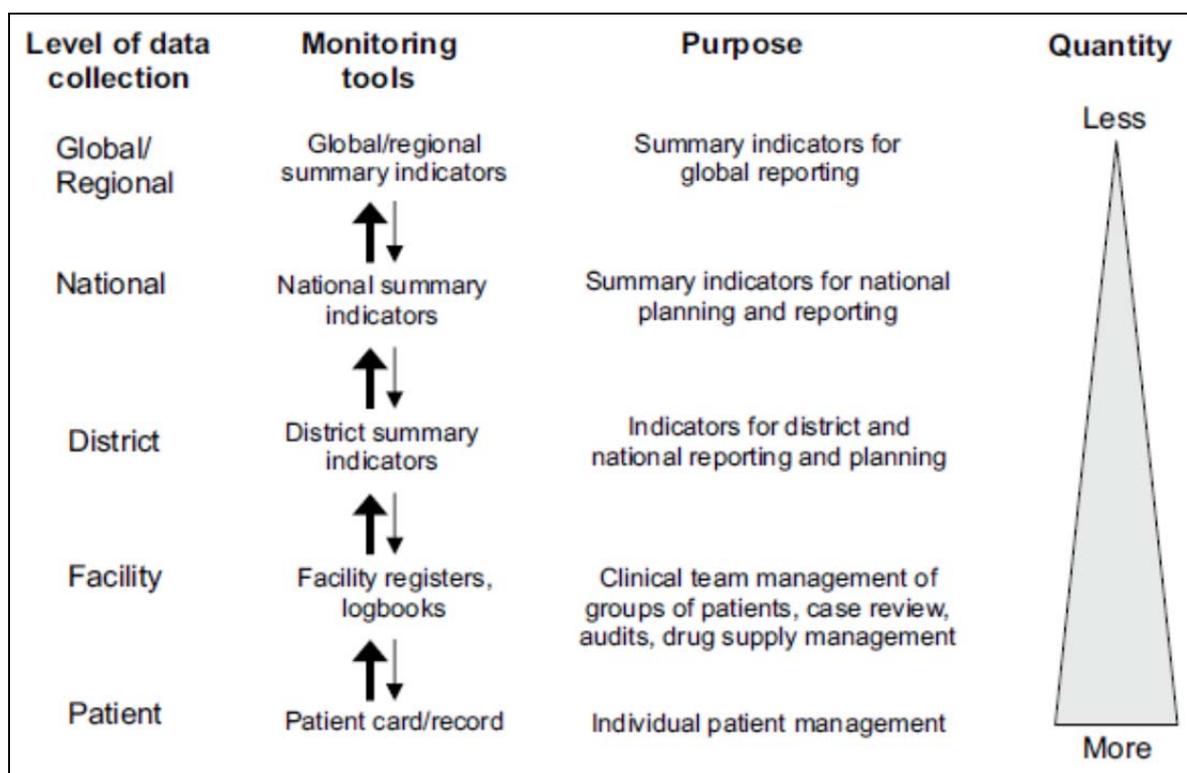
### Data Collection at Different Levels of the Health Care System

#### Client Monitoring

*Client monitoring* is the routine collection, compilation, and analysis of data on individual clients over time and across service delivery points, using information either from paper forms or entered into a computer.

#### Monitoring of Services

*Monitoring of services* is the routine reporting and tracking of key information about a service, and particularly of its intended outcomes. Monitoring of services requires many types of information (e.g., demographic, medical, psychosocial, financial, etc.) including aggregated client data.



#### References

World Health Organization. 2006. *Patient monitoring guidelines for HIV care and antiretroviral therapy (ART)*. Geneva.

## PARTICIPANT HANDOUT 6-C

### Sample Fistula Care Indicators

These fistula repair indicators are provided for illustrative purposes only.

Indicator	Definition/Explanation	Purpose/Use
1. Number of women arriving and seeking fistula repair surgery	Not all women seeking care will have a fistula, but the facility wants to know how many are seeking services and their perceptions of fistula.	<ul style="list-style-type: none"> <li>• Making decisions about fistula repair awareness and the potential need for community outreach and/or education</li> <li>• Helping to determine resources required to provide fistula care services (e.g., staffing, equipment)</li> </ul>
2. Number of women requiring fistula repair surgery	Women who have arrived seeking fistula care, have been screened, and have been found to have a urinary fistula and/or rectovaginal fistula (RVF). Urinary fistula include: <ul style="list-style-type: none"> <li>• Vesicovaginal</li> <li>• Urethrovaginal</li> <li>• Ureterovaginal</li> <li>• Vesicouterine</li> </ul>	<ul style="list-style-type: none"> <li>• Comparing with indicator 1 and looking for significant differences</li> <li>• Helping to determine resources required to provide fistula care services (e.g., staffing, equipment, supplies, beds)</li> </ul>
3. Number of women receiving fistula repair services (the sum of indicators 4.1, 4.2, and 4.3)	The number of women receiving fistula repair services at the facility during the quarter	<ul style="list-style-type: none"> <li>• Measuring overall volume of a key activity at a fistula treatment centre</li> <li>• Helping to determine resources required to provide fistula care services (e.g., staffing, equipment, supplies, beds)</li> </ul>
4. Type of fistula repair surgery (the sum of 4.1, 4.2, and 4.3 equals indicator 3)	A breakdown of the number of women who had surgery for: <ul style="list-style-type: none"> <li>4.1: Urinary only repairs</li> <li>4.2: Urinary-and-RVF repairs</li> <li>4.3: RVF-only repairs</li> </ul>	<ul style="list-style-type: none"> <li>• Making decisions about resource requirements (e.g., staffing, equipment, supplies)</li> </ul>

Indicator	Definition/Explanation	Purpose/Use
5. Number of repairs for urinary-only clients and urinary-and-RVF clients (the sum of indicators 5.1, 5.2., and 5.3 equals the sum of indicators 4.1 and 4.2)	For women who had either urinary-only repairs or urinary-and-RVF repairs, the number of times the women underwent repair surgery: 5.1: First repair 5.2: Second repair 5.3: More than two repairs	<ul style="list-style-type: none"> <li>Measuring effectiveness and or complexity of repair surgeries</li> <li>Making decisions about staffing requirements (e.g., trolley nurses)</li> </ul>
6. Number of women discharged who had urinary-only repairs	The number of women who had urinary-only repair (4.1) who were discharged in the quarter	<ul style="list-style-type: none"> <li>Informing managers about bed capacity</li> <li>Providing a denominator for calculating outcome measures</li> <li>(Potentially) measuring the quality of postoperative care (monitoring fluid intake, catheter, etc.)</li> </ul>
7. Number of women discharged who had urinary-and-RVF repairs	The number of women who had urinary-and-RVF repair (4.2) who were discharged in the quarter	<ul style="list-style-type: none"> <li>Informing managers about bed capacity</li> <li>Providing a denominator for calculating outcome measures</li> <li>(Potentially) measuring the quality of postoperative care</li> </ul>
8. Number of women discharged who had RVF-only repairs	The number of women who had RVF-only repair (4.3) who were discharged in the quarter	<ul style="list-style-type: none"> <li>Informing managers about bed capacity</li> <li>Providing a denominator for calculating outcome measures</li> <li>(Potentially) measuring quality of postoperative care</li> </ul>
9. Number of fistula repair clients discharged during the quarter (the sum of indicators 6, 7, and 8)	Number of women discharged after receiving fistula repair surgery at the facility	<ul style="list-style-type: none"> <li>Measuring surgical outcomes</li> </ul>
10. Number of women who had repair surgery but were not discharged during the quarter	Number of women who received any type of fistula repair surgery but have not been discharged (i.e., they are continuing to receive postoperative care). The number may include women who received surgery in the current quarter or in a previous quarter.	<ul style="list-style-type: none"> <li>Informing managers about bed capacity</li> <li>Identifying potential postoperative issues (e.g., complications, quality of care)</li> </ul>

Indicator	Definition/Explanation	Purpose/Use
11. Outcome of urinary-only and urinary-and-RVF cases discharged this quarter (the sum of indicators 11.1, 11.2, and 11.3 equals the sum of indicators 6 and 7)	A breakdown of outcomes at discharge for women who had urinary-only and urinary-and-RVF repairs: 11.1: Closed and dry 11.2: Closed with remaining urinary incontinence 11.3: Not closed	<ul style="list-style-type: none"> <li>Measuring impact of fistula treatment services</li> <li>Evaluating quality of care</li> </ul>
12. Outcome of RVF-only cases discharged this quarter (the sum of indicators 12.1, 12.2, and 12.3 equals indicator 8)	A breakdown of outcomes at discharge for women who had RVF-only repairs: 12.1: Closed and dry 12.2: Not closed; incontinent with watery stool and/or flatus (gas) 12.3: Not closed; incontinent with firm stool	<ul style="list-style-type: none"> <li>Measuring impact of fistula treatment services</li> <li>Evaluating quality of care</li> </ul>
13. Number of women discharged this quarter who experienced complications (the sum of indicators 13.1, 13.2, and 13.3)	A breakdown of the number of women who had any type of fistula repair surgery (urinary only, urinary-and-RVF, or RVF only) and who experienced any type of complication. Some women may experience more than one complication. 13.1: Major surgical complication 13.2: Anaesthesia-related complication 13.3: Postoperative complication related to perceived success of the Surgery	<ul style="list-style-type: none"> <li>Identifying areas needing improvement (e.g., complications, quality of care)</li> </ul>

## References

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 6-D

### Dimensions of Data Quality

#### Six Dimensions of Data Quality

The following six dimensions (desirable attributes) define data quality and are frequently used to evaluate client care data. All six dimensions are crucial in client records, client registers, and other health management information system forms.

Dimension	Description
<b>Accuracy</b>	Data must be valid, correct and free from error; documentation should reflect information factually.
<b>Reliability</b>	Data should be consistent; data collection, processing, and display should always follow established procedures and standards.
<b>Completeness</b>	All required data are present; the medical or health record should contain all pertinent documents.
<b>Legibility</b>	Data are readable and understandable; if any abbreviations or codes are used, they are standard and understood by all health care professionals involved in the service being provided to the client.
<b>Timeliness</b>	Data are recorded promptly at the time of observation or treatment.
<b>Accessibility</b>	Data are available to authorised persons when and where needed.

#### References

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 6-E

### Common Data Collection Errors

Whenever data are recorded, copied, or compiled (at any level in the health care system), there is the potential to introduce error. Some of the most frequent data collection errors include:

- **Mathematical errors**—for example, incorrect addition
- **Logical impossibilities**—for example, a pregnant woman’s date of birth is recorded as having taken place in the early 20th century)
- **Numbers out of the normal or expected range**—for example, a dramatic increase in fistula repairs, from fewer than 10 repairs per quarter to 300 in one quarter
- **Missing data**—for example, a client’s address is not provided or recorded
- **Transcription errors** Examples of these include:
  - **Transposition**—for example, the number *16* is entered as *61*
  - **Extra or missing zeros**—for example, the number *10* is entered as *100* (or vice versa)
  - **False zeros**—for example, a zero is recorded when a data element is missing (the correct entry is something other than zero)
  - **Illegible writing**—for example, the words or numbers entered are difficult or impossible to read
  - **Miscopied data**—for example, a data element from one record or document is entered incorrectly during the process of transferring that data to another record or document (or during the compilation of that data).

