Toolkit for the Rapid Prevention of Fistula

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(Early edition. Translations, formatting and text not fully polished)

February 2010

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INTRODUCTION

Obstetric fistula is permanent unless corrected by surgery. It is a communication (hole) between the bladder, the vagina and/or the intestines (rectum). Obstetric fistula results from prolonged labor during childbirth (obstructed labor). It is caused by the sloughing off of tissue squeezed between the baby's head and the woman's pelvis that became necrotic due to prolonged compression during childbirth. For a more precise description of how obstetric fistula arises, please see the Introduction to a presentation page 7.

A clinical definition exists which even illiterate villagers can diagnose as correctly as anyone prior to full medical examination. **Obstetric fistula is the constant leakage of urine, even at night while the woman is asleep, that began after she gave birth.**

Obstetric fistula is an incapacitating illness. Often associated with a perinatal child mortality of 95% or more. It entails permanent incontinence for urine and/or feces, which also favors genital infections. Economic and social activity become all but impossible. The odor of urine and/or feces which accompanies these young women turns them into outcasts, losing them their marriage, friends and sometimes even parents and siblings. Unable to carry out occupational activities, they are reduced to outcasts, or must seek refuge in health facilities where some have lived for years in hope of curative treatment.

Obstetric fistula is a strong indication of poor socio-economic development. It is a serious public health problem associated with high maternal mortality - an indicator of low-quality obstetric care. Now rare in developed and middle-income countries, it is all too common in developing countries where the principle underlying causes are:

- a lack of health infrastructure and qualified personnel in rural areas and many cities
- insufficient means of communication
- cultural factors that favor early marriage and giving birth unassisted by health workers
- malnutrition, especially in childhood, and illiteracy

Because of its nature, and its social, physical, and psychological consequences, obstetric fistula constitutes the most dramatic complication for women who survive childbirth. Yet women in labor often face heavy socio-cultural and economic constraints leading most of the time to childbirths without medical supervision.

Faced with that reality, the fundamental question is whether we absolutely MUST kill another 14 million women while waiting the 30 – 60 years before essential, long-term prevention initiatives have adequate effect, and condemn an additional 50.000 – 100.000 women/year (WHO estimate) to the indignities, suffering, and guaranteed permanent poverty that is obstetric fistula.

A community-based system is demonstrably saving lives and safeguarding women's dignity at an acceptable cost. Essential procedures can be put in place at the community level (together with the populations) through which women in prolonged labor can be brought directly to adequate obstetric treatment without delay.

This toolkit is designed to share the methods and tools used in the pilot project in Niger, so those who wish to can similarly protect women and their unborn infants elsewhere. The toolkit is also available in electronic form, for those who may wish to modify particular data registry forms or other tools for use in their own programs.

How to use this Toolkit

This Toolkit presents experiences, methods and tools developed under the program for rapid prevention of maternal mortality and obstetric fistula prevention, undertaken in Niger.

Read from the beginning to the end, the Toolkit gives a holistic view of the theory and practice of a community participatory approach to public health, as well as specific tools and methods for the rapid prevention of fistula. That said, we encourage the reader to dig into whichever section that may pique your interest, in whatever sequence you may prefer. We have tried to make each section useful in and of itself.

Chapter I presents the theory and ethical considerations that form the basis for the programming that was piloted in Niger. This is based both on widely recognized public health theory, as well as synthesis of tools honed by successful disease eradication programs, whether technologically based on vaccines, water filters, helicopter spraying of rivers, or annual mass drug administration to whole populations.

Chapter II describes the actual programming and lessons learnt through the pilot project in Niger. The hope is that this verbal "sketch" will allow the reader to "see" how to implement a similar program within her/his own context.

Chapter III breaks down the different elements of a fistula prevention project, and proposes a methodology for each element. This too is based on the experiences from Niger, but also based on generic methodologies that will hopefully also make these guidelines useful in other contexts, and perhaps even in other kinds of programs.

Chapter IV presents the actual tools that have been developed in Niger, with comments on each of them.

Except for specific items from Niger that are shared simply as illustrative examples, the methods and tools are meant to present general principles.

These tools should therefore be adapted to the context in which they are to be applied!!

I. Theory behind the reality – The Catalyst Approach to Public Health

Close observation of successful disease eradication and elimination programs over 15 years led to the identification of 11 elements that such programs seem to have in common (Box 1). These elements must arguably all be in place for the community-based catalyst approach to function, just as certain parts must be present for an automobile to function, while other parts are "nice to have.".

When specific criteria are met (Box 2), a community-based catalyst approach seems to be an ideal approach to deal resolutely with significant public health problems.

Community-based catalyst elements cost approximately $2 million US annually for a 12-country effort in Africa in one disease eradication program (dracunculiasis). It has been roughly estimated that catalyst elements of a program to rapidly reduce maternal mortality by supplementing ongoing longer-term solutions may cost on the order of $5 million/year for a similar group of 12 countries across Africa, paltry compared to economic and other benefits obtainable, including averted suffering and enhanced dignity. For consortia of donor countries and foundations, such amounts are well within reach.

BOX1

Eleven elements are arguably essential in The Community-Based Catalyst Approach to Public Health[1]

1. **A few people who really care**. 5-10 deeply committed people in a handful of organizations.
2. **A data manager and program manager in each country**. Data managers usually work full-time for the program. Program managers are usually Ministry of Health professionals, whether full- or part-time.
3. **An organization.** One or two people with considerable expertise in epidemiology must, through friendly insistence, collect data from countries, analyze it promptly, and provide monthly feed-back to all partners. A fast, non-bureaucratic organization is best.
4. **Resident technical advisors in each country.** Usually expatriates, resident advisors must work collaboratively but be funded from outside the infrastructure within which they work. They must have some funds for meetings, travel, and to stimulate activities, yet have no formal power. The combination of independence, commitment, and lack of formal power, makes them effective.
5. **International meetings.** Staff from countries and supporting agencies present data, plans, budgets, achievements, problems, and seek solutions, ideally twice a year. Broad annual meetings and smaller reviews 6 months later (e.g. organized by language) may be best.
6. **Annual program review meetings in each country**. Representatives from all levels of the national program from Village Volunteers to the Ministry of Health's senior leadership discuss successes, problems, and ways forward.
7. **Annual training and re-training for village volunteers.** Volunteers receive 2-3-day updates on progress in their localities, country, and elsewhere. They brush up and are given new technical information.
8. **A network of supervisors.** Supervisors visit each village volunteer at least monthly, gather collected data, and relay messages between villages and national level. They encourage volunteers, visit homes with them, and help them become more proficient. Regular, announced

[1] ***A National Task Force*** is sometimes established, traditionally one per disease. In Togo, a Task Force for Parasitic Diseases and Family Health maintains the focus of individual programmes while maximizing the effect of scarce resources and strengthening collaboration. Although potentially useful, national task forces are apparently not essential.

and unannounced visits by national staff to all levels of the program are part of the supervisory system.

9. **Transportation.** From bicycles to 4-wheel-drive vehicles and the occasional camel or boat for supervisors, transportation needs include annual funding for fuel and maintenance, and replacement of vehicles every 4-6 years.
10. **Course-correction mechanisms.** Continuous research is needed to improve technical tools and approaches specific to the health initiative.
11. **Political mobilization** in the population and its leadership at various levels, and internally within relevant organizations.

BOX 2

All 5 of the criteria in this box must arguably be met, before one can ethically ask individuals in impoverished communities to volunteer time that otherwise could be spent striving to sustain themselves and their families.

Criteria for effective use of local volunteers

1. **Diagnosis** by the trained volunteer must generally be as accurate as by a physician.
2. **Correct action** by the trained volunteer must positively and clearly affect the clinical outcome.
3. **The event** must initially not be so rare that individual volunteers are unlikely to experience it or so frequent as to require almost full-time activity.
4. **A functioning system** must provide annual re-training, regular supervision, monthly collection and analysis of data, timely re-supply of materials, and feed-back on progress achieved versus other districts, regions, countries, etc. (see Box 1).
5. **The issue must be important** to people of the community, e.g. carry a high risk of death, handicap, or suffering that “all” would wish to avoid.

II. The "How To"

II.1. The Niger Project – an example

Pilot Project for Rapid Reduction of Maternal Mortality

and

Prevention of Obstetric Fistula

Bankilare Canton

Niger

2008 - 2009

INTRODUCTION

For a brief, general introduction to obstetric fistula, please also see the Introduction section of this Toolkits document, on page 2.

A distinction is made between vésico-vaginal fistulas (VVF) and recto-vaginal fistulas (RVF). Some patients have both. The mechanism for creating a fistula is simple : during prolonged labor (defined as labor lasting more than 24 hours) the vaginal front (anterior) wall, the base (fundus) of the bladder, and the urethra are compressed between the head of the fetus and the inner surface of the pubic bone (front part of the pelvis) in the front side. And toward the back, the rectum gets squeezed between the head of the fetus and the back of the pelvis (the sacrum).

This compression leads to a reduction in the blood supply (ischemia). If that persists long enough, it leads to necrosis of the tissue where the blood circulation is being squeezed off. Sloughing off of the necrotic area follows after about three (3) to seven (7) days, resulting in a hole between the vagina and whatever is on the other side, either the urine and/or feces.

Prolonged compression inside the pelvis can similarly lead to nerve damage and paralysis of the leg, which makes walking difficult.

REASONS FOR THE PROJECT

Obstetric fistula is an incapacitating illness. Often associated with a perinatal child mortality of 95% or more. It entails permanent incontinence for urine and/or feces, which also favors genital infections. Economic and social activity become all but impossible. The odor of urine and/or feces that accompanies these young women turns them into outcasts, losing them their marriage, friends and sometimes even parents and siblings. Unable to carry out occupational activities, they are reduced to outcasts. Some seek refuge in health facilities where a number have lived for years in hope of curative treatment.

Obstetric fistula is a strong indication of poor socio-economic development. It is a serious public health problem associated with high maternal mortality - an indicator of low-quality obstetric care. Now rare in developed and middle-income countries, it is all too common in developing countries where the principle underlying causes are, among others:

- a lack of health infrastructure and qualified personnel in rural areas and many cities
- insufficient means of communication
- cultural factors that favor early marriage and giving birth unassisted by health workers
- malnutrition, especially in childhood, and illiteracy

Because of its nature, and its social, physical, and psychological consequences, obstetric fistula constitutes the most dramatic complication for women who survive childbirth. Yet women in labor often face heavy socio-cultural and economic constraints, leading most of the time to childbirths without medical supervision.

In Niger, obstetric fistula constitutes a serious medical and social problem which the government recognizes, although the exact extent of the problem there is not fully known. In spite of very considerable improvements and government efforts, obstetric fistula remains a major problem. For this reason, and to help reduce the risk that pregnancy entails, HDI (Health & Development International) is supporting Niger in implementing a pilot project for the rapid prevention of maternal deaths (especially obstructed labor deaths) and obstetric fistula in Bankilare Canton. Bankilare Canton is located in Tera District, the country's second largest, and consists of two administrative units (townships, "communes"), Bankilaré and Gorouol. One aim from the start has been to expand the program to the rest of Niger as rapidly as results may justify.

Faced with the realities of obstructed labor and its consequences, the fundamental question is whether we absolutely MUST kill another 14 million women while waiting the 30 – 60 years before essential, long-term prevention initiatives have adequate effect, and whether we must condemn an additional 50.000 – 100.000 women/year (WHO estimate) to the indignities, suffering, and guaranteed permanent poverty that is obstetric fistula.

This project fits perfectly into Niger's national policies for reducing the risks of pregnancy.

GENERAL OBJECTIVE

The aim is to rapidly prevent the occurrence of obstetric fistula and contribute to the reduction of maternal and infant mortality. If women are no longer getting obstetric fistula, they are also not dying of obstructed labor. This is a pilot, "proof of concept" project.

The goal is that at the end of the pilot phase, the populations (the several ethnic groups) will recognize, accept, and integrate prenatal consultations and medically monitored childbirths into their habits and practices, or at least that all women who have been in labor for close to 24 hours will be promptly evacuated to a hospital where adequate care can be provided.

This project should lead to effects that can be measured after a short time. Its activites supplement other initiatives already in place, such as to raise the age of girls' marriage, to increase the level of education of girls, increase the availability of emergency obstetric care, etc, all of which take much longer to have effect.

SPECIFIC OBJECTIVES

- Reduce the number of women dying in obstructed labor by at least 75% within two years
- Reduce obstetric fistula incidence (new cases) by at least 50% within two years
- Train the nurse in each Integrated Health Center (CSI; Niger's peripheral health unit) to supervise and train village volunteers
- Encourage participating villages to select two volunteers in each village: a man, and a woman who is a traditional birth attendant
- Train the village volunteers in the rapid prevention of obstetric fistula

- Teach village volunteers and the communities, the risks of prolonged labor, the importance of giving birth with assistance from a trained health professional – i.e. in an environment where trained medical staff are present - and immediate evacuation of all prolonged labor cases directly to a hospital which even today can perform adequate surgery at any time of day or night
- Introduce the medical personnel and the village volunteers to the evacuation plan for women in prolonged labor, a plan which is specific to each locality
- Refer women promptly to emergency surgery (usually a caesarian) when they are in obstructed labor, to prevent obstetric fistulas and deaths
- Optimize the use of existing reproductive health care services
- Detect all cases of obstetric fistula, be they new or previously existing, and refer them to corrective surgery. For new cases it is important to get the patient to treatment before anyone can even think of excluding her socially.

EXPECTED RESULTS

At the level of the health care system

- Increased number (percentage) of prenatal consultations, births occurring with professional health care assistance, and postnatal consultations
- Obstructed labor deaths down by at least 75% within two years. Women in localities that are within 2 days of travel from a hospital that can provide a caesarian section should not die.
- New fistula cases at least 50% down within two years, with continuing improvement after that.
- All cases of obstetric fistula receive prompt response at all levels of the health care system. Any new case of fistula should be brought to a competent medical center for detailed diagnosis and surgery so quickly that negative social consequences have not had time to develop.

At the community level

- Populations include prenatal consultations and health personnel presence during childbirth in their routine practices.
- All women who are in labor for more than 24 hours get promptly transferred to a medical setting where surgery can be performed (since tightened in the Niger project to 12 hours)
- All communities understand obstetric fistula and undertake the necessary prevention, post-operative follow-up and long-term social reintegration measures.

THE NIGER PROJECT's GEOGRAPHIC AREA

The multiethnic Bankilaré Canton covers 5,650 sq. kilometers of remote, dry sahelian terrain. There is one road (unpaved), little safe water, almost no place that has electricity, one midwife, and no doctor within the area.

At the project's start, the area's population was estimated to be 95.000 – 100.000. In 2006 the population in the area was estimated at 89 517 with 4 654 births expected, mostly among young women with diverse backgrounds. Five ethnic groups live in the area (Hausa, Songrhay, Touareg, Fulani, Gourmantché). 52.8% of the population is under 15 years of age. The two most important economic activities are subsistence agriculture and animal husbandry, although the area is a semi-desert. The majority of the habitation consists of hamlets and fixed or mobile encampments. Even sedentary farmers often move some distance to live near their fields during the agricultural season, during which villages are often virtually empty.

The initial pilot project area is part of Tera health district in the extreme western part of Niger, bordering Mali and Burkina Faso. Tera's hospital had one doctor when the project started, now has a second doctor, and is equipped to take care of surgical cases including caesarians, thanks to prior upgrading with UNFPA and EngenderHealth assistance. The administrative districts of Bankilare and Gorouol which constitute Bankilare Canton, the initial pilot area, had 7 (now 8) Integrated Health Centers (peripheral health units) with one nurse each. One peripheral health center area outside the administrative boundaries of Bankilare is included in the project because it lies so close, and many people from that particular area actually go to Bankilare when seeking heath care. It was therefore considered unethical to not offer the project to these people too.

Bankilare was chosen as the pilot for several reasons. Basically, the obstetric fistula problem was reported by various levels of the health care system to be worse there than many places, and there was less external support than in many parts of Niger:

- Obstetric care, including all emergency obstetric care, is free of charge for the patient throughout Niger. Presidential decree established that policy in July 2005. This is a critically important factor behind the program's success.

- The district of Téra has functioning medical services (as opposed to some parts of the country). Thanks to the combined efforts of several organizations (UNFPA,

Program II of the African Development Bank, Niger's Network for Obstetric Fistula Eradication (REF), and HELP (a German humanitarian organization with funding from the European Union), the district hospital is equipped to do surgery; a system of solar-powered 2-way radio communication between the hospital and the health centers exists; there is transportation (3 ambulances in the area of which 2 are 4-wheel-drive, and a motorbike at each Health Center). And transportation for pregnant women and children under 5 who need hospitalization are currently free of charge.

- Several sources of information indicated that Bankilare Canton was producing more obstetric fistulas than many parts of Niger. For one thing, Bankilare had been the main source of patients needing fistula repair at Niger's National Hospital in Niamey for several years. When there was talk of implementing the program in his district, the Chief Medical Officer at Tera Hospital implored the program to start in Bankilare, because that was the source of so large a proportion of the obstetric tragedies he was seeing, including ruptured uterus and obstructed labor deaths. According to the Tera Health District medical chief, half of the caesarians (often too late) and the fistula cases admitted to his hospital came from Bankilaré.

- Tera district is not supported by any large donor, such as what the government of Belgium provides in Dosso and French Cooperation provides to Zinder.

- Bankilaré was among the first areas in Niger to rid itself of guinea worm disease, in spite of being neither richer nor better served than other parts of the country. That success was achieved through the determination of its local leaders, population, volunteers, and health care workers. Bankilaré's success left no doubt about the realism of implementing a system of community-based interventions with monthly supervision and data collection. That the people of Bankilare could eradicate guinea worm before the rest of Niger, gave confidence that they would be able to implement an organizationally similar program to prevent women from dying in childbirth and prevent obstetric fistula.

INSTITUTIONAL FRAMEWORK / NEED FOR A FUNCTIONAL ORGANIZATION

The rapid prevention of obstetric fistula project is an activity of REF (Niger's "Network to Eradicate Fistula"), supported by HDI which also suggested the project. The REF is jointly led by the Ministry of Public Health and the Ministry for Promotion of Women and Protection of Children. Niger's Director General of Health is president of REF, and its vice-president is the Secretary General of the Ministry for Promotion of Women and Protection of Children. A coordinator appointed by REF is responsible for the project.

A technical advisor from HDI assists the REF in all aspects of the project from planning to coordination, follow-up and evaluation of the activities.

At the Regional level, the project is under the Regional Director of Public Health (DRSP).

At the District level, the program is under the District Medical Officer (DS), head of the District Hospital an initially its only physician).

At the village level, village-appointed volunteers implement the program in collaboration with the chief of the village and its population.

To summarize, the pilot project for rapid prevention of obstetric fistula is part of the normal health care system with its peripheral Health Centers, the District Hospital, and all administrative levels of the national health care system. The regular health care system has been extended using an existing but now dormant community-based organizational infrastructure put in place by the National Guinea Worm Eradication Program. The present program adds a woman volunteer in each village, an experienced traditional birth attendant who, along with her male colleague, receives annual re-training by the project. The structure of the Guinea Worm Eradication Program is being re-instated, partly because its deep community-based infrastructure has been so successful at extending the health care system beyond Health Centers to small rural communities up to 25 kilometers away from such health centers. The community-based system is used for activities at the community level including population-based information and education, while the classic health care system cares for the needs that this information and education of the population stimulates (prenatal consultations, births assisted by health professionals, evacuation of women in obstructed labor, rapid referral of any fistula cases, etc).

STRATEGIES, and ACTIVITIES in CHRONOLOGICAL ORDER

I. Strengthen the capacity of the health care system and the communities to rapidly prevent obstetric fistulas:

1.1. ***Inform and educate the administrative and traditional authorities as well as religious and other local leaders about the problems of obstetric fistula, its impact on the community, and its rapid prevention.***

- 1.1.1 Create the tools needed to inform the medical personnel (supervisors) and the village volunteers about the program and the (about 250 male volunteers mostly from the guinea worm program and the monthly data collection. These tools include 3 versions of culturally appropriate flip charts printed on cotton and designed for illiterate people, made in 4 local languages and French, as well as a training manual, and data registration forms for use at the village level and for compiling results. Each version contains the same messages but images with different clothing, house-designs, head-coverings etc. The aim is that no ethnic group shall have any excuse to point to drawings and say the program is relevant only for those "other" people (perhaps an ethnic group that they very much look down upon).

- 1.1.2. Those responsible for community-level health education (each health center nurse) are the project's supervisors. The project trains them on the same subjects that the community volunteers are taught. In addition, supervisors are taught how to teach, how to do effective supervision, good leadership qualities, data collection and concerning efficient field work.

- 1.1.3. The recruitment of village volunteers will be based on the village volunteers that already exist in the villages which have been endemic for guinea worm disease, with additional male volunteers recruited where necessary and the addition of women volunteers (almost 300 traditional birth attendants).

- 1.1.4, Supply documents and education and training tools adapted to rural populations that may be illiterate.

- 1.1.5. Conduct community education sessions on the importance of prenatal consultations, giving birth in a medical environment, the dangers of prolonged labor, the importance of the female village volunteer obtaining the family's permission in advance for evacuation to be implemented if it should become needed, and exactly how evacuations are to be organized and carried out under the leadership of the village volunteer. These sessions may be held for population groups or individual person. It is of fundamental importance to explain and discuss with each pregnant woman and decision-makers in her family the delivery plan and the evacuation plan to be put in motion in case of emergency. The evacuation plan should specify the criteria already agreed upon as to when, where and how the evacuation would be done if the head of the household is away (often happens for seasonal farming) at the time the birth occurs. Very important detail: Emergency evacuation of women in obstructed labor is free of charge for the family.

2. Monthly Supervision and Evaluation of the Activities

- **Epidemiologic surveillance:** choose the indicators; organize the monthly collection of data, transmission and analysis of data, and plan the epidemiologic surveillance system (See Annex 3).
- **Monthly supervision of the Village Volunteers.** Monthly transmission of the data to national level via the district. The district's regular health staff inserts collected data into their quarterly report via the normal government health information system. The program itself analyses data monthly, and among other things adjusts supervision trips from the regional and national level in light of results of the monthly data analysis. Monthly national level supervision is targeted to where there are problems, and to celebrate special achievements by particular communities.

- A **Annual National Program Review Meeting** is an important component of the project. Representatives from all levels, from the village volunteers to the national Ministry of Health, come together to discuss data, results, achievements, problems, and to find solutions.

3. Logistic support

Sufficient logistic resources need to be planned for, based on observations on the field.

II.2. Planning the evacuation process

Evacuation Plan for Bringing Obstructed Labor Cases to Hospital

Main principal:

The sun must NEVER rise twice over a woman in childbirth!!

The woman **must** be evacuated and have her baby delivered before that happens.

Women in blocked labor are taken from wherever they are located, **DIRECTLY** to the nearest hospital that is **currently able to do caesarian-section surgery at any time of day or night!** Women in blocked labor are **not** taken step-by-step to successively higher levels of the health care system.

- In Bankilare Canton, that means all women who are in labor for more than 24 hours (subsequently reduced to 18 hours) must be evacuated to the hospital in Tera, or to Niamey depending on the availability of the surgeon in Téra. If one knows the hospital's doctor is absent from Tera on a particular day, for example due to administrative planning meetings in the regional or national capital, the woman being evacuated due to blocked labor or any other obstetric emergency is brought directly to a maternity hospital in Niamey, 2.5-3 additional hours and a ferry-crossing from the Tera District Hospital. In reality, if onward transportation to Niamey is necessary, the 4-wheel drive Bankilare ambulance stops at Tera hospital long enough to transfer the woman to a normal ambulance with hospital staff for the onward journey. The initial ambulance then returns to Bankilare so as not to leave its 100.000 people and that 4,650 sq. kilometer area unserved by midwife and ambulance.

- The sole midwife serving the 100.000 people of Bankilare Canton is based at the Health Center in Bankiare town, as is the ambulance. The midwife has always accompanied the ambulance when called out for an obstetric emergency, even before the current project was put in place.

- Obstructed labor, massive birth-related bleeding, and eclampsia (generalized convulsions with loss of consciousness at birth) are conditions where differential diagnosis is irrelevant in determining the degree of urgency. That and the fact that the midwife in any case accompanies the ambulance on obstetric emergencies, fully justify the policy of going straight from the village to a hospital where one knows resources exist to handle the emergency, even in this developing-country setting, and even if an illiterate but trained and experienced village volunteer was the one who initiated the call for evacuation by ambulance. As opposed to almost every other kind of emergency evacuation, nothing is gained by stopping along the way for evaluation by health care professionals, even if there might be several hospitals along the route, unless one knows that the hospital in question is actually staffed and equipped to do an emergency C-section and handle bleeding or eclampsia on the day in question.

- The evacuation plan must have back-up alternatives. For example, if the village volunteer in this part of Niger has no mobile phone access or network coverage, she sends the laboring woman by donkey cart to the nearest health center, though this can sometimes be 25-30 kilometers away. If the village has no donkey cart, as is sometimes the case, she sends one person to fetch a donkey cart from the nearest village where one exists. And she sends a different person to alarm the nurse at the nearest Health Center, so he can call for the ambulance by 2-way radio.