#### References

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## **PARTICIPANT HANDOUT 6-F**

### **Assessing Data Quality Exercise**

#### **Exercise Instructions**

The purpose of this exercise is to assess the data on sample client forms and identify errors (and potential errors). You will have 15 minutes to examine the data on your assigned form.

- Groups 1 and 2 will look at Example 1 (Mabel Solo).
  - Groups 3 and 4 will look at Example 2 (Mercy Kastor).
1. Consider the six dimensions of data quality:
    - Accuracy
    - Reliability
    - Completeness
    - Legibility
    - Timeliness
    - Accessibility
  2. Look for common data collection errors:
    - Mathematical errors
    - Logical impossibilities
    - Numbers out of the normal/expected range
    - Missing data
    - Transcription errors
      - Transposition
      - Extra or missing zeros
      - False zeros
      - Illegible writing
      - Miscopied data
  3. Identify and categorise the data errors on your assigned form.
  4. List the data errors on a sheet of flipchart paper and select a spokesperson to present them to the full group.



## Example 2 (Mercy Kastor)

Tamaranda Hospital Fistula Care Services: Client Record

Date: January 6, 2010

Patient ID Number: \_\_\_\_\_

### Personal Data

1. **Patient Name:** Mercy Kastor
2. **Age:** 35 years old
3. **Marital status:** (single, **married**, divorced, widowed)
4. **Age at Marriage:** 17
5. **Home/Village (postal address):** Plot 269, Semperi
6. **Contact information for a relative:** Esther Kastor, Mother, Plot 268, Semperi
7. **Living with husband?** No                      **Living with family?** Yes
8. **Ethnic group:**
9. **Religion:** Christian
10. **Highest schooling:** Form 5
11. **Date of Arrival:** December 20, 2010
12. **Referred by/from:** Government Hospital, Waverly
  - a. If not referred, how did you hear about this service?

### History

13. **Age at first pregnancy:** 17
14. **Number pregnancies:**   4   premature births   0   abortions   1   stillbirths   1   number of living children   3  .
15. **When was the last baby born?** 10 months ago.                      **Condition of baby at birth?** Dead
16. **Labor complications:** "baby in wrong position"
17. **Type of deliveries:** (c-section, forceps, vacuum, vaginal) – vaginal
18. **When did leaking/soiling begin?** 9 months ago
19. **Has been to hospital for treatment?**                      **Results?**

### General Examination

20. **Height:** 182 cm
21. **Weight:** 90 kg
22. **Vital signs:**
23. **Heart:**
24. **Lungs:**
25. **Abdomen:** no scars, no enlarged organs
26. **Pelvic:** VVF                      **Dx:** medium sized fistula;

### Management

27. **Procedure:** Repair of fistula via vaginal approach
28. **Date:** January 10, 2011
29. **Pre-procedure preparations:** Blood type   AB+
30. **Complications:** Developed a fever of unknown origin on postoperative day 3; treated with IV antibiotics

### Discharge:

31. **Outcome:** Closed & Dry; Wet: Stress incontinence – mild, moderate, severe
32. **Counseling:** Self-care   x  ; sexual relations   x  ; family planning \_\_\_\_\_; future pregnancies & deliveries by c-section   x  ; and, Follow-up \_\_\_\_\_.

## **PARTICIPANT HANDOUT 6-G**

### **Evidence-Based Practise and Research**

#### **Definition of Evidence-Based Practise**

The term *evidence-based practise* (EBP) refers to the use of research and scientific studies as a basis for determining best practises in a particular field. In nursing and midwifery, EBP is the conscientious integration of best research evidence with clinical expertise and client values and needs in the delivery of quality, cost-effective health care (Burns and Grove, 2008). Research findings from rigorous studies constitute the best type of evidence for informing nurses' and midwives' decisions, actions, and interactions with clients (Polit and Beck, 2008).

#### **Definition of Research**

*Research* is diligent, systematic inquiry or investigation to validate and refine existing knowledge and generate new knowledge (Burns and Grove, 2008). In nursing and midwifery, the overriding purpose of research is improving outcomes (Cluett and Bluff, 2006).

#### **Categories of Research Methods**

Research methods can be divided into two broad categories, based on the types of finding they produce: numerical (quantitative research) and descriptive (qualitative research).

- **Quantitative research** is research based on traditional scientific methods, which generates numerical data and usually seeks to establish causal relationships between two or more variables, using statistical methods to test the strength and significance of the relationships (*A Dictionary of Nursing*, 2008). Quantitative research involves statistical analysis of data from records and reports; it can also include the use of methods such as surveys, questionnaires and structured interviews. Examples of quantitative findings relevant to fistula care are:
  - The incidence of fistula in a given district
  - The number of fistula repairs done at a given site over a given time period
  - The percentage of fistula repairs with a closed and dry outcome at a given site over a given time period
- **Qualitative research** is research that seeks to provide understanding of human experience, perceptions, motivations, intentions, and behaviours based on description and observation and utilizing a naturalistic interpretative approach to a subject and its contextual setting (*A Dictionary of Nursing*, 2008). Qualitative research methods include unstructured interviews, focus group discussions, direct observation, case studies, and photographic documentation. Examples of qualitative findings relevant to fistula care are:
  - The experiences of women seeking medical care for fistula
  - The emotional and social impacts of fistula on women living with fistula and their families
  - Women's experiences with reintegration after fistula repair

#### **References**

- Burns, N., and Grove, S. K. 2005. *The practice of nursing research. Conduct, critique, and utilization*, 5th ed. Philadelphia: Elsevier.
- Cluett, E., and Bluff, R. 2006. *Principles and practice of research in midwifery*, 2nd ed. Philadelphia: Elsevier.
- Martin, E., and McFerran, T. 2008. *A Dictionary of Nursing*, 5th ed. Oxford: Oxford University Press.
- Polit, D., and Beck, C. 2008. *Nursing research: Generating and assessing evidence for nursing practice*, 8th ed. New York: J. B. Lippincott.

## **PARTICIPANT HANDOUT 6-H**

### **Fistula Care–Related Research Homework Assignment**

#### **Reading Assignment**

Your instructor will either:

- Provide you with the title and URL for your assigned article, which you will access online
- Provide you with a hard copy of your assigned articles

#### **Discussion Questions**

1. Briefly describe the research project in the article, noting its purpose, focus, location, and key findings.
  
  
  
  
  
  
  
  
  
  
2. Does the article use quantitative research, qualitative research, or both types of research?
  
  
  
  
  
  
  
  
  
  
3. What do you think is the most important finding of this article?
  
  
  
  
  
  
  
  
  
  
4. How could you apply the research findings to fistula care services (preventive, management, and/or reintegration) at your facility?

## **PARTICIPANT HANDOUT 6-I**

### **Displaying Data—Lists**

List format is one of the simplest ways to display data, but it is also the most limited.

- Lists are best when they are short. The human brain has difficulty processing long lists.
  - If a list has more than five items, try to find a way to group them into two or three categories.
  - If there are more than 10 items, another type of presentation will probably be more effective.
- Bullets or numbers can make lists easier to follow and understand. Numbered lists work best for presenting sequential data.
- A useful way to organise list data is ranking—listing items in a meaningful order. For instance, a facility could rank the types of fistula repairs it has performed in order of frequency, with the most frequent type listed first, the next most frequent listed second, and the least frequent listed last. For example, fistula repairs for the first quarter of a given year:
  - Urinary fistula only: 143 repairs
  - Both urinary fistula and RVF: 9 repairs
  - RVF-only: three repairs

#### **References**

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: Trainer's manual*. New York: EngenderHealth.

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 6-J

### Displaying Data—Tables

Tables clarify the representation of data in ways that lists cannot.

- Tables display data in an ordered grid arrangement of horizontal rows and vertical columns.
- The top row of a table, often called the *header*, does not display data; it identifies the column contents.
- The table format makes it easy to compare data. In the example below, data is compared:
  - Across time (Quarter 1 versus Quarter 2)
  - By category (type of fistula repaired)

Repair type	Quarter 1 repairs	Quarter 2 repairs
Urinary fistula only	143	156
Both urinary fistula and RVF	9	7
RVF-only	3	1

- For tables with many rows, shading can be used to enhance readability.
- Tables can include totals for columns, rows, and the whole table. For example:

Repair type	Quarter 1 repairs	Quarter 2 repairs	Total
Urinary fistula only	143	156	<b>299</b>
Both urinary fistula and RVF	9	7	<b>16</b>
RVF-only	3	1	<b>4</b>
<b>Total</b>	<b>155</b>	<b>164</b>	<b>319</b>

#### References

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: Trainer's manual*. New York: EngenderHealth.

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 6-K

### Displaying Data—Graphs

*Graphs* make greater visual impact than either lists or tables. To be effective, graphs should be limited to making only one or two major points. Graphs do not need to be generated on a computer to be effective; equally good graphs can easily be made by hand with available supplies.

Common types of graphs include:

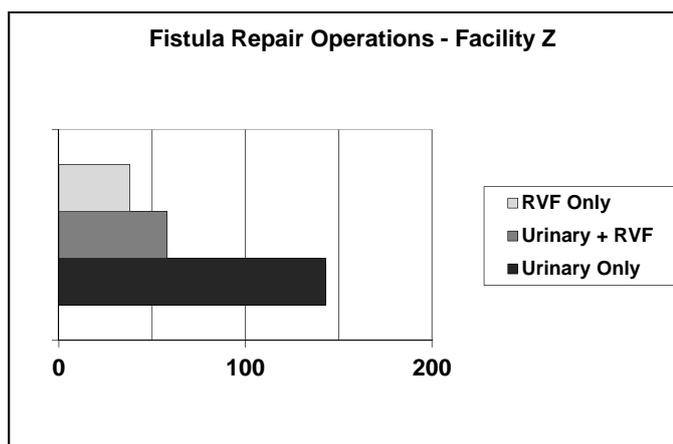
- Bar and column graphs
- Stacked and 100%-stacked bar and column graphs
- Line graphs
- Pie graphs

Examples of all these types of graphs appear below.

#### Bar and Column Graphs

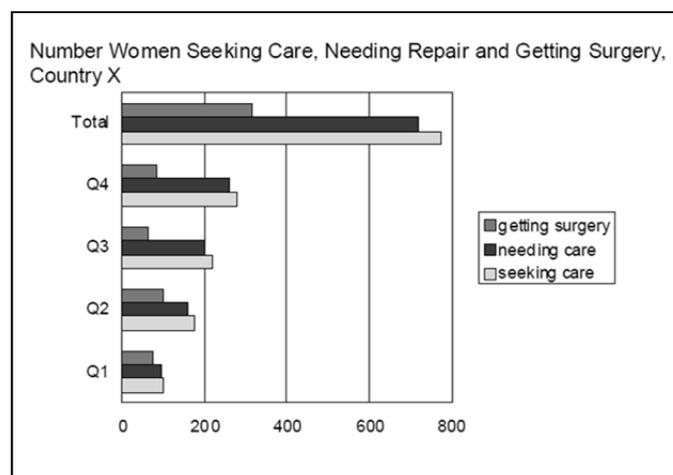
A simple bar or column graph compares a data element or indicator over time. The only difference between a bar graph and a column graph is its orientation; bar graphs are horizontal, while column graphs are vertical. Sometimes one orientation is easier to read than the other.