NOTE: In the Langtang are of Plateau State, Nigeria, a similar program was planned but not funded. People there do not use donkey carts. The Langtang evacuation plan is based on the fact that “every” village is home to at least one person who owns a motorbike taxi. In Langtang, Nigeria, the plan was for the laboring woman to mount the motorbike behind its owner, and a big strapping man would mount the bike behind her, holding her tightly around both of her arms as the motorbike made its way along the narrow, winding pathways toward the pre-designated hospital, again, not necessarily the closest hospital, but the closest hospital that even now can reliably be counted on to have staff and functioning equipment in place to do a c-section.

CONCLUSIONS

1. Neither a donkey cart ride for hours nor being held in a vice-like grip on a motorcycle is tempting for a woman who has already been in labor for 24 hours. But it’s better than dying or ending up with a fistula.

2. You must tailor your evacuation plan very specifically to the situation in each and every community where you intend to implement a program like this.

Available Resources in Bankilare Canton, Niger

Medical Centers:

- Hospital with functioning operating rooms : Téra, and Niamey
- 8 Health Centers

Means of Transport when the program started:

- 2 ambulances in Téra, 1 ambulance in Bankilaré
- Donkey carts in most villages. Not all villages have a donkey cart.
- The possibility of being transported lying on a special platform mounted on a camel, as in the olden days, has been explored. Camels walk faster than donkeys.

Means of communication

- Health Centers are equipped with solar-powered 2-way radios. In 3 Health Centers the radios did not work when the project stared
- There is now mobile phone network coverage in most parts of the project area.

Evacuation Plan (Please see above for a detailed description.)

- If the patient is in an area having mobile phone coverage: call the nearest of the two ambulance bases. If the surgeon is not actually in Téra, the patient gets transported straight to Niamey.

- If the patient is in a location without mobile phone coverage :

    - In villages equipped with a donkey cart, transport the patient to the nearest Health Center which will then call for an ambulance by radio.

- If there is no donkey-cart in the village, send someone to the nearest Health Center so it can call the ambulance. Send someone else in search of a donkey cart in a nearby village so as to transport the woman to the nearest Health Center.

III. More about specific program elements

1. Mobilize administrative and popular support

A project for rapid prevention of obstetric fistula should encompass the normal health care system (Health Centers or peripheral health units, and the District Hospital) along with a community based organizational infrastructure. The community-based organization is used for activities at the community level including population information and education, while the classic health care system is used to care for patients (prenatal consultations, births assisted by health professionals, evacuation of women in obstructed labor, rapid referral of any fistula cases, etc).

It is therefore necessary to start such programs by mobilizing the normal administrative structures (local mayors, prefects, etc), the health care system (Ministry staff, regional public health leaders, district medical chiefs and other district staff), and the communities (traditional leaders, religious leaders, and the populations themselves). This can be done through the following activities;

Meetings With Administrative Leaders
Meetings individually and/or in groups, with government administrative leaders, and with high-level traditional leaders, to get these people onboard before approaching the population.

Local leaders meeting
A one-day meeting with local leaders such as chiefs of sub-districts and villages, local religious leaders, other opinion leaders, to explain the project and solicit their support and participation. If there are too many traditional chiefs in the area to invite them all, leave it to higher-level traditional leaders to pass invitations to the number of participants you can handle. That said, several hundred people can gather under a large tree, and inclusiveness is often appreciated. Showing respect by being inclusive for as many local leaders as possible is often a very good "first step" for a program like this, that depends for its success on commitment by the population and its leaders.

Mobilize Support in Communities and Get Village Volunteers Appointed
Organize a tour of villages after the meeting with village chiefs and other opinion leaders. To cover a population of some size, this will probably have to be done by the supervisors. Using the supervisors even for this preparatory step has the advantage of beginning to build the prestige of the supervisor (who comes bearing good news of a program aiming to prevent women from dying in childbirth). It also further strengthens relationships between each supervisor and "his" communities.

During this tour, encourage each community to select a woman and a man volunteer; announce when the training of village volunteers is to take place, and inform the community that the volunteers will be transported to the training venue, as well as about perdiem arrangements.

NOTE: Money (perdiem) is paid to village volunteers for only 5 days per year: one day of travel to the training venue (even though they are picked up by vehicle), three days of the actual training workshop, and one day for the return trip home (even though they are brought home by vehicle).

The reason for picking up volunteers and bringing them home after the annual 3-day training is that experience shows this to be the best (only?) way to ensure they actually show up. People also appreciate this, as a sign that you really do want them to come to the training.

The reason for paying them perdiem even for the day of travel to the training and the day of travel home afterward, is that it is not possible for them to do anything economically useful during either of those two days, and the perdiem compensates for that to some degree.

NOTE: It is important that participation by villages is voluntary!

Almost all villages will want to see their wives and daughters better protected against death and indignity. But there are villages where the leadership does not want to designate any volunteers, where they simply do not want to participate due to skepticism of one kind or another.

It is important to respect that reticense. Typically, these villages too will wish to join the program subsequently, when their leaders realize that they are being met with respect, when they see their views and decisions taken seriously, and when they see advantages accruing to their neighbors but not to their own wives, daughters or themselves. It is in our view much better to wait a year and have people join the effort because they wish to, than to in any way exert coercive power. More women's lives will be saved by waiting than by coercion, painful though that wait may be for us to observe.

The same is true if a Health Center nurse refuses to participate, perhaps due to displeased with the lack of additional money (other than perdiem and fuel costs) for the added work. In our experience, it is normally possible to arrange for another person to supervise this person's area of responsibility. And the nurse in question usually changes his mind after the first year, if not before.

The program needs communities and others to participate in this program because they WISH TO so they can achieve better results for themselves and their fellow citizens, not through coercion.

2. Roles and responsibilities

This section outlines roles and responsibilities of the actors involved at different levels in the project's routine operation. Of course, the national Director of Reproductive Health, the Director General of Health, the Regional Director of Public Health, and many others are also crucially important contributors to the success of this program, Those presented below will arguably need to be involved in any setting where one wishes to replicate Niger's Rapid Prevention of Maternal Mortality and Obstetric Fistula Project, which is why these roles but not others are being described in this Toolkit.

Village Volunteers

Each village selects one woman and one man as village volunteers in the project. The volunteers receive 3 days of training as described elsewhere in this toolkit. Even topics for conversation are quite strictly segregated by gender in the pilot area. Men may never talk with a woman about pregnancy, except perhaps with his wife. Therefore too, the male and female volunteers in each village have different but equally important roles.

If the community first appoints volunteers who prove unable or unwilling to do the work sufficiently well, the program asks the village to appoint someone else.

Female Volunteers

Volunteer women are existing Traditional Birth Attendants (TBAs), selected and respected by their community. After their 3-day training course, female volunteers are responsible for discussing the project with women in their community, especially with each pregnant woman and the pregnant woman's family. Specifically, the female volunteer must:

- Register each time she becomes aware of a new pregnancy
- Meet the pregnant woman and her family to explain the program, and ask permission in advance to evacuate the woman if anything untoward occurs during childbirth, for example in case the husband happens not to be around due to seasonal agricultural work elsewhere or for other reasons, when the birth occurs
- Encourage pregnant women to go for prenatal consultation at the Health Center
- Encourage the woman and her family that it's a good idea to give birth at the Health Center, to give birth with assistance from a health professional
- Encourage women who have given birth to go for postnatal consultation at the Health Center
- Organize prompt evacuation for each woman in the community who is in or on the verge of obstructed labor, in accordance with that locality's evacuation plan, to ensure that **the sun must NEVER rise twice over a woman giving birth**
- Register each birth, evacuation, maternal or neonatal death, and each new or old obstetric fistula that occurs in the community
- Collaborate with the community's male volunteer, the supervisor (Health Center nurse), and the community leadership on implementation of the program
- Attend the annual re-training course

Male Volunteers

Male volunteers, also selected by their community, are responsible for discussing the project with the men of their community, especially with the husband of each pregnant woman. Specifically, the male volunteer must:

- Encourage each man to send his pregnant wife for prenatal and, when the time comes, for postnatal consultation
- Encourage each man to have his wife give birth assisted by a health professional, i.e. at the Health Center
- See to it that data is collected and that the monthly sheet on self-copying paper is filled out correctly.
- Collaborate with the community at large, the supervisor, program-staff, and the female volunteer, to implement the program
- Attend the annual re-training course

Supervisors (the nurse at each Health Center)

The nurse at each Health Center supervises activities in his geographical area of responsibility. In the Niger project, these nurses are all men. They must often travel alone and ride a motorcycle as part of their job (also before this project started). Neither of those things is considered appropriate for women to do in this culture. The nurse/supervisor must:

- Train the volunteers from each participating village in his area
- Visit each village monthly, to meet with and supervise the activity of the volunteers there, and collect the monthly data-registration sheet
- Encourage the population to send its pregnant women for prenatal and postnatal consultations, and encourage births in a health setting
- Collaborate with the national level program staff
- Present his area's data at the Annual National Program Review
- Attend the annual re-training, and re-train the volunteers each year

Midwife (initially just one for the 100.000 population)
In addition to her previous responsibilities at Bankilare Health Center where she is posted, the midwife continues to accompany the Bankilare ambulance every time it goes to an obstetric emergency.

Ambulance evacuation of women during childbirth has become a much more frequent occurrence since this project started. To prevent the midwife from collapsing, HDI eventually hired a second mid-wife in the area, placed where local politicians at their own initiative arranged for a second ambulance to be located. That too illustrates the catalytic effect of the current project's approach. This second midwife ahs the same kind of responsibilities as the Bankilare midwife.

District Health Education Officer
The district health team's health education officer is a principle liaison for the project. He accompanies the project team during monthly supervision activities, participates at training sessions, and during all kinds of health education sessions undertaken by the project.

District Doctor
The Chief Medical Officer, initially the entire district's only doctor, is located at the district hospital. He must operate promptly on women who are brought to him in obstructed labor. If he is known to be away for administrative meetings or other reasons, the woman is transferred straight into a smaller ambulance and brought directly to the maternity hospital in the capital city, several hours drive away. He also ensures that all data collected are channeled through the normal, routine health system data collection mechanism.

Data Manager
The national-level project team has a data manager who is responsible for entering data from the paper registration forms into the project's computerized data-base. He prepares graphs and tables as needed, to analyze results on a monthly basis, as a major part of the program oversight mechanism that allows program weaknesses to be discovered rapidly, and addressed efficiently.

Resident Technical Advisor
The resident technical advisor's role is also key! This person must provide technical guidance to all levels, from villages to the Ministry of Health. A physician in this case, he also conducts a verbal autopsy after each maternal death in the project area, by talking with the deceased woman's family to ascertain what caused her death, and filling out a form as best one can. He participates in the monthly supervision and provides formal and informal leadership. One important role for the resident technical advisor is to be an independent

convener and helper. Unencumbered by bureaucratic constraints as to whom he can talk with, he can discuss with people across ministries, in UN agencies, NGOs, the official government and traditional leaders of all kinds. Having a respected person in that independent role is absolutely critical for success with this kind of program.

3. Training

As part of the effort to mobilize the community and the health care system, it is important to inform and negotiate with the administrative and traditional authorities, as well as religious and other local leaders. You must explain the problems of obstetric fistula, its impact on the community, its rapid prevention, and the roles and responsibilities under the new program. Roles and responsibilities are elaborated on in the previous section.

The program's first formal training sessions are for supervisors, i.e. peripheral health unit nurses. They are trained on the same subjects as they themselves will teach to village volunteers. In addition, the supervisors are taught how to train village volunteers, and how to conduct supervisory visits. Their training also focuses on and practice, good leadership qualities, data collection and efficient field work. (See Training Module in the Annex) Because all supervisors are literate, usually trained nurses, elementary realities behind the program are usually understood quickly by the supervisors. It is therefore possible to complete this training within 2.5 - 3 days, even though it covers more topics than the training of village volunteers.

When supervisors have been trained, they make tour of communities to encourage communities to designate a woman and a man volunteer. The supervisors then train the volunteers within their geographical area of responsibility.

Experience unambiguously indicates that village volunteer training is best done at each Health Center rather than in one central location. Training at the Health Center tends to strengthen connection between the population and its local Center. And bringing 600 people together in one location for 3-days of training creates too much chaos.

It is a good idea to split the health centers training into portions so not all train their village volunteers simultaneously, during any given 3-day period. In Bankilare Canton, for example, all eight Health Centers can train the almost 600 volunteers within about two weeks when the process is conducted in a properly staggered manner. The need to stagger the training for village volunteers arises because vehicles need to be rented or mobilized to pick people up from their communities and take them home 3 days later. And national-level staff should be present during part of each training, which becomes impossible if too many locations conduct training simultaneously.

4. Tools

A set of tools is needed to inform and train the medical personnel (supervisors) and the village volunteers. These tools include culturally appropriate flip charts printed on cotton and data registration forms designed for use at the village level by illiterate people. In addition, there is a Village Register for compiling results and a training manual, both for use by the (always literate) supervisor.

Each community receives a fairly robust cotton cloth bag at their initial training. In Niger, the bag has shoulder straps so it can be carried like a back-pack, a short strap at the top so it can be carried like a bag, and a long strap so it can be carried as a shoulder-bag. It has a zipper across the top so it can be closed securely during travel by foot or on a camel, to prevent items falling out. These bags are large enough to fit the rolled-up cotton flip-chart and data-registry materials. The bags were custom-made locally, intended to be robust and attractive but not fancy.

Each bag contains one set of "tools":

- Cotton flip-chart
- Village Data Registry Booklet
- Village Register book
- A small notebook
- A simple ballpoint pen

The notebook and pen are included becuse some village volunteers do know how to read and write, and their children are in any case hopefully going to school. These are low-cost, popular items, whether the person is literate or not, and can be useful.

Comments about each of the other tools are provided below. And there is a link or reference in each section to the Annex at the back, where an example form Niger's program can be found.

Tool III 2.1 Cotton flip chart

Having seen quite a variety of health education materials developed for use in communities, we are convinced that cotton flip-charts are the best alternative in most settings. In almost every developing country, it rains. Roofs in developing countries are not always water-tight. Cotton flip-charts dry out after rain. Plastic-covered paper and other alternatives tend not to be as robust.

The Niger program uses an 11-page flip chart. Eleven pieces of thick, printed, cotton cloth with one drawing and one message on each page are squeezed between two flat pieces of wood and kept together by metal bolts with "wing-nuts." Each flip-chart is easily rolled up and inserted into the village-volunteer bag for safe keeping. While robust, these flip-charts can easily be taken apart if one wishes to add a page or replace one of the messages.

It is important that all at-risk populations (ethnic groups) fully comprehend that the messages and the program are for them. Especially for something like obstetric fistula that is so strongly associated with stigma, it is important that no group has any excuse to say or feel that the messages are "only" relevant for a different ethnic group, perhaps a group that they themselves may look down upon.

Therefore, in the Niger context we have made three artistic versions of the cotton flip-charts, with writing in a total of 4 local languages. In each version, messages are also written in French, Niger's official language. Each message is the same in every version, but clothing, houses, facial markings, and head-coverings are different in each of the three versions. Each version of the flip-chart was produced in enough copies to cover the relative proportion of ethnic group villages in the project area, with some extras for replacing the rare lost or damaged one, for additional villages that may be added, etc.

Tool III 2.2 Training Manual

An English translation of Niger's Training Manual has been included in this Toolkit, in the Annex at the very back of this publication.

The same manual is used by national-level program staff to train the supervisors, and by the supervisors (each Health Center's nurse) when he trains village volunteers in his geographical area of responsibility. The manual was written and designed for use by these nurses. A significant portion of the manual focuses on how best to conduct the sessions when they train volunteers, how to lead group discussions, how to conduct face-to-face teaching sessions, respect for all members of the community that the program intends to be permeated by, etc.

5. IEC (Information, Education, Communication)

Sessions of community education focus on the importance of prenatal consultations, giving birth in a medical environment, the dangers of prolonged labor, the importance of the female village volunteer obtaining the family's permission in advance for evacuation to be implemented if it should become needed, and how evacuations are to be organized and carried out under the leadership of the village volunteer. These sessions may be held for groups or an individual person. It is of fundamental importance to explain and discuss with each pregnant woman and decision-makers in her family, the delivery plan and the evacuation plan to be put in motion in case of emergency. The plan should specify the criteria already agreed upon as to when, where and how the evacuation would be done if the head of the household is away at the time the birth occurs (often happens for seasonal farming, etc). Across much of Africa it has proven a problem that women can die of obstructed labor while living within sight of a hospital that would do a c-section for free, if the husband happened not to be there to give his permission when she was experiencing obstructed labor. And, "If we are not dealing with reality, we won't get there."

Important: Emergency evacuation of women in obstructed labor is free of charge for the family.

6. Epidemiologic Surveillance

Before starting epidemiologic surveillance it is necessary to define indicators and organize the monthly collection, transmission and analysis of data. (See the Annex for examples of indicators and forms used by the Niger project).

• **Monthly supervision of the Village Volunteers.**
Monthly transmission of the data to national level via the district and quarterly analysis of the data locally to include in their report via the normal government health information system. Adjust supervision trips from the regional and national level in accordance in light of results of the monthly data analysis.

• **A national annual meeting** with participation of all levels from village volunteers to the Ministry of Health level is of major importance, to discuss the data, results, achievements, problems, and find solutions.

Tools for Epidemiologic Surveillance

Tool III 4.1 Village data registration booklet

Behind the cover, each page has spaces at the top for the supervisor to write the name of the Region, District, and Village, so you know where the data comes from. The data registration booklet is for one year and contains at least 24 pages (sometimes a few extra to provide a buffer), of which 12 are self-copying "carbon" copies. Each page has 9 boxes, each with an image and a caption for each indicator. In Niger's pilot area, the village data booklet has explanatory text below each drawing in 4 languages. The caption for each image is written in French, Djerma, Tamasheq, and Fulfulde, including transcription into Arabic script for the latter three languages. The village data registration booklet is for the village volunteers to register specific events and their main activities. *The form is filled using dashes. Each dash represents a person or activity according to the defined criteria*

Tool III 4.2 Village register for obstetric fistula surveillance

The Village Register is a monthly report which makes it possible for the supervisor to synthesize data in each village. The Register indicates the name and age of the women that have a new pregnancy, who die in childbirth, or have a new obstetric fistula. It has space where the number of home-births and other key indicators can be noted.

For new pregnancies, the supervisor is to indicate information that is relevant in each case, e.g. whether the woman goes for a postnatal consultation, whether she is lost to follow-up, or other pertinent information. For any new case of fistula, the supervisor is to indicate whether the woman has been referred for treatment. Where outcomes are other than expected, for example if someone declines to be referred for treatment or to be evacuated in an emrgency, the supervisor is to explain why. For the number of home births, obstructed labor evacuations, public information sessions held, maternal and perinatal deaths, the supervisor indicates the relevant number in the Village Register. The box "observations and recommendations" at the bottom of the page is there for extra observations and suggestions that the supervisor has, as concerns problems, insufficiencies, things that village volunteers noticed during their activities, etc.
At the end of each month, the supervisor must write his name, the date of his supervisory visit, and sign the Village Register and the data entry form, taking one copy with him.

Tool III 4.3 The cumulative reporting form

This form is filled out monthly and synthesizes data collected in the villages by each supervisor. The form has three types of information:

- Fixed data which remains the same each month (District name, population, etc)
- Data that changes monthly, including the 10 indicators from village registration sheets
- Observations. At the bottom of the page is a box where one can synthesize key information, such as the number of localities supervised, etc.

This form too is to be signed by the supervisor, i.e. the head of the Health Center, and then by the Medical Chief of the District (a physician), to indicate that he has seen the data.

Tool III 4.4 System of epidemiologic surveillance

It is true for all successful disease elimination/eradication programs, that one wishes for but cannot have good quality baseline data.

One simply cannot count women dying for a year or more to secure quality baseline data from a geographic area, while knowing full well what must be done to prevent a goodly number of those deaths. Resources that might suffice to secure good-quality baseline data can also save women's lives in childbirth. The choice is simple. We see only one option: save lives and prevent fistulas where one can, while collecting what baseline data one can retrospectively though that data will be of admittedly poor quality.

It's a consolation that when the indicator goes to zero – number of women dying in obstructed labor or new fistula cases, for example – the reduction was 100%, regardless of what the starting point was. In societies where you know maternal mortality is high, that is as good a measure of success as anyone can ask for.

Monthly epidemiologic surveillance starts when village volunteers fill out the village data registry form as events occur throughout the month. Literacy is not required to fill the form. The village data registry form has a drawing for each indicator, and each event is registered with a tick mark.

The village data registration form is on self-copying paper. That is important so a complete set of data remains in the village, even after the supervisor takes the original with him for relaying to the national level.

The percentage of villages that submit a report each month is an important process indicator.

You may prefer to use fewer indicators than the 10 chosen by Niger.

In addition to the Village Data Collection Form, there is a register (bound, soft-cover book) in each village with a page for each of about 24 months. There, the supervisor can write the name of each pregnant woman and make observations concerning outcomes and program activities in the village. The supervisor and every visitor from the national or international level of the program dates and signs the register at every visit to any village. These dates and signatures form an important part of

the supervisory system. They allow central-level program staff to see whether villages have been receiving the prescribed monthly supervisory visits.

Village data is aggregated by the supervisors and collected from them each month by the district liaison and national-level program staff. Data is then analyzed monthly. Any identified program weaknesses are addressed as rapidly as possible.

Each reported maternal death regardless of cause, and any reported fistula case, leads to a visit by the program manager to the relevant village for a verbal autopsy (see separate form), and in the case of fistula, a conversation with the woman and her family. (Note: Any women with fistula is normally brought to a fistula treatment center by the program vehicle when it returns from the field, so the woman can receive treatment as quickly as possible.)

7. Medical Care

While the aim is to rapidly prevent women from dying and keep them from getting obstetric fistula, the program of course makes every effort to arrange surgical treatment for each and every woman it encounters who has a fistula, be it new or old.

When detected soon enough, small fistulas can sometimes close spontaneously if the woman is catheterized for several weeks (about 6 weeks), thus averting the need for surgery. That and the program's desire to have each new fistula patient treated before anyone can even think of casting her out, are reasons to resolutely arrange for rapid, efficient, and effective medical examination and treatment for any new fistula case that may occur in spite of the program.

NOTE: The number of fistulas might actually increase initially, if a program saves a woman's life by getting her to surgical delivery just in time to save her life, but too late to prevent fistula.) Fortunately, the Niger project did not experience that, though we did worry about the possibility.

It is arguably unethical to start a rapid fistula prevention program unless you have a place to refer women for surgery when a fistula does occur, and each time you find a woman who has had a fistula for years. It is therefore important to establish good working relationships with a facility that offers quality fistula surgery, also so you can telephone them and bring a woman with you (and a relative of hers) when you return from the field each time the program detects a case of fistula.

8. Follow-Up / Evaluation

Unlike most health programs, but just like all successful disease elimination and eradication programs, tight follow-up on hard-data biological outcomes is absolutely critical if a rapid maternal mortality and obstetric fistula prevention program is to be successful.

A few process indicators may also be useful, such as the number (percentage) of villages that report every month, in each geographical area (health center, district, region, or country).

Other process indicators that may be useful if the information is used to compare and stimulate further improvement are the number of pregnant women who go for at least one prenatal consultation, how many give birth assisted by a health professional, and how many go for postnatal consultation.

Fundamentally, all that really counts when measuring this program's degree of success are hard-data outcomes, such as: How many women died a birth-related death that the program could have prevented? How many women got an obstetric fistula?

Answers to these and other questions are used each month to search for program weaknesses, and to guide the search for solutions every time a weakness is uncovered.

Knowledge is power; we should share it. And almost nothing stimulates good work as effectively as the healthy competition that results when you share information about which areas had the greatest reduction and who had the least reduction on key outcome indicators, such as how many women died of obstructed labor last year.

Conclusion

Niger's ***Rapid Prevention of Maternal Mortality and Obstetric Fistula Project*** is a proof-of-concept pilot.

The aim was to reduce the number of women dying in obstructed labor by at least 75% and new fistula cases by at least 50%, both within 2 years.

Both aims were quite heavily criticized for being unrealistically ambitious.

In the event, 23 months into the project through January 2010, no woman died of obstructed labor in the project area since May 2008, which was 4 months after the project started. That's 20 months and counting since the last obstructed labor death, in an area where that was reportedly the main cause of birth-related maternal deaths, not unlike what one sees in parts of Afghanistan and other remote locations.

It also looks like maternal mortality as a whole may have declined. And although the numbers are small and comparisons therefore difficult, obstetric fistula incidence is apparently also down considerably, if not quite to the level aimed for.

The question therefore arises as to whether this project is worth implementing elsewhere. As a first step, Niger's proof-of-concept project is expanding from its current 100.000 to cover 263.000 people by the end of 2010.

As an additional step, this Toolkit has been prepared in hopes that it may be useful to anyone who might wish to implement the same kind of project in their own geographical area of responsibility. This first version of the Toolkit is certainly far from perfect! (Nor is producing it the project's main goal.) Knowing it could be better, we aim to improve the Toolkit based on feed-back from others and program-experience as the Niger project continues.