Example of a simple bar graph:

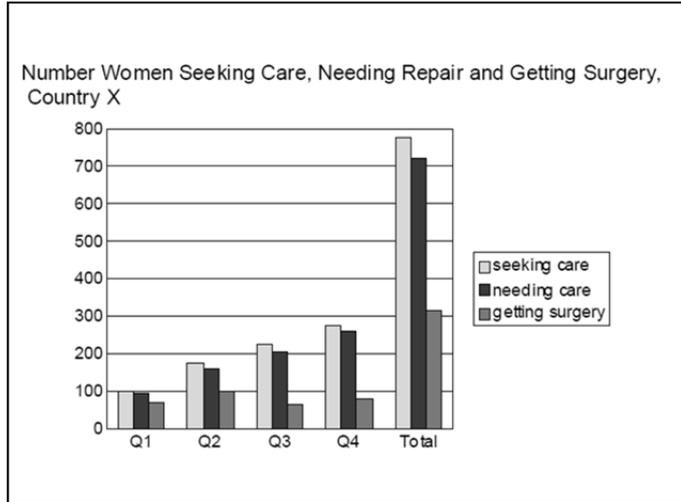


More complex bar or column graphs combine data into small groups, called clusters, and are good for showing comparisons between these clusters over time.

Example of a bar graph with data clusters:



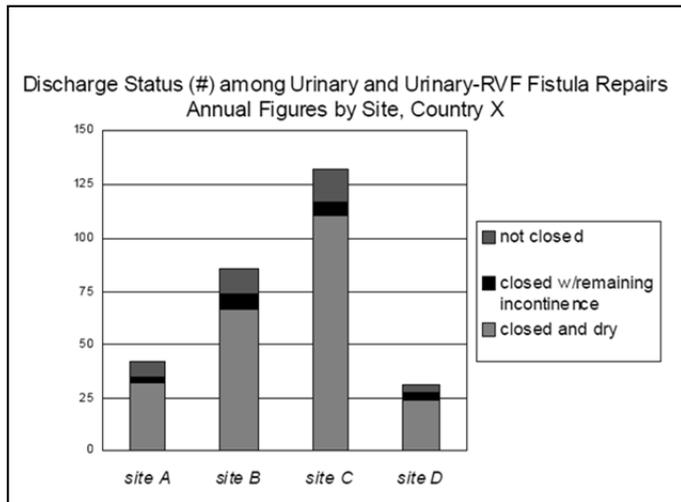
Example of the same data clusters formatted as a column graph:



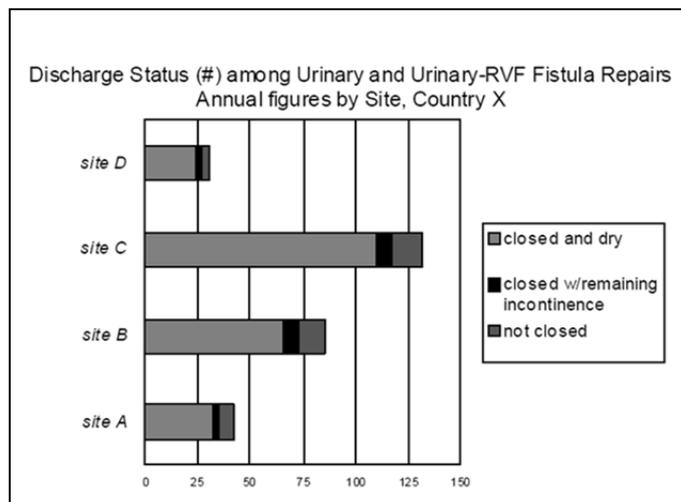
### Stacked Bar Graphs and Stacked Column Graphs

Stacked bar graphs and stacked column graphs show the cumulative total for a cluster of data. All units within a cluster appear on the same bar or column. The reader can easily see the total for each cluster and can compare totals across clusters.

Example of a stacked column graph:



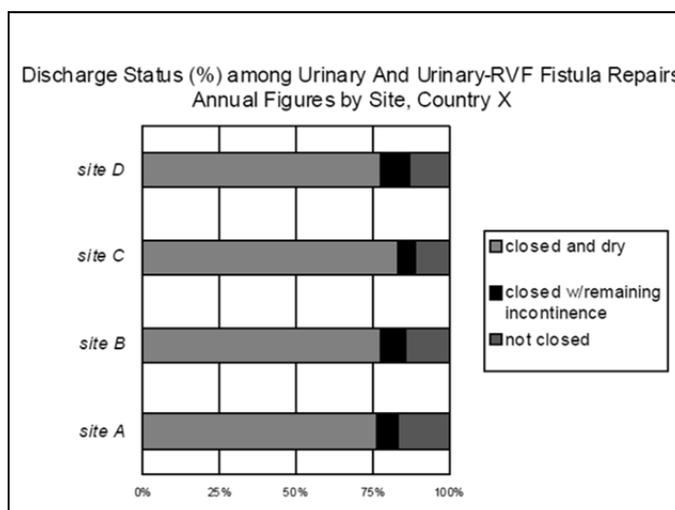
Example of a stacked bar graph:



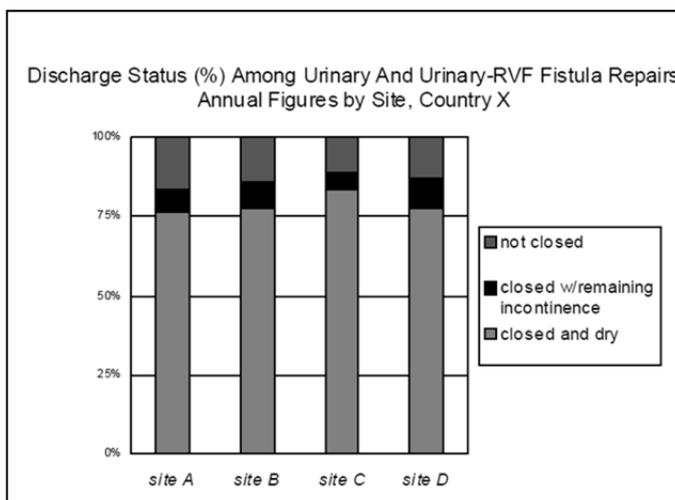
### 100%-Stacked Bar Graphs and 100%-Stacked Column Graphs

One-hundred-percent-stacked graphs display percentages. Each bar or column equals 100%. These graphs make it easy to compare percentages across the bars and columns.

Example of a 100%-stacked bar graph:



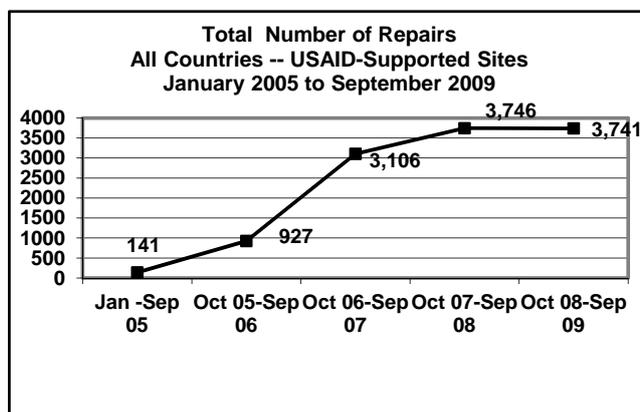
Example of a 100%-stacked column graph:



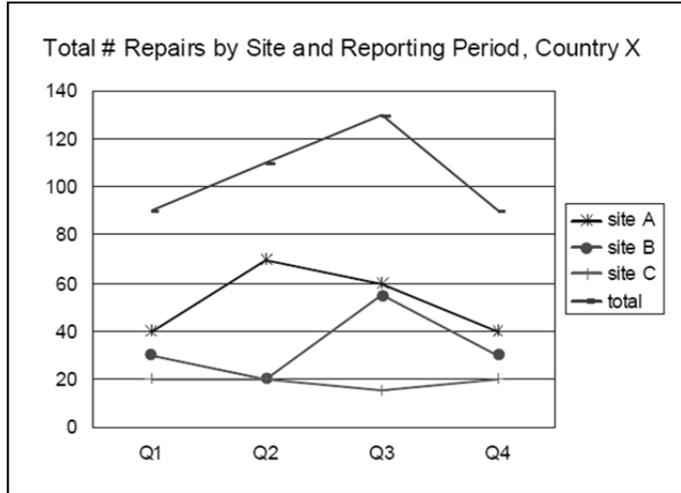
### Line Graphs

Line graphs are often used to show trends across time. The line connects a series of data points over time.

Example of a line graph with one line:



Example of a line graph with multiple lines:



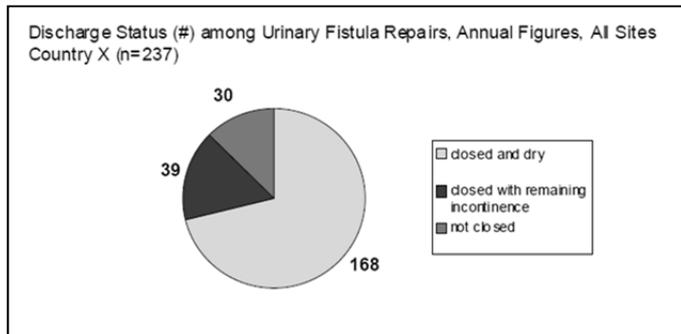
### Pie Graphs

A pie graph shows parts of a whole. It consists of a circle divided into sectors that illustrate proportions. The circle (the “pie”) represents 100 percent; the sectors within the pie must always add up to 100 percent.

Pie graphs are good for highlighting the majority value. They can also be an effective way to show the relative size of one or more sectors in comparison to the whole.

Pie graphs work best when the sectors represent 25 to 50% of the data; they become difficult to read if there are too many sectors and/or if any of the sectors are very narrow.

Example of a pie graph:



### References

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: Trainer’s manual*. New York: EngenderHealth.

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## **PARTICIPANT HANDOUT 6-L**

### **Presenting and Disseminating Data**

#### **Audience Analysis**

- Identify your audience(s).
- Analyse their informational needs. Instead of trying merely to impress your audience, give them information that they will find meaningful and valuable.
  - Consider your audience's level of technical and clinical knowledge, as well as their interests and motivations, to determine how best to communicate with them.
  - Anticipate their questions and concerns so that you can be prepared with answers.
  - Offer solutions for any problems that you present them.

#### **Message Development**

- Prioritise the information to share with your audience(s) and avoid presenting nonessential information.
- For most presentations, select only the three to five most important points. Most people can keep only three to five pieces of information in their minds at any one time. If you limit what you present, you will not overwhelm your audience.
- As you craft your messages, identify possible actions for your audience(s) to take. This will help them stay focused, and will also appeal to their sense of logic; they will see the connection between data and action.
- Avoid presenting only negative information. Too much negative information may create a sense of helplessness, and may also suggest that change is impossible.