I. TOOLS

Tool IV.1. Budget

This pilot project for 100.000 people in a vast, remote, multiethnic area cost on the order of $210.000 in its first year, including significant one-time start-up costs like the procurement of a national-level planning meeting, a 4-wheel drive vehicle, several all-terrain motorbikes, etc. We put the budget into this toolkit because we hope it may be useful to see the line-items. We have removed the numbers because each program must use numbers that are realistic in its own context.

The budget set-up can be seen on the next two pages.

The budget presented here presents a compressed overview of the project's activities in chronological order of implementation, and it may serve as a check-list for planning purposes, of things needing to be done if one wishes to start a similar project.

STRATEGIES		Number/Quantity	Cost/Unit	Total
Plaidoyer/ Mobilisation				
	Meeting Admin. Leaders			
	Total Perdiem to Participants			
	Total Transportation Costs			
	Other			
Sub Total Meeting of Admin. Leaders				
	Meeting Local Leaders			
	Total Perdiem to Participants			
	Total Transportation Costs			
	Other			
Sub Total Meeting of Local Leaders				
	Trip to mobilize the villages			
Sub Total Mobilization				
Sub Total Plaidoyer/Mobilisation				
Training				
	Develop the training module			
	Supervisors' Module			
	Photocopies			
	Training of Supervisors			
Sub Total Training of Supervisors				
	Training Traditional Birth Attendants and Villlage Volunteers			
Sub Total Training the Village Volunteers				
Sub Total Training				
IEC				
	Sensibilisation by the Village Volunteer and/or Supervisor			
	IEC media			
	Educational Materials			
Sub Total IEC				

Item	Detail	Note
Epidemiologic Surveillance		
	Data collection	
	Initial Survey	
	Forms / Materials	
Sub Total Epidemiologic Surveillance		
Follow-Up/ Evaluation		
	Initial evaluation of Trained Volunteers shortly after initial training	
Sub Total Evaluation of Volunteers		
	Evaluation at 1 Year	
Sub Total Evaluation at 1 Year		
	Monthly & other Supervision	
Sub Total Supervision		
Sub Total Follow-Up/Evaluation		
Medical Care		
	Evacuation	Paid by a different project
	Treating detected fistula cases	Paid by a different project
	Consult at fairs	Paid by a different project
	Social reintegration	Paid by a different project
Logistics		
Sub Total Logistics		
Operating Budget		
Grand Total		

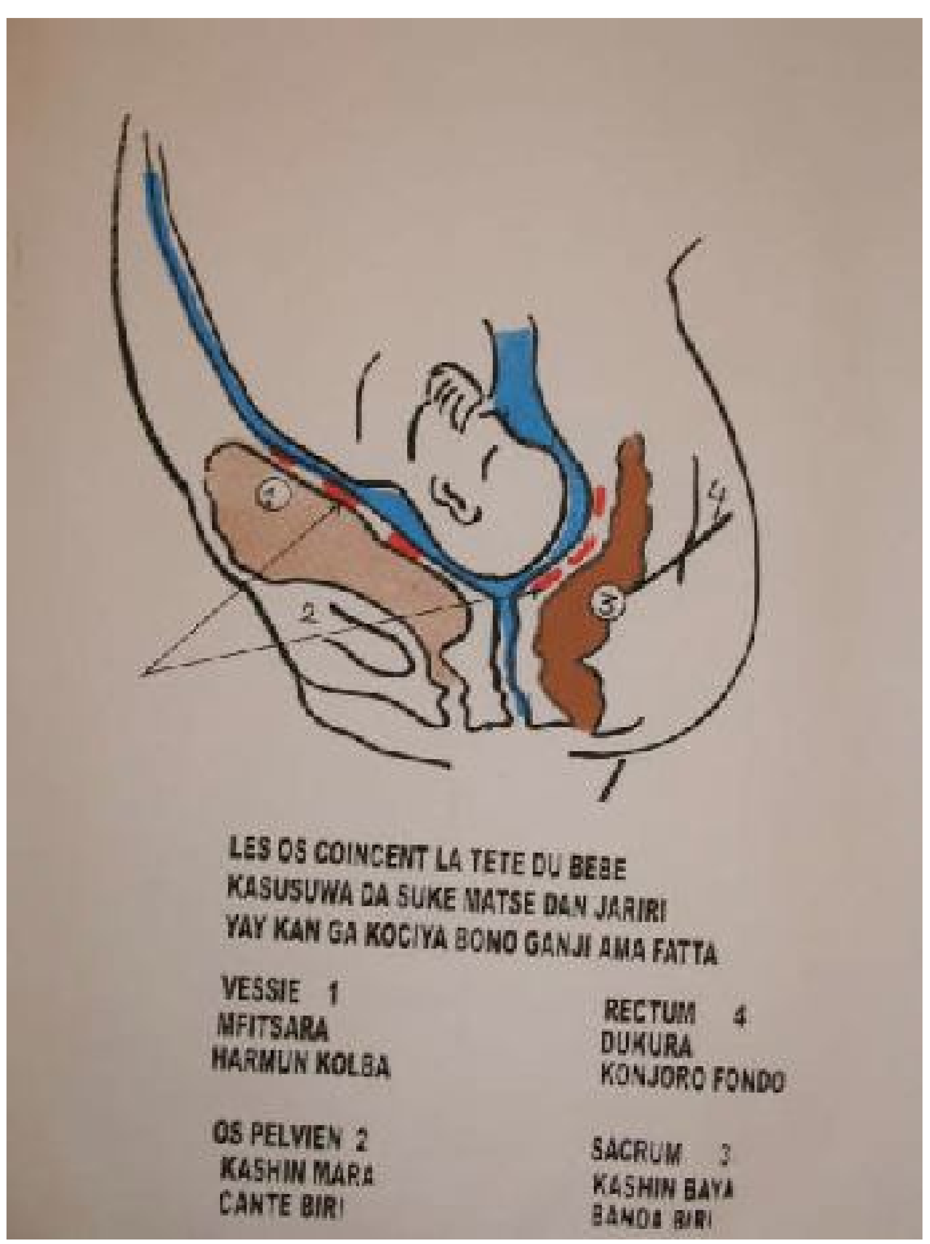
Tool IV. 2. Cotton Flip-Chart

Drawings for the Cotton Flip-Chart, Used at the Community Level

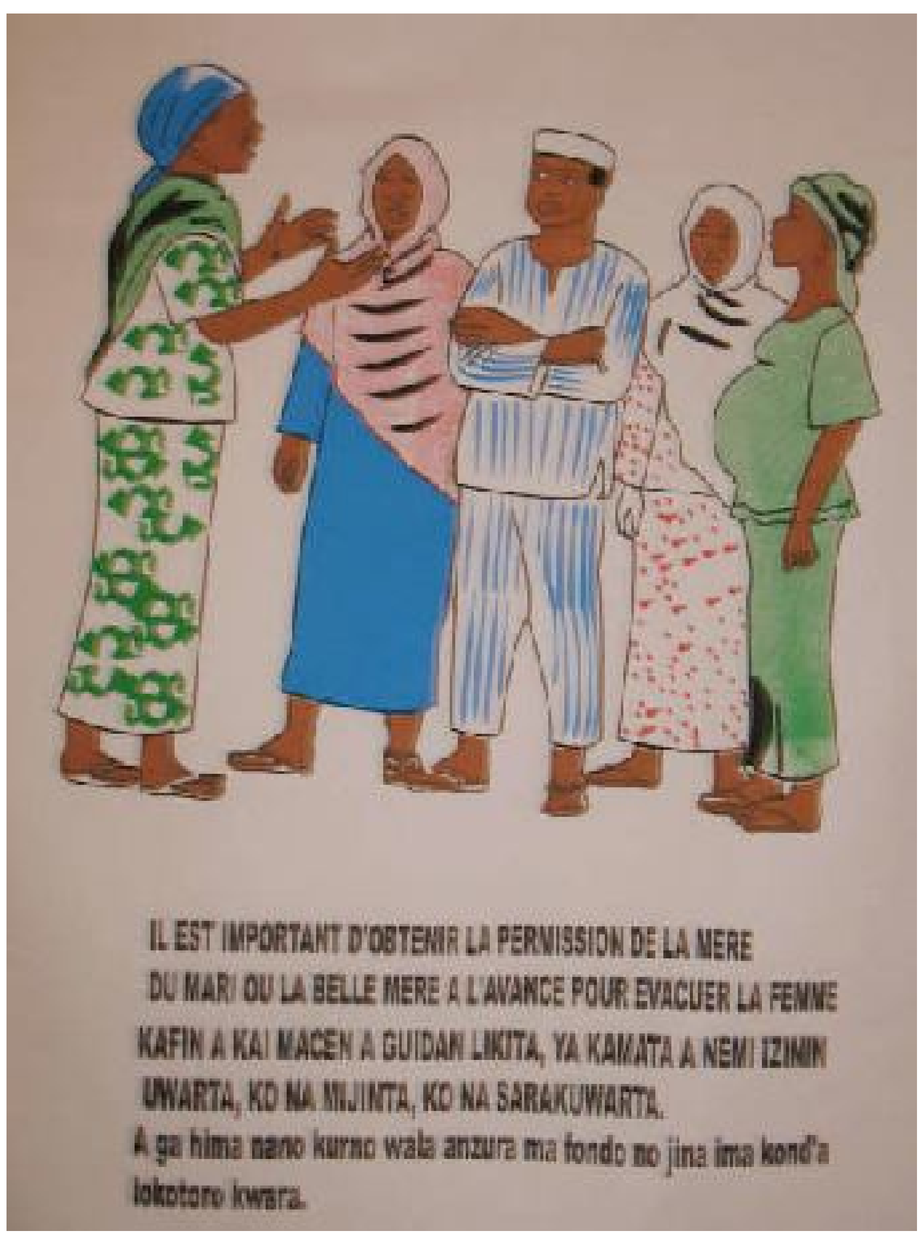
Note: Drawings shown here are just one of the three versions in four regional languages in which the flip-chart was made, so as to be relevant to the main population groups in the Bankilare area.

Message 1 : This woman has a fistula. After a birth, she leaks urine even at night.

Message 2 : Fistula comes after labor lasting through two sunsets or longer.



Message 3 : The fistula is produced when the head of the child presses on the inside of the pelvis for too many hours.

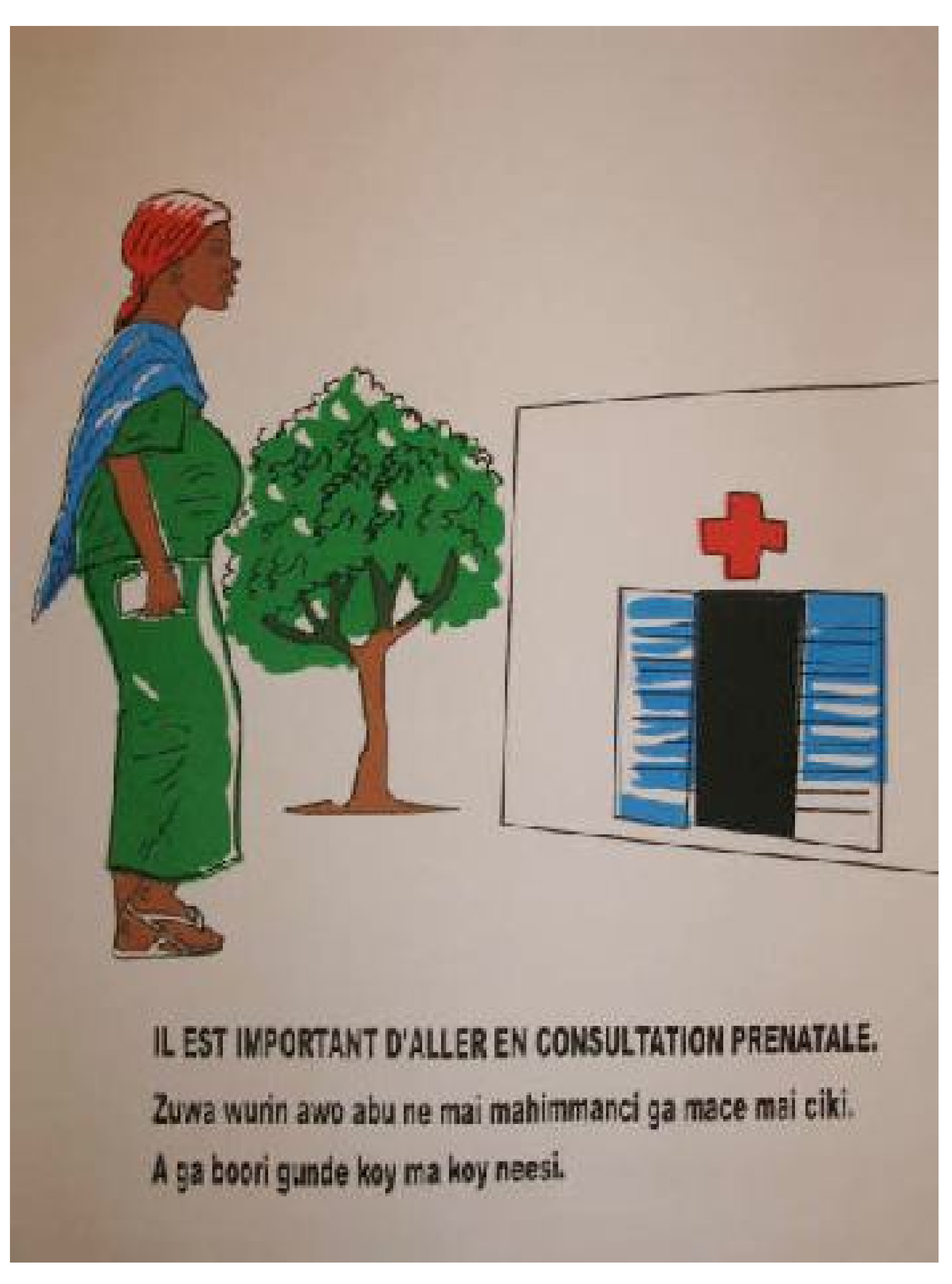


Message 4 : It is important to obtain permission from the woman, her husband, the grandmother, and other family decision-makers in advance, before the birth, for her to be evacuated if that becomes necessary.

Message 5 : *The community's female volunteer(a Traditional Birth Attendant) must organize evacuation of a woman who is in labor for more than 12 hours.*
The sun must* NEVER *rise twice over a woman in childbirth!!

Message 6 : How to get help ? Call Bankilare for the ambulance.
If the Bankilare ambulance is unavailable, Bankilare will call Tera Hospital for theirs.

Message 7 : How to get help ? If you do not have mobile phone coverage, go to the nearest Health Center (CSI) by donkey cart.



Message 8 : It is important to go for prenatal consultation.

Message 9 : It is important to deliver your baby at the Health Center (CSI).

Message 10 : It is important to go for postnatal consultation.

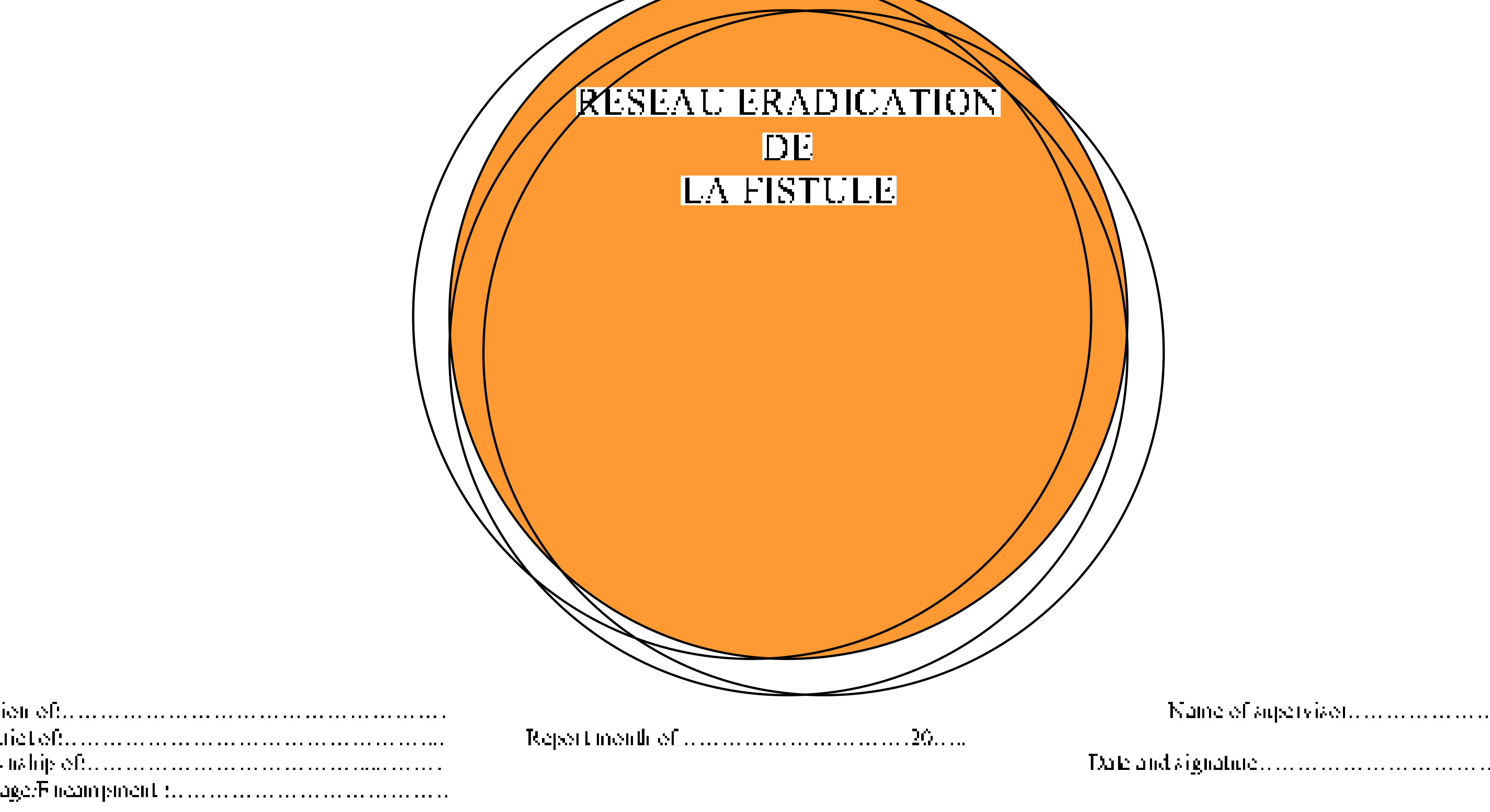
Message 11 : If you know a woman with a fistula, new or old, tell her to go the nearest health center.

Tool IV. 3. Village Data Registration Booklet

Republic of Niger
Ministry of Public Health
Ministry for Promotion of Women and Protection of Children
Network for Eradication of Obstetric Fistula

Region of :……………………………………
District of :……………………………………
Township of :……………………………………
Village/Encampment :…………………………

Booklet for Epidemiologic Surveillance of Obstetric Fistula in villages



Region of:……………………………………
District of:……………………………………
Township of:……………………………………
Village/Encampment :…………………………

Report month of ……………………………20…..

Name of supervisor……………………………
Date and signature……………………………

Transcription in Djenne Djenne in Arabic script	New Pregnancies	[illegible] Prenatal Consultation	Home Births	Women evacuated in prolonged labor	Women going to Postnatal Consult.	Educational sessions	Fistula cases	Fistula cases referred	Maternal Deaths	Perinatal Deaths
Transcription Tamasheq Fulfulde										
Other [illegible]										

- Nb of new pregnancies (not previously counted)
- Nb of women going to prenatal consultation (for 1st time in this pregnancy)
- Nb of home births
- Nb of cases of prolonged labor (>24 hours)
- Nb of women going to postnatal consultation (for 1st time in this pregnancy)
- Nb of health education sessions
- Nb of fistula cases during the month
- Nb of fistula cases referred during the month
- Nb of maternal deaths
- Nb of perinatal deaths

Description of the Booklet for Epidemiologic Surveillance of Obstetric Fistula in villages

The cover page lists, at the top, the different government entities involved in the project on the left, i.e. the Ministry of Public Health, the Ministry for Promotion of Women and Protection of Children, and the Network for Eradication of Fistula. And on the right, the name of the Region, the District the commune s (township), and the village/encampment concerned.

The data registry booklet consists of 24 pages, of which 12 are copies. It's a good idea to make it for 15-16 months, having some extra as a buffer, but the booklet is for one year. Each page has 9 images and text concerning the 10 pieces of information to be collected in the villages each month by the village volunteers.

The text for each image is written in the French, Djerma, Tamasheq, and Fulfulde languages, with a transcription into Arabic script for each of the latter three languages.

The Village Data Registry Booklet is designed for village volunteers to register data, also concerning their activities, each month.

The form is filled using dashes. Each dash represents a person or activity according to the defined criteria.

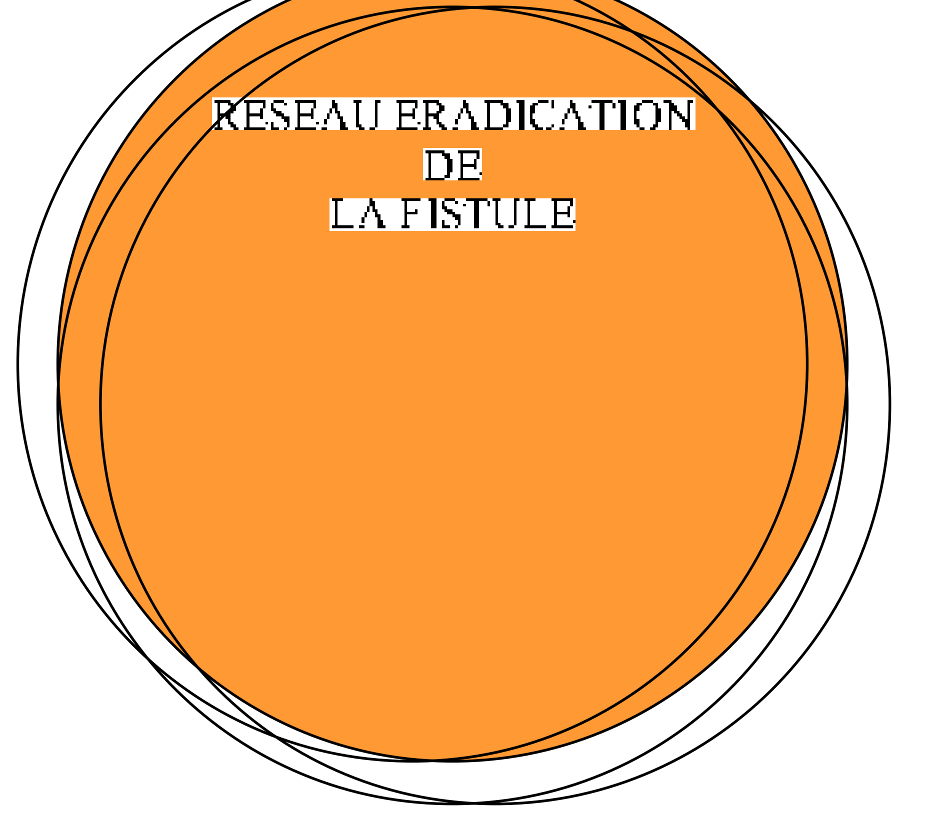
One booklet is placed in each individual village or encampment.

Each month, the supervisor visits the village to collect the data, provide supportive supervision, and summarize data concerning the activities carried out during the month. He takes one page with him, leaving the carbon copy. And he signs and dates the booklet to indicate when he was there. He leaves the booklet in the village.

Tool IV. 4. Village Register for Obstetric Fistula Surveillance

Republic of Niger	Region of:..
Ministry of Public Health	District of:..
Ministry for Promotion of Women and Protection of Children	Township of:..
Network for Eradication of Obstetric Fistula	Village/Encampment :..................................

VILLAGE REGISTER FOR SURVEILLANCE OF OBSTETRIC FISTULA



Report month of ....20....

NEW PREGNANCIES				CASES OF FISTULA		
FAMILY NAME First Name		Age	Comments	FAMILY NAME First Name	Age	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						

Nr. of Home Births	Nr. of Obstructed Labor cases	Nr. of Health Ed. Sessions	Nr. of women who died in labor lasting >24 hrs	Nr. of perinatal infant deaths

Observations and recommandations from the supervisor :

Name of the supervisor : Date and Signature :

Description of the Village Register for Obstetric Fistula Surveillance

The Register is a monthly report which makes it possible for the supervisor to synthesize the data collected at the village level.

It shows the First and Family Name and age of women registered as having a new pregnancy or a new fistula. It also shows the number of Home Births, the number of cases of prolonged (obstructed) labor, the number of health information sessions conducted, the number of maternal deaths, and the number of perinatal infant deaths.

Under Observations concerning new pregnancies, the supervisor includes pertinent information about each woman. For example, whether the woman goes for prenatal consultation or not, if she is lost-to-follow-up, if she refuses prenatal consultation, and other pertinent information.

Under Observations concerning new fistula cases, the supervisor is to indicate whether the woman has been referred to the health care system whether she has been lost-to-follow-up. If the woman refuses prenatal consultation or is not referred for a new fistula, the supervisor is to explain why.