#### **Formats for Presenting Data**

If it is feasible, use several formats for elaborating your points, including:

- Numerical data, presented in lists or tables
- Visual data, presented in graphs
- Narrative formats (e.g., stories, reports, two-page information sheets)

#### **References**

ACQUIRE Project. 2008. *Facilitative supervision for quality improvement: Trainer's manual*. New York: EngenderHealth.

Fistula Care. 2011. *Data for decision making in fistula care: A supplemental module for facilitative supervision*. New York: EngenderHealth.

## PARTICIPANT HANDOUT 6-M

### Presenting and Disseminating Data Exercise

#### Exercise Instructions

Each group will have approximately 30 minutes to:

1. Analyse and interpret their assigned data
2. Create a graph that effectively displays this data
3. Identify who would be interested in this data (i.e., the audience)
4. Analyse that audience
5. Select and develop two or three key messages
6. Prepare a brief (approximately three-minute-long) presentation that appropriately communicates those messages to that audience
7. Assign a presenter

#### Group 1: Women seeking care, needing repair, and receiving care, by quarter

Quarter	Women seeking care	Women needing repair	Women receiving care
Q1	95	80	74
Q2	74	65	59
Q3	99	92	75
Q4	102	60	51

#### Group 2: Complications among fistula repair clients, 2008 and 2009

Complications	2008	2009
Minor postoperative complications related to perceived success of surgery	15	8
Major surgical complications	3	6
Minor complications related to anaesthesia	1	4

#### Group 3: Outcome of fistula repair surgery at time of discharge, by type of fistula

Outcome	Urinary Fistula only/ Urinary and RVF	RVF only
Closed and dry	141	43
Closed with remaining incontinence	114	22
Not closed	15	4

## TRAINER'S RESOURCE 6-I

### Module 6 Evaluation and Answer Key

#### TRAINING TIP

Based on the sessions and content covered, select approximately 20 relevant questions for the Module 6 Pretest and/or Posttest. The correct answers are shown below in **boldface** and the source of the correct answer is shown in [brackets].

1. Using data for decision making is a process that consists of:
  - a. Obtaining, analysing, and interpreting data
  - b. Making decisions based on such data
  - c. Taking actions based on such data to strengthen the delivery of services
  - d. All of the above**[Participant Handout 6-A]
  
2. Monitoring continuously tracks performance against what was planned by collecting and analysing data on predetermined indicators.
  - a. True**
  - b. False[Participant Handout 6-A]
  
3. The performance information generated from monitoring \_\_\_\_\_.
  - a. Enhances learning from experience
  - b. Improves decision making
  - c. Both A and B**
  - d. None of the above[Participant Handout 6-A]
  
4. Evaluation is a one-time, quick analysis of performance.
  - a. True
  - b. False**[Participant Handout 6-A]

Evaluation is a periodic, in-depth analysis of performance.
  
5. Which of the following are sources of information used in evaluation?
  - a. Data generated through monitoring activities
  - b. Information obtained from studies and research
  - c. Information obtained from in-depth interviews, focus group discussions, and surveys
  - d. All of the above**[Participant Handout 6-A]
  
6. Which of the following is a unit of quantitative or qualitative information that provides a simple and reliable way to measure achievement, assess performance, or reflect changes connected to an activity or service?
  - a. Data element
  - b. Indicator**
  - c. Outcome
  - d. None of the above[Participant Handout 6-A]

7. Some of the reasons for monitoring and evaluation of services include:
- Adjusting plans
  - Identifying best practises
  - Supporting advocacy and resource mobilisation
  - All of the above**
- [Session 1, Part A, Activity 3]
8. \_\_\_\_\_ is the routine collection, compilation, and analysis of data on individuals over time and across service delivery points.
- Client monitoring**
  - Monitoring of services
  - Both A and B
  - None of the above
- [Participant Handout 6-B]
9. Monitoring of services requires many types of information (e.g., demographic, medical, psychosocial, financial, etc.) including aggregated client data.
- True**
  - False
- [Participant Handout 6-B]
10. Which of the following are the primary data sources of key monitoring indicators for fistula care services?
- The client register
  - The client record
  - Both A and B**
  - None of the above
- [Session 2, Part A, Activity 2]
11. The fistula repair indicator “Number of women discharged this quarter who experienced complications” would be used for decision making regarding resource requirements (equipment, supplies, etc.).
- True
  - False**
- [Participant Handout 6-C]  
The indicator is used for identifying areas needing improvement (e.g., complications, quality of care).
12. What role do nurses and midwives play in relation to client monitoring and monitoring of services?
- Nurses and midwives are responsible for client monitoring and responsible for documenting client data.
  - Service monitoring depends on client monitoring data and its accurate documentation.
  - Both A and B**
  - None of the above
- [Session 2, Part B]

13. The statement, *Data must be valid, correct and free from error; documentation should reflect information factually*, describes which dimension of data quality?
- Accuracy**
  - Timeliness
  - Accessibility
  - None of the above
- [Participant Handout 6-D]
14. The statement, *Doctors' notations are undecipherable and include nonstandard symbols*, is a negative example of which data quality dimension?
- Reliability
  - Completeness
  - Both A and B
  - None of the above**
- [Session 3, Part A, Activity 2]  
This is a negative example of Legibility.
15. An example of a logical impossibility in a client record would be a pregnant woman with a date of birth in the early twentieth century.
- True**
  - False
- [Participant Handout 6-E]
16. Examples of transcription errors include:
- Transposition
  - Extra or Missing Zeros
  - Miscopied Data
  - All of the above**
- [Participant Handout 6-E]
17. All of the elements needed in order to assure that quality data are part of routine practise are beyond nurses' and midwives' control.
- True
  - False**
- [Session 3, Part C, Activity 1]  
Ensuring data quality starts with nurses' and midwives' awareness of its importance and commitment to it.
18. Evidence-based practise (EBP) refers to \_\_\_\_\_.
- The use of research and scientific studies as a basis for determining best practises in a particular field
  - The conscientious integration of best research evidence with clinical expertise and client values and needs in the delivery of quality, cost-effective health care
  - Both A and B**
  - None of the above
- [Participant Handout 6-G]
19. In nursing and midwifery, the overriding purpose of research is improving outcomes.
- True**
  - False
- [Participant Handout 6-G]

20. Qualitative research produces \_\_\_\_\_ findings.
- Numerical
  - Descriptive**
  - Both A and B
  - None of the above
- [Participant Handout 6-G]
21. Quantitative research involves \_\_\_\_\_.
- Statistical analysis of data from records and reports
  - The use of methods such as surveys, questionnaires and structured interviews
  - Both A and B**
  - None of the above
- [Participant Handout 6-G]
22. Qualitative research methods include \_\_\_\_\_.
- Unstructured interviews
  - Focus group discussions
  - Direct observation
  - All of the above**
- [Participant Handout 6-G]
23. Examples of quantitative findings relevant to fistula care are:
- The percentage of fistula repairs with a closed and dry outcome at a given site over a given time period**
  - The emotional and social impacts of fistula on women living with fistula
  - Both A and B
  - None of the above
- [Participant Handout 6-G]
24. Research on fistula and fistula care is quite extensive; nurses and midwives working in fistula care are unlikely to be involved in research studies.
- True
  - False**
- [Session 4, Part B, Activity 1]  
 Research on fistula and fistula care is limited and nurses and midwives working in fistula care may take part in research studies and make important contributions to them.
25. Which of the following statements about lists are true?
- Bullets or numbers can make lists easier to follow and understand.
  - Numbered lists work best for presenting sequential data
  - Both A and B**
  - None of the above
- [Participant Handout 6-I]
26. The table below includes totals for columns, rows, and the whole table.

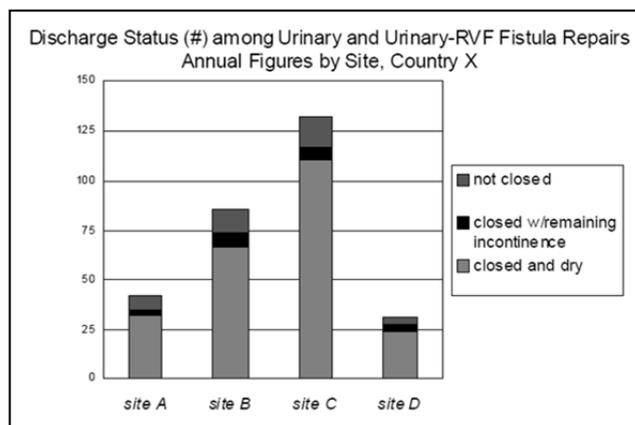
Repair type	Quarter 1 repairs	Quarter 2 repairs
Urinary fistula only	143	156
Both urinary fistula and RVF	9	7
RVF-only	3	1

- a. True
- b. False**

[Participant Handout 6-J]

This table does not include any totals.

27. The graph below is an example of a \_\_\_\_\_.



- a. Stacked bar graph
- b. Stacked column graph**
- c. 100% stacked column graph
- d. None of the above

[Participant Handout 6-K]

28. Which of the following statements about line graphs are true?

- a. Line graphs are often used to show trends across time.
- b. The line connects a series of data points over time.
- c. Line graphs can have a single line or multiple lines.
- d. All of the above**

[Participant Handout 6-K]

29. Pie graphs \_\_\_\_\_.

- a. Are good for highlighting the majority value
- b. Are an effective way to show the relative size of a sector in comparison to the whole
- c. Both A and B**
- d. None of the above

[Participant Handout 6-K]

30. For most presentations, select only the \_\_\_\_\_ most important points.

- a. 3—5**
- b. 7—10
- c. 12
- d. None of the above

[Participant Handout 6-L]

## **TRAINER'S RESOURCE 6-2**

### **Examples of Monitoring and Evaluation Terms in Nursing and Midwifery**

**Analysis:** The process of systematically applying statistical techniques and logic to interpret, compare, categorise, and summarise data collected in order to draw conclusions.

*Example:* Monitoring fistula case outcomes at discharge to measure programme performance

**Data:** Specific quantitative and qualitative information or facts that are collected and analysed.

*Example:* Recorded observations in numeric or textual form

**Data collection:** Systematically gathering information on predetermined indicators.

*Example:* Data collection methods may include the review of records, surveys, or interviews.

**Data element:** A basic unit of information built on standard structures having a unique meaning and distinct units or values.

*Examples:* Blood pressure reading; “closed and dry” status postfistula repair

**Impact:** The long-term or ultimate effect attributable to an activity or service, including changes—whether planned or unplanned, positive or negative, direct or indirect, primary or secondary—that an activity or service helped to bring about.

*Example:* Effective use of ARV resulting in improved health, return of fertility, with unanticipated conception

**Indicator:** A unit of quantitative or qualitative information that provides a simple and reliable way to measure achievement, assess performance, or reflect changes connected to an activity or service.

*Example:* The number of women receiving fistula repair services during the quarter

**Input:** A financial, human, material, technological or information resource needed to implement an activity or service (such as funding, personnel, facilities, equipment, and policies).