For the number of home deliveries, the number of obstructed labor cases, the number of health information sessions, the number of maternal and perinatal deaths, the supervisor simply indicates the number of tick-marks registered that month in the Booklet for village based data registration.

The box, « Observations and Recommendations » at the bottom of the page allows the supervisor to make comments concerning any problems encountered by the Village Volunteers when carrying out their activities.

At the bottom, the supervisor is to write his/her name, write the date of the visit, and sign the page.

Tool IV. 5. Cumulative Reporting Form

Republic of Niger
Ministry of Public Health
Ministry for Promotion of Women and Protection of Children
Network for Eradication of Obstetric Fistula

District of:
Supervisory Zone:
Year:
Month of:

Nr	Village/Encampment	Total No. of Maternal Deaths Preceding Year	Total No. of Fistula Cases the Preceding Year	Population	No. of Anticipated Pregnancies	No. of New Pregnancies	No. of Women Going to Prenatal Consultation	No. of Home Births	No. of obstructed labor cases	No. of Women Going for Postnatal Consultation	No. of Health Education Sessions	No. of New Fistula Cases	No. of Fistula cases Referred	No. of Maternal Deaths in Obstructed Labor	No. [illegible]
1															
2															
3															
4															
5															
6															
7															
TOTAL															

Nr. of localities supervised
Nr. of home births:

Nr. of new pregnancies :

Nr. of obstructed labor cases :
Nr. of fistula cases :

Supervisor
Date and Signature :

Chief of the CSI
Date and Signature :

District Medical Chief
Date and Signature :

Tool IV . 6. System of Epidemiologic Surveillance

ADMINISTRATIVE LEVEL	DATA COLLECTION	Timline	TOOLS	FEEDBACK	SUPERVISION
INTERNATIONAL OMS, UNICEF, FDI, UNFPA, Other donors	[illegible]	Monthly 12th - 15th of the month		- Direct contact - Review Fistula	- International meetings - Direct, regular contact (Tel, E-mail, Fax)
NATIONAL Min. Public Health and Prevention	[illegible]	Monthly 5th - 10th of the month	- Data Entry + Analysis using Epi Info, Excel and Healthmapper - Line listings - Tables of data	- Monthly report - Direct Contact - Weekly - Supervision - Annual Meeting	- Quarterly visits - Frequent phone calls - Investigations - Annual Evaluation
REGION Regional Direction Pub. Health, Tillabéri	[illegible]	Monthly 5th - 10th of the month	- Data collection forms - Maps - Line listings - Tables of data	- Monthly Report - Direct Contact - Weekly - Supervision - Quarterly meetings	- Quarterly visits - Confirmation of cases - Investigations - Annual Evaluation
SUB-REGION Téra Health District	[illegible]	Monthly 5th - 9th of the month	- Data collection forms - Maps - Line listings - Tables of data	- Monthly visits - Training re-training - Confirmation of cases - Investigations - Quarterly meetings	- Monthly visits - Confirmation of cases - Investigations
LOCAL CSI and Health Hut	[illegible]	Monthly 25th - 5th of the month	- Data collection forms - Maps - Line listings - Tables of data	- Monthly visits - Training re-training - Confirmation of cases - Investigations	- Monthly visits - Confirmation of cases
VILLAGE/ENCAMPMENT Localities in the Townships of Bankilaré and Gorouol	[illegible]	Monthly	- Village data registration module - Village Register	- Monthly visits - Training re-training	- Monthly visits

REPUBLIQUE DU NIGER

MINISTRY OF PUBLIC HEALTH

MINISTRY FOR PROMOTION OF WOMEN AND PROTECTION OF THE CHILD

NETWORK OF OBSTETRICAL FISTULA ERADICATION

PILOT PROJECT FOR RAPID PREVENTION OF OBSTETRICAL FISTULA

Regional Direction of Public Health of : ……………………………….
Health District of : ……………………………………………………………………………..
Integrated Health Centre of : ……………………………………………………………………..
Health Hut/ Village of : ………………………………………………………………………….

YEARS : 2008 – 2010
OBSTETRIC FISTULA
EPIDEMIOLOGIC SURVEILLANCE BOOK

STARTING DATE : ____/___/___

NIGER REPUBLIC

MINISTRY OF PUBLIC HEALTH

FISTULA ERADICATION NETWORK

PILOT PROJECT OF RAPID PREVENTION OF OBSTETRIC FISTULA

GENERAL INFORMATION ON THE VILLAGE

Name of the village : …………………………..
Number of families in the village:…………

Integrated health center of : ……………
Health District of: …………………
Health Region of : ………………….

Population of the locality : ……………….

Number of Women 12-49: ………….

Births Expected : …………………

▪ OBSTETRICAL SITUATION

1. Births registered last year: ……………
2. Maternal Deaths due to Prolonged labor the last year: …………….
3. Number of new fistulas last year : ………………..
4. Number of evacuations due to prolonged labor last year: …………………

▪ REPRODUCTIVE HEALTH SERVICES UTILIZATION

1. Number of women in prenatal consultation last year : ………………
2. Number of women in postnatal consultation last year: ……………….……..
3. Number of normal deliveries in healthcare settings last year: ………….

▪ MEDICO-SOCIAL INFRASTRUCTURES:

1. Existence of a school : Yes /__/ No /__/

3. Existence of a Integrated Health Center Yes /__/ No /__/

3. Existence of a Health Hut Yes /__/ No /__/

▪ HUMAN RESOURCES :

1. Number of Village Volunteers in the locality: ………………

Men /__/ Women/__/

▪ OTHER USEFUL INFORMATION : …………………………

………………………………………………………………………

Last and First Name of Village Volunteer(s) ……………………..

Last and First Name, Chief of the Village …………………………

Date : __/__/__ ……………………

MONTH OF ....

NEW PREGNANCIES				FISTULA CASES		
LAST NAME First Name		Age	Observations	LAST NAME First Name	Age	Observations
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Number of Home Births	Number cases of obstructed labor	Number of Health Education Sessions	Number of women who died in obstructed labor	Number of children who died

Observations and recommendations of the supervisor :

LAST and First Name of supervisor : ....

Date and Signature : ....

MONTH OF ....

- **Prenatal Consultations (CPN) :**
- **Postnatal Consultations (CPON) :**
- **Births**

Number of Births	Births taken care of locally	Nr. of Births referred	Observations

- **Fistulas**

Number of Fistulas Detected	Number of Cases Referred	Observations

- **Evacuations following prolonged labor**

Number of Evacuations	Observations

- **Other Integrated Activities**

....

Observations and recommendations of the supervisor :

Name and signature of supervisor : Date of supervision : ___/___/___ ;

Tool IV.7. Training manual

REPUBLIC OF NIGER

MINISTRY OF HEALTH

MINISTRY FOR PROMOTION OF WOMEN
AND CHILD PROTECTION

NETWORK FOR FISTULA ERADICATION

Pilot Project for Rapid Prevention of Maternal Mortality and Obstetric Fistula

Training Module

for Fistula and Maternal Death Prevention

INTRODUCTION

Reproductive health has for the past two decades, been an ongoing concern for the international community.

By WHO estimates, 585,000 maternal deaths occur worldwide each year from complications related to pregnancy or childbirth, i.e. one death every minute.

95% of these deaths occur in Africa and Asia, 4% in the Americas and the Caribbean and 1% in developed countries.

In Niger, according to the EDSN MICS-3 / 2006 survey, maternal mortality rate is estimated at 648 maternal deaths per 100,000 live births, with 4 out of 5 deliveries taking place at home, without the assistance of any trained personnel.

Among the main complications of child delivery responsible for maternal deaths or disability are: obstetric fistulas, postpartum hemorrhage (PPH), hypertensive states (eclampsia / vasculo-renal syndromes), and infections.

An obstetric fistula is the constant leakage of urine and/or intestinal content through the vagina, day and night, even while the woman sleeps, which started after a birth. This disability results from disrupted blood circulation during a prolonged child delivery, and it is permanent unless corrected by surgery.

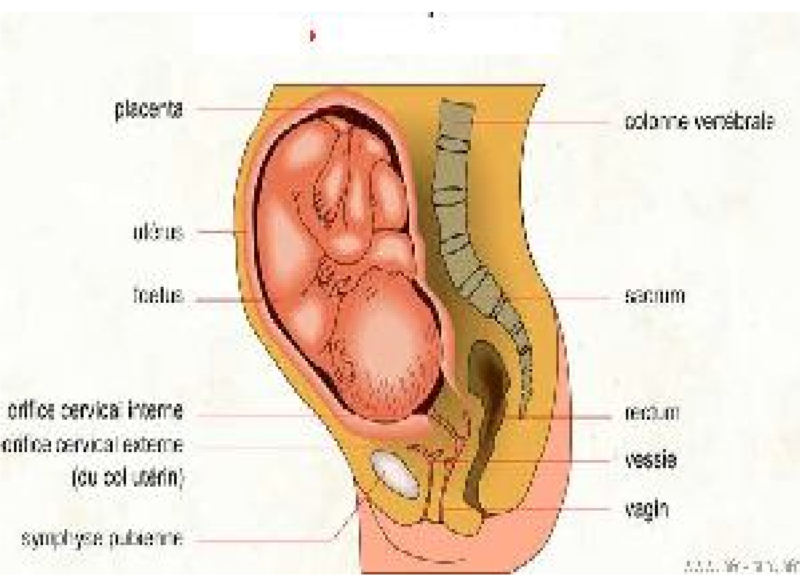
Obstetric fistula is one of the strongest indicators of health system failure, and it provides a targeted proof of such failure.

Experts distinguish between vesico-vaginal fistula (VVF), the recto-vaginal fistula (RVF).

The mechanism for developing obstetric fistula is simple: During a prolonged labor and delivery, the anterior wall of the vagina, the lower back of the bladder and the urethra are compressed between the head of the fetus and the inside of the woman's bone pelvis, both at the front and at the back of the pelvis.

This compression causes disruption of the blood supply (ischemia). If the blood supply is disrupted long enough, that squeezed tissue cannot survive and it becomes necrotic. Necrotic tissue is always "sloughed off" or discarded by the body 3 to 7 days later. This leads to the formation of a large or a small hole. The urine or feces flow into the vagina through the hole.

The compression can also cause damaged to specific nerves, and resulting damage can cause permanent difficulty in walking.



Obstetric fistula is a debilitating disability.

The characteristic bad smell that accompanies the flow of urine or stool makes these young women marginalized people, losing their homes, their friends and relatives.

In Niger, obstetric fistula is recognized as a public health problem, a problem which reflects the failure of the health system to provide primary health care to women; however, its prevalence still remains unknown.

Given the scope of this disability, the Nigerien government decided to react, together with all those who have been working for many years to provide safer child delivery and to prevent and treat the obstetric fistula (i.e. doctors, nurses, traditional birth attendants (TBAs), social workers, associations and NGOs). Niger joined the international campaign launched in 2003 to eradicate obstetric fistula.

It is in this context that the Network for the Eradication of the obstetric fistula (REF) was established in February 2004.

This network, under the supervision of the MOH (MSP) and the Ministry for the Promotion of Women and Protection of Children, has three areas of intervention:

- Prevention through awareness raising, training and advocacy
- Medical and surgical case management
- Socio-economic reintegration of cured women former victims of the obstetric fistula.

The REF's goal is the eradication of the obstetric fistula through a mobilization of internal and external resources.

It is in this spirit that HDI (Health & Development International), after a successful decade

of intervention for the eradication of dracunculiasis (Guinea worm), decided to lend its support to the REF. Its strategy of action is largely identical to that used successfully in the eradication of dracunculiasis, namely the training and retraining of the concerned stakeholders in the field, optimizing use of existing resources, and monthly collection and analysis of data to guide program improvements. HDI's aim is to provide simple and clear messages to populations even in the most remote areas.

This training module for facilitators has been developed for that purpose.

The module was designed for supervisors, traditional birth attendants (TBAs) and community workers in the framework of the Rapid Prevention of Maternal Mortality and Obstetric Fistulas Project in the Canton of Bankilaré.

The training module is divided into seventeen (17) sessions, supported by eleven (11) supporting texts, as well as by related topics and practical exercises.

Its main learning methods are brainstorming, lectures, games, questions and answers, practical demonstrations, role-play, etc.

To facilitate learning without overburdening participants, the material covered by the module is taught over a three-day period.

Finally, the question and answer method is used to evaluate comprehension of the materials taught during the training sessions.

NOTE: This Module is designed for health workers, especially Health Center nurses. The Module's vocabulary reflects that fact. In this translation, which is designed for public health professionals who wish to better understand Niger's Rapid Maternal Mortality and Obstetric Fistula Prevention Project, and who will in any case want to modify it before using the Module in other countries, no effort has been made to remove technical words or to translate using wording that would be appropriate for people who have had little schooling. Most or all technical words are defined in the text.