*Example:* Equipment, supplies, medication specific for the needs of a facility providing emergency obstetric care (EMOC); personnel trained to perform cesarean sections to a specified standard

**Objective:** A statement defining a desired result that an activity or service seeks to achieve by or during a specified time period.

*Example:* By 2015, X organisation will have established simple fistula services at four of their 12 district hospitals

**Outcome:** The short- to medium-term result of an activity's or service's output; it represents a change that occurs between the completion of the output and the achievement of the impact.

*Example:* Training of fistula care counselors in family planning has resulted in increased uptake of family planning by women postrepair

**Output:** The immediate result of processes or activities.

*Example:* The number of individuals trained, number of clients using services, or number of supervisory visits conducted

**Process:** An activity in which inputs are used in a specific way to achieve desired results.

*Example:* Training with practicum, on-site mentoring during service delivery, or coaching during supervisory visits

**Qualitative Data:** Information that is nonnumeric (i.e., rendered in words) and describes attributes, characteristics, or behaviours that can be observed but not measured (e.g., religion, socioeconomic status, opinions, attitudes).

*Example:* Gender dynamics, socioeconomic status, satisfaction with treatment during service delivery

**Quantitative Data:** Information that is numerical and can be counted.

*Example:* Clients treated (e.g., procedures performed) or measured (e.g., weight, height)

**Record Keeping:** A defined process for documenting information using designate tools. Accurate record keeping (either manual or computerised) helps facilitate client tracking, continuity of care, and also provides data for reporting, monitoring, and decision making.

*Example:* Client records, clinic register, stock inventory forms

## **TRAINER'S RESOURCE 6-3**

### **Fistula Care Data Success Stories**

A study at a hospital in Bangladesh reviewed the records of women who had had a caesarian delivery. One objective of the study was to assess the quality of record keeping and reporting within the context of caesarean delivery services. As part of this study, maternity in-charges and maternity staff (including surgical, nursing and information systems staff) were asked the following question about data on labour and delivery outcomes and procedures, “Can you give me an example of the types of decisions which are/were made based on review of your data?” At one facility, the response was: “Practises that changed as a result of wound infection data being discussed at a data review meeting included: a separate operating theatre for caesarean sections only.”

*Source:* Fistula Care. 2011. *Retrospective record review of indications for cesarean deliveries at Kumudini Hospital, Bangladesh: Study report.* New York: EngenderHealth/Fistula Care.

Another study of caesarian deliveries was conducted at a hospital in Uganda. There, the Maternity Unit data are reviewed on a quarterly basis. Maternal and neonatal deaths are reviewed immediately during rounds and occasionally during continuing medical education (CME) sessions. Because the hospital staff periodically review data, key informants were able to give examples of decisions that have been made based on review of the periodic data from Maternity Unit. Examples of decisions taken include:

- The number of beds in Maternity Unit was increased from 37 to 50 after analyzing the bed occupancy rate, which was over 100%, with many clients lying on the floor.
- By analyzing the annual institutional cesarean section rate (which was more than 50% prior to 2008), the chief of obstetrics urged all doctors and surgeons working in the Maternity Unit to carefully assess all the referrals for possible wrong cesarean section indications.
- Management staff have also attempted to reduce the hospital stay in the Maternity Unit by (a) hiring another obstetrician on a part-time basis to help in assessing women following delivery, (b) ensuring the unit always has a general practitioner attached to them, and (c) insisting that the working schedule for Maternity Unit has a on-call doctor at all times.

*Source:* Fistula Care. 2010. *Retrospective record review of indications for cesarean deliveries at Kitovu Hospital, Uganda: Study report.* New York: EngenderHealth/Fistula Care.

## TRAINER'S RESOURCE 6-4

### Assessing Data Quality Exercise—Answer Key

#### Example I (Mabel Solo)

REG. No : 0644381 Dr. Massa

NAME : Mabel Solo HOSPITAL.....Fairville.....IP No.

AGE : 22 TRIBE:

ADDRESS : Referred by: Bytheway HC

HEIGHT : 4' 9" Weight: 38.5 Kg

CLASSIFICATION of FISTULA : VVF

AGE at which fistula developed : 17 years old

DURATION of leakage : 17 years

OUTCOME of delivery, causing fistula : stillbirth

CAUSE of FISTULA: Obstetric (no CS related) : Obstetric (no CS related)

Obstetric (CS related) :

Hysterectomy :

Other causes :

PARITY when fistula developed : 0

DURATION of labour : >24 days

INTERVAL between delivery and leakage : 4 weeks

SEX of infant : female

CONDITION of infant : poor WEIGHT: 3 KG

PREVIOUS deliveries : 0

SUBSEQUENT deliveries : 0

SUCCESSFUL VVF-repair in the past : No at repair attempts made

UNSUCCESSFUL VVF-repair in the past :

MENSTRUATION : No

SOCIAL STATUS

Living with husband, yes or no : No. Other Wife: None known

Living with family, yes or no : Yes.

Living alone, yes or no : No.

Remarried (with fistula) : No

Single/Never married : Yes

Husband died : No

EDUCATION woman: Standard 3 EDUCATION partner: Standard 6

PROFESSION woman: Used to be a merchant PROFESSION partner: Mechanic's assistant

CONCURRENT LESIONS

RVF : No

Paralysis perineal nerve : No

Pressure sores (excoriations) : No

Vaginal stenosis : Don't know

Others : Severely underweight

Condition of woman : Fair

DATE and KIND OF REPAIR : TBS

POSTOPERATIVE COMPLICATIONS :

OUTCOME: Dye test, pos. or neg. : FOLLOW-UP: Dye test, pos. or neg. :

DATE Incontinence : DATE Incontinence :

Vagina : Vagina :

Catheter removed : Menstruation :

: Pregnancy :

## Example 2 (Mercy Kastor)

Tamaranda Hospital Fistula Care Services: Client Record

Date: January 6, 2010

Patient ID Number: \_\_\_\_\_

### Personal Data

1. **Patient Name:** Mercy Kastor
2. **Age:** 35 years old
3. **Marital status:** (single, **married**, divorced, widowed)
4. **Age at Marriage:** 17
5. **Home/Village (postal address):** Plot 269, Semperi
6. **Contact information for a relative:** Esther Kastor, Mother, Plot 268, Semperi
7. **Living with husband?** No                      **Living with family?** Yes
8. **Ethnic group:**
9. **Religion:** Christian
10. **Highest schooling:** Form 5
11. **Date of Arrival:** December 20, 2010
12. **Referred by/from:** Government Hospital, Waverly
  - a. If not referred, how did you hear about this service?

### History

13. **Age at first pregnancy:** 17
14. **Number pregnancies:** 4 premature births 0 abortions 1 stillbirths 1 number of living children 3.
15. **When was the last baby born?** 10 months ago.                      **Condition of baby at birth?** Dead
16. **Labor complications:** "baby in wrong position"
17. **Type of deliveries:** (c-section, forceps, vacuum, vaginal) – vaginal
18. **When did leaking/soiling begin?** 9 months ago
19. **Has been to hospital for treatment?**                      **Results?**

### General Examination

20. **Height:** 182 cm
21. **Weight:** 90 kg
22. **Vital signs:**
23. **Heart:**
24. **Lungs:**
25. **Abdomen:** no scars, no enlarged organs
26. **Pelvic:** VVF                      **Dx:** medium sized fistula;

### Management

27. **Procedure:** Repair of fistula via vaginal approach
28. **Date:** January 10, 2011
29. **Pre-procedure preparations:** Blood type AB+
30. **Complications:** Developed a fever of unknown origin on postoperative day 3; treated with IV antibiotics

### Discharge:

31. **Outcome:** Closed & Dry; Wet: Stress incontinence – mild, moderate, severe
32. **Counseling:** Self-care x; sexual relations x; family planning       ; future pregnancies & deliveries by c-section x; and, Follow-up       .

## TRAINER'S RESOURCE 6-5

### Fistula Care–Related Research

#### TRAINING TIP

Identify several fistula care-related research articles for the participants to read as a homework assignment.

- If there are eight or fewer participants, select two articles.
- If there are nine to 12 participants, select three articles
- If there are more than 12 participants, select four articles.

#### Sources of Fistula Care–Related Research Articles

Campaign to End Fistula—Global Network Reference Centre

[http://www.fistulanetwork.org/FistulaNetwork/?option=com\\_content&task=reference&id=31](http://www.fistulanetwork.org/FistulaNetwork/?option=com_content&task=reference&id=31)

*Note:* This site requires registration at no cost for health care professionals.

EngenderHealth Technical Publications and Resources

<http://www.engenderhealth.org/pubs/maternal/fistula.php>

Fistula Care Project—Research Reports

<http://www.fistulacare.org/pages/resources/publications/research-reports.php>

Fistula Care Project—Virtual Research Center

<http://www.fistulacare.org/pages/resources/vrc/>

*Note:* The site says that only Fistula Care Project partners can download references in their entirety, but Google searches seem to bypass this.

*The Lancet*

<http://www.thelancet.com/home>

*Note:* This site requires registration at no cost for health care professionals.

#### Links to Sample Fistula Care–Related Research Articles

“Health of Women after Severe Obstetric Complications in Burkina Faso: A Longitudinal Study”

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61574-8/fulltext?\\_eventId=login](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61574-8/fulltext?_eventId=login)

“Making Motherhood Safer by Addressing Obstetric Fistula (OF)”

[http://www.endfistula.org/docs/south\\_africa\\_october2005.pdf](http://www.endfistula.org/docs/south_africa_october2005.pdf)

“Risk and Resilience: Obstetric Fistula in Tanzania”

<http://www.engenderhealth.org/files/pubs/maternal-health/Risk-and-Resilience-Obstetric-Fistula-in-Tanzania.pdf>

“Sharing the Burden: Ugandan Women Speak About Obstetric Fistula”

<http://www.engenderhealth.org/files/pubs/localized/uganda/Sharing-the-Burden-Ugandan-Women-Speak-About-Obstetric-Fistula.pdf>

For the homework reading assignment, you have two options depending upon the resources available:

- Provide the participants with the title and URL for their assigned article and have them access it online
- Download the articles, make copies of them, and distribute them to the participants

### Sample Answers to Discussion Questions

For the article “Risk and Resilience: Obstetric Fistula in Tanzania,” discussion questions and answers are:

1. Briefly describe the research project in the article, including its purpose, focus, location, and key findings.

**Answer:**

- The purpose of this study was to understand the many dimensions of fistula and its related social vulnerability through the experiences and views of girls and women living with fistula as well as their families and communities and the health workers who care for them. The study also explored the participants’ recommendations on locally appropriate solutions to prevent and manage fistula.
- The study was conducted in three districts of Tanzania: Singida Rural, Songea Rural, and Ukerewe. Additional interviews were conducted with clients at a partner hospital in Mwanza.
- The six major findings and recommendations from the study are:
  - Fistula affects girls and women of all ages, both at first pregnancy and in later pregnancies.
  - Antenatal care services, while widely available and used, are inconsistent and inadequate.
  - The lack of birth preparedness, including basic information on childbirth and taking action around “delays,” increases risk.
  - Lack of access to emergency caesarean section poses a great threat to women’s lives.
  - The cost and inaccessibility of quality fistula repair services represent a barrier to care for many girls and women.
  - Even though most women with fistula have support from others, the emotional and economic impacts of fistula are substantial for the woman herself, as well as for her family.

2. Did the article use quantitative research, qualitative research, or both types of research?

**Answer:** Quantitative research

3. What did you think was the most important finding of this article?

**Answer:** The need to save money for transportation and delivery costs; the fact that transportation to the proper health care facility was often unaffordable or unavailable (because of poor roads).

4. How could you apply the research findings to fistula care services at your facility?

**Answer:**

- Community education efforts must inform people that all women (regardless of age) are potentially at risk of obstetric fistula.
- Health care workers require specific training in appropriate, effective, and respectful communication with a variety of clients, including nondiscriminatory communication to vulnerable populations such as poor, disabled, and other marginalised girls and women.
- Advocacy, support, and reintegration efforts should be instituted to mitigate the emotional and economic impacts of fistula.

## TRAINER'S RESOURCE 6-6

### Table and Graph for Session 5 Prepared Flipcharts

#### Part A, Activity 2

Prepare the following flipchart pages:

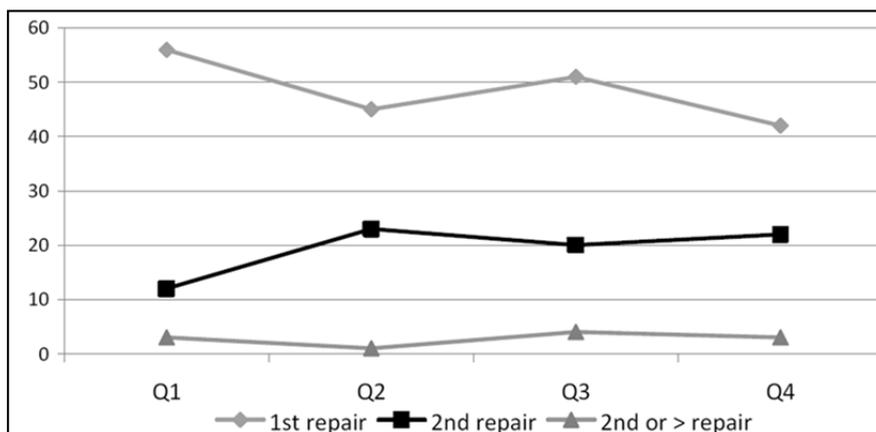
- Table

**Women seeking care, needing repair, and women receiving care, by quarter, 2008**

Quarter	Women seeking care	Women needing repair	Women receiving care
Q1	95	80	74
Q2	74	65	59
Q3	99	92	75
Q4	102	60	52

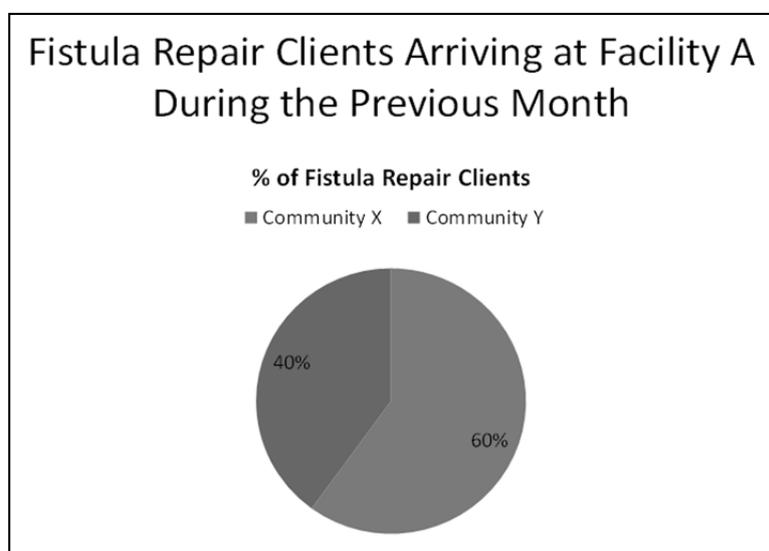
- Graph

**Surgery repair order among women getting surgery, by quarter, 2009**



#### Part B, Activity 2

Prepare the following flipchart page:



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# **APPENDIX A: PRACTICA: FISTULA CARE SKILLS CHECKLISTS**

- Use of the Partograph
- Urinary Catheterisation
- Physical Assessment
- Preoperative and Postoperative Care
- Counselling
  - First Contact
  - Clinical Intake
  - Admission and Preoperative Period
  - Intraoperative Period, Spinal Anaesthesia
  - Intraoperative Period, General Anaesthesia
  - Postoperative Period
  - Discharge and Follow-Up



## Fistula Care Skills Checklist: Use of the Partograph

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

S = Satisfactory (done correctly and consistently)

NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance using the partograph. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in partograph skills.

*Note:* The modified WHO partograph begins with the space for active phase of labour.

Task	1	2	3	Comments
1. Welcome client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Fill out client information at top of partograph (name, age, gravida/para, hospital number, date and time of admission, time labour started, time of rupture of membranes).				
5. Correctly record cervical dilatation on partograph.				
6. Record time of exams in correct space.				
7. Correctly record descent of presenting part hourly in active phase and before each vaginal examination.				
8. Feel uterine contractions for 10 minutes to determine strength, frequency, and duration. <ul style="list-style-type: none"> <li>• Correctly record findings on partograph using standard symbols.</li> <li>• Monitor contractions every 30 minutes in active phase.</li> </ul>				
9. Monitor maternal temperature, pulse, respirations, and blood pressure at least every four hours and correctly record on partograph.				

<b>Task</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>Comments</b>
10. Monitor maternal urine output every two hours, correctly recording colour and amount and presence of glucose, acetone, or protein on partograph.				
11. Correctly record fluid intake (IV, p.o.) and drugs administered on partograph.				
12. Correctly record oxytocin on partograph when augmentation/ induction is in progress.				
13. Take foetal heart rate at least every hour and correctly record on partograph.				
14. If membranes are ruptured, record status of membranes and condition of amniotic fluid under foetal heart rate, using standard code.				
15. Record presence and/or condition of moulding during each vaginal exam, using standard symbols.				
16. Complete the second/back page of partograph with requested information.				
17. Sign and date the partograph as the birth attendant.				
18. Correctly identify deviations from norm in labour assessment and take appropriate, timely nursing or midwifery action.				
19. Correctly identify deviations that require medical intervention or emergency obstetrical care and consult with doctor; stabilise and refer the client for more skilled care if labour is being managed at a site that cannot handle emergency obstetric conditions.				
20. Document consultation and proposed medical management and/or emergency obstetrical care on partograph.				
21. Carry out nursing or midwifery tasks as directed by doctor during emergency obstetrical care.				
22. When appropriate, fill out partograph or client record with findings from fourth stage monitoring of mother and baby (every 15 minutes during first two hours; every 30 minutes during third hour).				
<b>Additional Comments</b>				

## Fistula Care Skills Checklist: Urinary Catheterisation

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in catheterisation skills.

Task	1	2	3	Comments
1. Welcome client.				
2. Make introductions.				
3. Gather equipment and supplies* for catheterisation.				
4. Introduce yourself and explain what you are going to do.				
5. As you perform catheterisation, explain what you will do next before taking each action.				
6. Wash your hands.				
7. Help client into the supine position with legs spread and feet together.				
8. Protect client's privacy using screens or visual barriers.				
9. Aseptically open catheterisation kit and catheter.				
10. Prepare sterile field.				
11. Put on sterile gloves.				
12. Check balloon for patency.				
13. Generously coat distal portion of catheter with sterile lubricant (2 to 5 cm).				
14. Apply sterile drapes.				
15. Using nondominant hand, separate labia and identify urethral meatus.				
16. Using dominant hand to hold forceps, cleanse the periurethral mucosa with cleansing solution.				

Task	1	2	3	Comments
17. Cleanse anterior to posterior, inner to outer, one swipe per swab.				
18. Discard swabs away from the sterile field.				
19. Keeping labia separated, pick up catheter with sterile, gloved hand while holding end of catheter loosely coiled in palm of dominant hand.				
20. Identify urinary meatus; gently insert catheter 1 to 2 cm beyond where you observe urine.				
21. Inflate balloon, using the correct amount of sterile liquid (usually 5 cc).				
22. Gently pull catheter until inflated balloon is snug against bladder neck.				
23. Connect catheter to drainage system.				
24. Secure catheter to client's abdomen or thigh without tension on tubing.				
25. Place drainage bag below the level of the bladder or attach silicone tubing to catheter and extend it into drainage bucket.				
26. Remove gloves.				
27. Correctly dispose of equipment, following standard precautions; wash your hands.				
28. Document size of catheter inserted, amount of water in balloon, client's response to procedure, and your assessment of urine.				
<b>Additional Comments</b>				

### \*Equipment and Supplies

- Sterile gloves
- Sterile drapes
- Antiseptic solution (e.g., Savlon)
- Cotton swabs
- Forceps
- Sterile water (usually 10 cc)
- Foley catheter (usually 16 to 18 French)
- Syringe (usually 10 cc)
- Lubricant (sterile water-based jelly, such as K-Y jelly, or xylocaine [lidocaine] jelly)
- If using urinary bags: collection bag, tubing
- If using the “drink, drip, and dry method”: straight, clean silicone tube, small bucket with lid

## Fistula Care Skills Checklist: Physical Assessment

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in physical assessment skills.

Task	1	2	3	Comments
1. Welcome client.				
2. Make introductions.				
3. If a pelvic examination is to be done, gather equipment and supplies.*				
4. Introduce yourself and explain what you are going to do.				
5. As you perform the assessment, explain what you will do next before taking each action.				
6. Help client into supine position.				
7. Inspect client's abdomen for scars or swellings.				
8. Palpate client's abdomen for masses and pain.				
9. Help client into lithotomy or Sims position.				
10. Protect client's privacy using screens or visual barriers.				
11. Position light source for optimal visualization.				
12. Put on examination gloves.				
13. Inspect vulva (looking for visible urinary meatus, vaginal stenosis or occlusion) and inner thighs (looking for urine dermatitis).				
14. Cleanse vulva with antiseptic solution, moving from front to back, once with each swab.				

Task	1	2	3	Comments
<p>15. Lubricate index finger; gently insert it into vagina to:</p> <ol style="list-style-type: none"> <li>Determine patency and depth</li> <li>Palpate cervix</li> <li>Identify presence of: <ul style="list-style-type: none"> <li>Fibrous tissue in vaginal walls</li> <li>Shortened anterior vaginal wall</li> <li>Defect in anterior vaginal wall (VVF)</li> <li>Defect in posterior vaginal wall (RVF)</li> </ul> </li> </ol>				
16. <i>Alternatively:</i> Inspect the vagina using a Sims speculum.				
<p>17. If fistula cannot be seen but woman complains of wetness:</p> <ol style="list-style-type: none"> <li>Ask client to drink a large amount of water.</li> <li>Position client in either left lateral position with right leg supported or lithotomy position.</li> <li>Insert a Sims speculum, exposing the anterior vaginal wall.</li> <li>Ask client to cough and observe for visibility of fistula.</li> </ol>				
<p>18. <i>Alternatively:</i> Perform a dye test:</p> <ol style="list-style-type: none"> <li>Have ready three dry cotton swabs for insertion into vagina.</li> <li>Dilute methylene blue or gentian violet.</li> <li>Insert urinary catheter.</li> <li>Fill catheter balloon with sterile water, water for injection, or normal saline.</li> <li>Insert dry cotton swabs, one at a time, the length of vagina.</li> <li>Slowly instill ~60 cc of dye solution into bladder.</li> <li>Wait one minute; then ask client to cough.</li> <li>Remove one cotton swab at a time, inspecting for presence of dye or wetness from urine. [<i>Note:</i> Dye on any swab, depending upon where swab was, indicates a fistula or leakage from the urethra. Wetness without dye on the swab (distal) from the pouch of Douglas indicates possible ureterovaginal fistula outside the bladder. If swab is not dyed but is wet, refer for IVU to rule out ureterovaginal fistula.]</li> <li>If none of swabs are stained, inform doctor or refer for further assessment.</li> </ol>				

<b>Task</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>Comments</b>
19. Discard used supplies according to infection prevention protocols.				
20. Remove gloves and wash hands.				
21. Document results of examination in client record.				
22. Share findings with client.				
23. Share findings with doctor managing fistula repair.				
<b>Additional Comments</b>				

### **\*Equipment and Supplies**

- Examination gloves
- Foley catheter
- Uterine sound
- Metal catheter
- Bladder syringe, 60cc with big nozzle
- Syringe, 5 to 10 cc
- Observation chart
- Sims or vaginal speculum
- Betadine or Savlon
- Methylene blue or gentian violet
- Gauze
- Probe
- Water-soluble lubricant
- Kidney basin
- Cotton swabs or balls
- Sponge-holding forceps
- Light source that can be positioned

## Fistula Care Skills Checklist: Preoperative and Postoperative Care

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in preoperative and postoperative care.

Task	1	2	3	Comments
<b>Preoperative Care: Initial</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Explain to client preparatory activities that support optimal surgical outcomes: a. Teach client to take sitz bath twice daily. b. Provide high-protein diet. c. Administer iron supplement and antihelminthics. d. Encourage client to drink at least 5 L of fluids daily. e. Teach preoperative exercises, including pelvic floor exercises. f. Assist client with exercises that require assistance.				
5. Carry out informed consent procedure, obtaining client's signature or mark on consent form.				
<b>Preoperative Care: Two Days before Surgery</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Provide client with light diet only (potatoes, rice, noodles/pasta, clear soup, low-fibre bread/cereals).				
5. Administer rectal washout with warm, soapy water, repeating until return water is clear.				

Task	1	2	3	Comments
6. For rectovaginal fistula repairs, administer 30 cc castor oil with plenty of water or <b>two</b> enemas, depending on surgeon's orders.				
7. Determine with surgeon if blood will be needed; work with client to identify donor.				
<b>Preoperative Care: Day/Night before Surgery</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Check that informed consent form is signed or marked by client and signed by surgeon.				
5. Allow nothing by mouth after midnight or encourage high-fluid intake, as per surgeon's orders.				
6. Administer preoperative medication(s), as per surgeon's orders or local protocol.				
7. Administer prophylactic antibiotics, as per surgeon's orders.				
<b>Day of Surgery</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Check client's ID band and records to ensure that correct person is being taken to operating theatre.				
5. Wash and clip pubic hair from labia and perineum, depending on surgeon's orders or local protocol.				
6. Take vital signs, recording in appropriate forms/records.				
7. Help the anaesthetist explain the anaesthetic procedure to client and what she can expect.				
8. Insert IV or assist with insertion of the IV line, monitoring flow of IV fluids as per surgeon's order.				
9. Assist in transferring client to operating theatre.				
<b>Postoperative Care: Immediate in Recovery Room</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Prepare bed and space to receive client from surgery.				
5. Have ready the BP machine, stethoscope, thermometer, and IV stand.				
6. Prepare vital signs and fluid balance forms and place them at bedside; include client's name, identifying information, and surgeon's name on forms.				

Task	1	2	3	Comments
7. Receive client with report from operating theatre nurse.				
8. If client received general anaesthesia, take vital signs: a. Every 15 minutes for first postoperative hour b. Then every 30 minutes for the next three hours c. Then twice daily				
9. If client received spinal anaesthesia, take vital signs: a. Every 30 minutes for four hours b. Then twice daily				
10. Check urinary catheter for patency (making sure it is not twisted or kinked), noting colour and amount of urine.				
11. Check for bleeding in vaginal area (checking also for saturation of pack) and around urinary catheter.				
12. Record findings in client's record and fluid balance chart.				
13. Assess client's pain, providing analgesia according to surgeon's orders or local protocol.				
14. Notify surgeon if there are any concerns, bleeding, signs of shock, or anuria.				
15. Facilitate transfer to postoperative ward according to surgeon's orders or local protocol.				
<b>Postoperative Care: Within First 24 Hours Postoperatively</b>				
1. Greet client.				
2. Make introductions.				
3. Protect client's privacy and confidentiality.				
4. Check vital signs: a. Every 30 minutes for the next four hours b. If stable after the first five hours, check vital signs every four hours thereafter.				
5. Check for bleeding: a. Vaginal b. Around urinary catheter				
6. Check the urinary catheter for position, twisting, or kinking, noting colour and amount of urine.				
7. Record findings in client's record and fluid balance chart.				
8. Assess client's pain, providing analgesia according to surgeon's orders or local protocol.				
9. Initiate continuity of care beyond the first 24 hours with fistula repair team.				

## Fistula Care Skills Checklist: Counselling—First Contact

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client at first contact.

**Note:** The woman should be encouraged to allow her spouse and/or family members to attend the counselling session, if such participation is in her best interest.

Task	1	2	3	Comments
1. Welcome client.				
2. Make introductions.				
3. Ensure confidentiality.				
4. Assess whether counselling is appropriate at this time (if it is not, arrange for client to be counseled at another time).				
5. Introduce subject of obstetric fistula.				
6. Explore client's needs, problems, and concerns.				
7. Assess client's knowledge and give information as needed: a. Provide directions to appropriate unit. b. Provide information that client needs about her condition; include any further details requested by client. c. Address any myths and misconceptions, as appropriate.				
8. Identify decisions client needs to make in this session.				
9. Identify client's options for each decision.				
10. Weigh benefits, disadvantages, and consequences of each option with client.				

Appendix A: Practica: Fistula Care Skills Checklists

<b>Task</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>Comments</b>
11. Help client make her own realistic decisions, sharing comparable stories or anecdotes, as appropriate.				
12. Help client make concrete, specific plan for carrying out her decisions.				
13. Identify skills with client that she needs to carry out decisions.				
14. Help client practise skills as needed.				
15. Make plan for follow-up.				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Clinical Intake

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client at clinical intake.

**Note:** The woman should be encouraged to allow her spouse and/or family members to attend the counselling session, if such participation is in her best interest.

Task	1	2	3	Comments
1. Meet with clinician responsible for client and read clinician's notes about client in order to know what clinical findings are, what laboratory and other investigations are foreseen, what procedures and surgery are contemplated, and what prognosis is likely.				
2. Welcome client.				
3. Make introductions.				
4. Ensure confidentiality: a. Assess whether counselling is appropriate at this time; if it is not, arrange for client to be counselled at another time. b. Ask client if she would like anyone else present during counseling				
5. Reintroduce subject of obstetric fistula.				
6. Explore client's needs, problems, and concerns: a. Explore any attitudes, myths, misconceptions, religious beliefs, fears, or concerns client has about repair surgery. b. Assess client's knowledge and give information, as needed.				

<b>Task</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>Comments</b>
7. Identify decisions client needs to make in this session. Based on client's condition and in consultation with surgical team, provide information about the following, as appropriate: <ol style="list-style-type: none"> <li>a. Overall physical condition</li> <li>b. Results of physical and pelvic examinations and laboratory tests</li> <li>c. Present condition and its causes</li> <li>d. Possibility of treatment and/or treatment options and timing</li> <li>e. Self-care</li> <li>f. Need for referral and transport to another facility</li> <li>g. Procedures to be done and their risks and benefits</li> </ol>				
8. If client's condition is not treatable, provide information on community support networks and on coping strategies for daily life.				
9. Identify client's options for each decision, weighing benefits, disadvantages, and consequences of each option with client.				
10. Help client make her own realistic decisions: <ol style="list-style-type: none"> <li>a. Share comparable stories or anecdotes, as appropriate.</li> <li>b. Help client make concrete, specific plan for carrying out her decisions.</li> </ol>				
11. Identify skills with client that she needs to carry out her decisions.				
12. Help client practise skills, as needed.				
13. Make plan for follow-up: <ol style="list-style-type: none"> <li>a. Arrange for client to talk with other obstetric fistula clients, as appropriate.</li> <li>b. Provide information on available client support groups within facility.</li> </ol>				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Admission and Preoperative Period

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

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NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client at admission and during the preoperative period.

**Note:** The woman should be encouraged to allow her spouse and/or family members to attend the counselling session, if such participation is in her best interest.

Task	1	2	3	Comments
1. Meet with surgeon/surgical staff who are responsible for client and read their notes about client, in order to know what clinical findings are, what laboratory and other investigations are foreseen, what procedures and surgery are contemplated, what preoperative preparation is ordered, and likely prognosis.				
2. Welcome client.				
3. Make introductions: Introduce client to ward staff and other clients in ward.				
4. Ensure confidentiality: a. Assess whether counselling is appropriate at this time; if it is not, arrange for client to be counselled at another time. b. Ask client if she would like anyone else present during counseling.				
5. Reintroduce the subject of obstetric fistula.				
6. Explore client's needs, problems, and concerns, exploring any attitudes, myths, misconceptions, religious beliefs, fears, or concerns client has about repair surgery.				

Task	1	2	3	Comments
<p>7. Assess client's knowledge and give information, as needed. Based on client's condition and in consultation with surgical team responsible for her care, provide information about the following, as appropriate:</p> <ol style="list-style-type: none"> <li>a. Surgical repair (steps, possible exams or lab tests, expected feelings, consent, success rates, possible side effects, complications, and risks) and expected length of hospital stay</li> <li>b. Type of anaesthesia to be used, risks of anaesthesia, pain, and what to expect while being anaesthetized</li> </ol>				
<p>8. As part of preoperative teaching, do the following:</p> <ol style="list-style-type: none"> <li>a. Prepare client and her family for expected events on day of surgery.</li> <li>b. Inform client and her family of expected tubes, therapies, routines, etc.</li> <li>c. Instruct client in preoperative preparation (e.g., bowel preparation, nutrition).</li> <li>d. Instruct client about activities to prevent postoperative complications.</li> <li>e. Address client's fears of: <ul style="list-style-type: none"> <li>• Loss of control</li> <li>• The unknown</li> <li>• Anaesthesia</li> <li>• Pain</li> <li>• Death</li> <li>• Separation</li> <li>• Disruption of life</li> <li>• Changes in body image or functions</li> </ul> </li> </ol>				
<p>9. If client's condition is not treatable, provide her with information on community support networks and on coping strategies for daily life.</p>				
<p>10. Identify decisions client needs to make in this session:</p> <ol style="list-style-type: none"> <li>a. Discuss: client's role in management of condition.</li> <li>b. Identify client's options for each decision.</li> <li>c. Weigh benefits, disadvantages, and consequences of each option with client.</li> </ol>				

Task	1	2	3	Comments
11. Help client make her own realistic decisions: a. Ensure and document informed consent for surgical treatment, making sure that: <ul style="list-style-type: none"> <li>• Client verbalises understanding of preoperative teaching.</li> <li>• Client correctly demonstrates postoperative exercises (i.e., coughing and deep breathing, leg exercises).</li> </ul> b. Share success stories, as appropriate.				
12. Help client make concrete, specific plan for carrying out her decisions.				
13. Identify skills with client that she needs to carry out her decisions.				
14. Help client practise skills, as needed.				
15. Make plan for follow-up: a. Arrange for client to talk with other obstetric fistula clients, as appropriate. b. Provide information on available client support groups within facility.				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum.* New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Intraoperative Period, Spinal Anaesthesia

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

S = Satisfactory (done correctly and consistently)

NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client during the intraoperative period who has undergone spinal anaesthesia.

Task	1	2	3	Comments
During the procedure, never leave the client alone.				
1. Welcome client.				
2. Make introductions: Introduce client to other operating theatre staff.				
3. Ensure confidentiality; speak gently and provide reassurance, comfort, and hope.				
4. Reintroduce subject of obstetric fistula and repair surgery.				
5. Explore client's needs, problems, and concerns.  <b>Before procedure</b> a. Reassure client that you or another caring staff member will be beside her during entire procedure. b. Ask client if she would like you to hold her hand or to just sit next to her during procedure. c. Explain steps of procedure in advance.  <b>During procedure</b> a. Speak reassuringly to client during procedure. b. Assess client's response to anaesthesia/surgery and address any fears, concerns, or questions as they occur. c. Provide information on progress, as appropriate.				

Task	1	2	3	Comments
<p>7. Assess client's knowledge and give information, as needed</p> <p><b>Before procedure</b></p> <ul style="list-style-type: none"> <li>a. Provide or review information on type of anaesthesia to be used, risks of anaesthesia, pain, and what to expect while being anaesthetized.</li> <li>b. Discuss how client will feel as spinal anaesthesia wears off.</li> <li>c. Discuss pain management.</li> </ul> <p><b>Immediately after procedure</b></p> <ul style="list-style-type: none"> <li>a. After consulting with surgeon/surgical staff, review outcome of surgery.</li> <li>b. Discuss again, or update as appropriate, immediate postoperative procedures.</li> <li>c. Ask client if she has any questions, and answer appropriately.</li> </ul>				
<p><b>Additional Comments</b></p>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Intraoperative Period, General Anaesthesia

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

S = Satisfactory (done correctly and consistently)

NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client during the intraoperative period who has undergone general anaesthesia.

Task	1	2	3	Comments
Do not leave the client alone until she is fully anaesthetised.				
1. Welcome client.				
2. Make introductions: Introduce client to other operating theatre staff.				
3. Ensure confidentiality; speak gently and provide reassurance, comfort, and hope.				
4. Reintroduce subject of obstetric fistula and repair surgery.				
5. Explore client's needs, problems, and concerns. <b>Before procedure</b> a. Reassure client that you or another caring staff member will be beside her until she is fully anaesthetised b. Ask client if she would like you to hold her hand or to just sit next to her during procedure. c. Explain steps of procedure in advance (before anaesthesia).				
6. Assess client's knowledge and give information, as needed. <b>Before procedure</b> a. Provide or review information on type of anaesthesia to be used, risks of anaesthesia, pain, and what to expect while being anaesthetized.				

Task	1	2	3	Comments
b. Discuss how client will feel as general anaesthesia wears off, side effects, and pain management.  <b>Immediately after procedure</b> a. After consulting with surgeon/surgical staff, review outcome of surgery. b. Discuss again immediate postoperative procedures. c. Ask client if she has any questions, and answer appropriately.				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum.* New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Postoperative Period

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

S = Satisfactory (done correctly and consistently)

NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client during the postoperative period.

**Note:** The woman should be encouraged to allow her spouse and/or family members to attend the counselling session, if such participation is in her best interest.

Task	1	2	3	Comments
1. Welcome client				
2. Make introductions: Introduce client to other staff.				
3. Ensure confidentiality: a. Assess whether counselling is appropriate at this time (if it is not, arrange for the client to be counselled at another time). b. Ask client if she would like anyone else to be present during counselling.				
4. Reintroduce subject of obstetric fistula and repair surgery.				
5. Explore client's needs, problems, and concerns, exploring any fears or concerns client might have about repair surgery.				
6. Assess client's knowledge and give information, as needed. Based upon client's condition and in consultation with surgical team, provide information about the following, as appropriate: a. Postoperative routines b. Outcome of surgery c. Self-care d. Catheter care				

Task	1	2	3	Comments
<ul style="list-style-type: none"> <li>e. Position and mobility</li> <li>f. Nutrition and hydration</li> <li>g. Pain relief</li> <li>h. Complications and danger signs</li> <li>i. Physiotherapy (if necessary)</li> <li>j. Necessary period of abstinence from sexual intercourse (usually three months)</li> <li>k. Need to delay pregnancy for at least one year after surgery by using family planning</li> <li>l. Need for careful antenatal care and hospital delivery (cesarean section) for future pregnancies</li> <li>m. Availability of sexual and reproductive health services, including family planning</li> </ul>				
7. Identify decisions client needs to make in this session.				
8. Support participation in available client support groups within facility, or if she is not yet participating, provide information on available support groups within facility.				
9. Identify client's options for each decision.				
10. Weigh benefits, disadvantages, and consequences of each option with client.				
11. Help client make her own realistic decision.				
12. Help client make concrete, specific plan for carrying out her decisions.				
13. Identify skills with client that she needs to carry out her decisions.				
14. Help client practise skills, as needed.				
15. Make plan for follow-up.				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.

## Fistula Care Skills Checklist: Counselling—Discharge and Follow-Up

Name \_\_\_\_\_  
 Date 1 \_\_\_\_\_  
 Date 2 \_\_\_\_\_  
 Date 3 \_\_\_\_\_  
 Examiner's name \_\_\_\_\_

### Legend

S = Satisfactory (done correctly and consistently)

NI = Needs improvement (done incorrectly or not consistently done correctly)

NO = Not observed

**Instructions:** Observe the provider's performance. Using the legend above, write the appropriate letters in the boxes for the tasks listed below during at least three progressive observations. When performance is assessed as NI (needs improvement), record comments in the Comments column, describing observations and problem-solving suggestions. Use the space at the end of the checklist to (a) record additional comments or (b) document that the participant has demonstrated consistent competence in counselling a client during the postoperative period.

**Note:** The woman should be encouraged to allow her spouse and/or family members to attend the counselling session if such participation is in her best interest.

Task	1	2	3	Comments
1. Welcome client.				
2. Make introductions: Introduce client to other staff.				
3. Ensure confidentiality a. Assess whether counselling is appropriate at this time; if it is not, arrange for the client to be counselled at another time. b. Ask client if she would like anyone else to be present during counselling.				
4. Reintroduce subject of obstetric fistula and repair surgery				
5. Explore client's needs, problems, and concerns, exploring any fears or concerns client might have about repair surgery and the postoperative course.				
6. Assess client's knowledge and give information, as needed; give client written postprocedure information.				
<b>If surgery was successful</b>				
1. Identify decisions client needs to make in this session				
2. Remind client of possible side effects, risks, and warning signs; develop plan in case complications or warning signs occur				

Task	1	2	3	Comments
3. Discuss with client how to care for herself at home by: <ol style="list-style-type: none"> <li>Observing period of abstinence from vaginal intercourse (usually three months); if rectovaginal fistula was repaired, client will also need to abstain from rectal intercourse</li> <li>Refraining from introducing foreign bodies (e.g., tampons) into vagina</li> <li>Delaying pregnancy for at least one year and using family planning</li> <li>Managing stress incontinence</li> </ol> 4. Discuss reproductive tract infections and sexually infected infections, including HIV.           5. Remind client of importance of follow-up.           6. Identify client's options for each decision           7. Discuss available contraceptive methods, as appropriate.           8. Weigh benefits, disadvantages, and consequences of each option with client.           9. Help client make her own realistic decisions.				
<b>If surgery was unsuccessful</b>				
1. Identify decisions client needs to make in this session. Based on client's condition, provide information about the following, as appropriate: <ol style="list-style-type: none"> <li>Personal hygiene and good nutrition</li> <li>Managing incontinence (e.g., exercises)</li> <li>Delaying pregnancy; using family planning</li> <li>Possible complications, including infection, and what to do about them</li> <li>Cost-effective sources of supplies (e.g., pads, colostomy bags)</li> </ol> 2. Identify client's options for each decision. <ul style="list-style-type: none"> <li>Discuss available contraceptive methods, as appropriate.</li> </ul> 3. Weigh benefits, disadvantages, and consequences of each option with client.           4. Help client make her own realistic decisions.				
<b>Implementing decisions</b>				
1. Help client make concrete, specific plan for carrying out her decisions.				
2. Identify skills with client that she needs to carry out her decisions.				
3. Help client practise skills, as needed.				
4. Make plan for follow-up.				
<b>Additional Comments</b>				

*Adapted from:* Fistula Care. 2012. *Counseling the obstetric fistula client: A training curriculum*. New York: EngenderHealth.



# APPENDIX B

## TRAINING EVALUATION FORM

**Instructions:** For each item, check the box that best reflects your opinion. Your honest responses will help us improve future trainings. Your comments are also welcome.

Name (optional): \_\_\_\_\_

1. The objectives of the training were:

- Very clear
- Clear
- Not clear

Comments: \_\_\_\_\_

\_\_\_\_\_

2. The objectives of the training were:

- Completely met
- Mostly met
- Insufficiently met

Comments: \_\_\_\_\_

\_\_\_\_\_

3. The length of the training was:

- Too long
- Adequate
- Too short

Comments: \_\_\_\_\_

\_\_\_\_\_

4. The workshop content maintained my interest:

- All of the time
- Most of the time
- Some of the time

Comments: \_\_\_\_\_

\_\_\_\_\_

5. The material presented in the course was:

- Almost all new to me
- Mostly new to me
- Mostly known to me

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. The skills I acquired are:

- Directly applicable to my everyday work
- Somewhat applicable to my everyday work
- Not very applicable to my everyday work

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. The training facilities were:

- Very satisfactory
- Somewhat satisfactory
- Unsatisfactory

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. What was/were the most effective feature(s) of the training?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. What was/were the least effective feature(s) of the training?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. What aspects of the training could be improved, and how?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Do you have any last words of advice or suggestions?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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