This is a slightly modified English translation of the March 2009 version of the Training Module, which was originally written in French. The Module is regularly being updated and improved.

Session No. 1

ADMINISTRATIVE MATTERS, EXPECTATIONS, NORMS AND OBJECTIVES OF THE TRAINING PROGRAM

Objectives:

At the end of this session, each participant should be able to:

1. Find answers to administrative issues
2. Express their expectations about the training
3. Become aware of the standards of a working group
4. Identify the objectives of this training
5. Know the training program

Duration: 40 minutes

Contents of the session:

1. Attendance list, accommodation, per diem, travel
2. Recording of participants' expectations
3. Standards of a working group
4. Objectives and Training Program

Progress of the session: The facilitator will provide the necessary clarifications regarding subsistence, accommodation and transportation allowances for participants.

- Using the technique of brainstorming (i.e. proposing an idea or asking a question and seeking the views of participants on the issue), the facilitator will collect participants' expectations.
- He/she will proceed in the same way in defining the working standards that each participant will be required to comply with during the training.
- He/she will explain the objectives and program of the training.
- At the end of the session, he/she will draw the attention of participants to the need to know the desired objective before starting any action.

Supporting Text No. 1

A. Objectives of the Training of Supervisors

1. General objectives

- To teach people in the villages, hamlets and nomadic camps how to prevent the occurrence of obstetric fistulas
- To raise the awareness of people in improving their health status

2. Specific objectives

At the end of this training each participant should be able to:

- Describe the institutional framework of the REF
- Describe the structural organization of the early prevention of obstetric fistulas project
- List the objectives and strategies of the early prevention of obstetric fistulas project
- Describe the functions and roles of TBAs (Traditional Birth Attendants) and male community volunteers in the program, and group leaders
- Define obstetric fistula
- Describe how obstetric fistula occurs
- List the various forms of obstetric fistula
- Know the causes and contributing factors behind obstetric fistula
- Know the consequences of obstetric fistula
- Know how to prevent the occurrence of obstetric fistula
- Know the medical evacuation plan in his/her specific area, for women who have been in labor for at least 24 h
- Know the case management plan for women with an obstetric fistula (where to refer them to?)
- Facilitate a training / retraining session for TBAs
- Organize and conduct interpersonal communication groups and group discussions

B. Schedule of the training

TRAINING SCHEDULE FOR SUPERVISORS

Day 1:

8:00 - 8:30: Welcome and Seating of Participants

8:30 - 9:30: Opening Ceremony of the training

9:30 -10:30 Introduction of participants

Administrative matters, expectations, working standards, objectives and agenda of the training

10:30 -11:00: Coffee Break

11:00 -13.00: - REF's Institutional framework, organizational structure, objectives and strategies of the Rapid Prevention of Obstetric Fistulas Project

Responsibilities and roles of TBA- and male volunteers, and supervisors

13:00 -14:30: - Lunch Break and Prayer

14:30 -17:30: - The obstetric fistula, how it happens, clinical forms, causes

Consequences of the obstetric fistula

Prevention of obstetric fistula

A woman who has been in labor for 12 h must be sent to hospital

Medical evacuation plan

17:30: End of the day

Day 2:

8:00 - 8:30: Summary of previous day's lessons

8:30 - 10:00: Strategy for the early prevention of the obstetric fistula

10:00 - 10:30: Coffee Break

10:30 - 12:45: Epidemiological surveillance materials

12:45 -14:00: Lunch break and prayer

14:00 -17:15: Communication methods
Explanation of messages and use of visual aids

17:15: End of the day

Day 3:

8:00 - 8:30: Summary of previous day's lessons

8:30 - 10:00: Interpersonal or face to face communication techniques

10:00 -10:30: Coffee Break

10:30 - 12:45: Group discussion technique:
Role-play technique

12:45-14:00: Lunch break and prayer

14:00-15:45: Role-play technique (continued)
Evaluation of the training

15:45-17:15: Closing Ceremony of the training

Session No. 2
Goals and Strategies of
The Rapid Prevention of Obstetric Fistulas Project

Objectives:

At the end of the session, each participant should be able to:

- Explain the objectives and strategies of the Rapid Prevention of Obstetric Fistula Project.

Contents of the session:

- Explanation of the different objectives of the Project
- Explanation of the Project's action strategies

Progress of the session

This session may be conducted as a reminder to participants about the vision of the program. Particular emphasis should be placed on the strategies of the Project.

Supporting Text No. 2

OBJECTIVES OF THE RAPID PREVENTION OF OBSTETRIC FISTULAS PILOT PROJECT (Bankilaré Canton, Niger)

Background

The diagnosis of a woman in labor is the same regardless of where it is performed (health facility or elsewhere) and regardless of who does it (doctor or other). And it requires no instrument or test. Any trained person can measure the duration of labor. Childbirth is considered to be obstructed, or blocked, if the baby is not out within 24 hours. Furthermore, the risk of an obstetric fistula normally only appears after 24 hours of regular contractions during childbirth.

One may infer that obstetric fistulas can be eliminated if all women in labor for more than 24 hours are quickly referred to a hospital that even today can do emergency surgery.

This working hypothesis led to the Rapid Prevention of Obstetric Fistula project.

General objective

To prevent new cases of obstetric fistula in the pilot region, contribute to reducing maternal and infant mortality, and improve indicators defined in the National Program of Reproductive Health, through actions carried out together with rural populations.

Intermediate objectives:

- Raise the number of prenatal and postnatal medical consultations
- Raise the number of deliveries in health facilities
- Lower the number of maternal deaths related to pregnancy
- Lower the number of new obstetric fistulas
- Get old and new fistula cases treated quickly

EVALUATION INDICATORS

- Number of prenatal consultations
- Percentage of attended deliveries
- Percentage of problem deliveries referred
- Number of new cases of fistula. GOAL: At least 50% reduction within 2 years
- Percentage of new fistula cases referred for treatment
- Percentage of villages covered / reporting monthly
- Number of IEC sessions (information- education- communication)
- Number of maternal deaths
  GOAL: At least 75% reduction in obstructed labor deaths within 2 years
- Number of perinatal infant deaths
- Percentage who go for postnatal consultations

STRATEGIES

Activities aiming to achieve rapid prevention of obstetric fistula combine several strategies. These strategies are integrated with community-based activities.

They are:

- Advocacy and social mobilization
- Training and retraining
- Community-based epidemiological surveillance
- Information, Education and Communication (IEC)
- Monitoring and evaluation activities
- Case management of fistulas
- Support of the health system, including a logistics system for evacuating women during obstetric emergencies, using existing resources

Session No. 3

ROLES AND RESPONSIBILITIES OF COMMUNITY VOLUNTEERS and SUPERVISORS

AND

RELATIONSHIPS BETWEEN THE COMMUNITY VOLUNTEER AND OTHER VILLAGE-LEVEL SYSTEMS

Objectives:

At the end of the session each participant should be able to:

1. Identify the roles and responsibilities of the supervisor, the traditional birth attendant/female village volunteer (TBA) and the male volunteer;
2. Know the relationships that should exist between community volunteers, supervisors and other village-level systems of participation.

Duration: 1 hour 30 minutes

Contents of the session:

1. Definition of supervisor and community volunteer
2. Duties of the supervisor and the female and male community volunteers
3. Role of community volunteers in the rapid prevention of fistulas program
4. Knowing the relationships with other existing village-participation systems

Progress of the session:

This session may be conducted in the form of a brainstorming using the experience of participants. The trainer will need to make necessary clarifications, to facilitate achievement of the objectives and especially a good understanding of the roles of community workers and supervisors.

Supporting Text N ° 3

a) Roles and Responsibilities of the Community Worker

- Inform and educate the population
- Register and monitor each pregnancy
- Obtain permission in advance to evacuate each woman, in case needed
- Medical evacuation of women in labor for 12 hours or more
- Regular feedback of activities to the village chief and the community
- Home visits
- Identify and report fistula cases (old and new)
- Refer fistula cases to the health system for free treatment
- Participate in other health activities

b) Roles and Responsibilities of the Supervisor

- Train community workers
- Education for Health (EPS)
- Immediately manage each emergency evacuation
- Ensure referral of fistula cases to hospital care
- Check the recording of each indicator
- Collect and transmit data each month
- Home visits
- Regular feedback on activities to the village chief and the community
- Report on activities to higher level supervisors
- Participation in all activities of the obstetric fistula week

Session No. 4

DANGER SIGNS RELATED TO PREGNANCY AND DELIVERY

Objectives

1. Define a danger sign
2. Teach how to recognize danger signs during pregnancy
3. Teach how to recognize danger signs during delivery
4. Teach how to recognize danger signs for the mother and the child during the postpartum period

Duration: 1 hour 15 minutes

Content

♣ **What is a danger sign?**

- It is an event that alerts the woman and those around her to the existence of a complication. The complication can be serious and threaten the lives of the woman and / or her baby during pregnancy, during delivery or during the period following delivery.

- In the presence of a danger sign, the woman must be quickly taken to a health center for care.

♣ **What are the danger signs during pregnancy?**

- Pain in the stomach and lower abdomen
- Severe vomiting
- Bleeding (blood) from the vagina
- Swelling (edema) of the feet, hands, face, sometimes accompanied by severe headaches
- Pallor of the hand-palms, the eyelids and the gums
- Feeling hot or having chills
- Baby no longer moving in the belly
- Dizziness
- Convulsions
- Flow of water from the vagina even before the start of labor
- Vaginal discharge with a very bad smell
- Difficulty breathing

(NB: remind participants of the proper action to take in any case of danger sign)

♣ **What are the danger signs during delivery?**

- Very long labor (lasting more than 12 hours)
- Convulsions or unconsciousness
- Heavy flow of blood from the vagina
- Unbearable abdominal pain
- Feeling very tired
- High fever (body very hot)
- Baby's arm coming out of the vagina (the baby is lying face down in a bad position)
- The placenta does not come out of the vagina within 30 minutes after delivery
- A green or brown liquid flowing out of the vagina.

(NB: remind participants of the proper action to take in any case of danger sign)

♣ **What are the danger signs during postpartum for the mother?**

- Pain in lower abdomen
- Heavy flow of blood from the vagina
- Vaginal discharge with a very bad smell
- Feeling very hot
- Swelling of the face, hands and feet
- Severe headaches
- Convulsions
- Feeling very tired
- Difficulty breathing
- Inability to hold urine (fistula? incontinence?)

(NB: remind participants of the proper action to take in any case of danger sign)

♣ **What are the danger signs during postpartum for the baby?**

- Bleeding (blood) or pus in the umbilical cord
- Difficulty breathing or sucking
- Body hot
- Vomiting
- Jaundice
- Convulsions
- Eyelids swollen, sticky with flowing of pus

(NB: remind participants of the proper action to take in any case of danger sign)

Session No. 5

PREVENTING COMPLICATIONS OF CHILDBIRTH

Objectives:

1. To make the couple, the family and the community aware of the need to prepare for the child delivery and its possible complications
2. To explain the medical evacuation plan and the need to comply with it

Duration: **45 minutes**

Contents:

1. Preparing for the child's delivery and its possible complications

- Why is it necessary to prepare for the delivery and its possible complications?
- Preparation for the delivery allows the family to avoid "the 3 delays", and to have a plan for a better management of the delivery and its possible complications
- What are the 3 delays? (Here the trainer must clearly explain the 3 delays)
- Who is involved in preparing for the child's delivery?
- Preparing for the child's delivery is not the sole responsibility of women.
  To effectively prepare for the delivery:
  - The woman must announce her pregnancy early to her husband or an influential member of her family
  - There must be a dialogue between the woman and her husband on how to prepare for the child's delivery and what to prepare
  - This dialogue and exchanges must also be conducted with other family members and even members of the community that can help the couple to muster all the necessary elements to prepare for the child's delivery and its possible complications

- Why is it important that men be involved in preparing for the delivery and its possible complications?

  Because:

  - Men should support women by accompanying them to prenatal consultations
  - Men should discuss with their wives the issues concerning the pregnancy
  - Men should seek the means of transportation in advance
  - If possible, men should accompany their wives when they go to the health center for delivery
  - Men should save money to deal with any problems that may arise during the pregnancy
  - Men should ensure proper nutrition of their pregnant women, and also allow them to rest and avoid hard and painful work
  - When a man is involved and has all the information he needs, he can make a quick decision if necessary.

2. Complying with the MEDICAL EVACUATION PLAN

- **Any woman in labor for nearly 12 hours must be evacuated from the village. (Her transportation to the medical facility is free)**

- **The medical evacuation Plan:**
  - If the patient lives in an area with access to the cellular phone network, call the Bankilare midwife to send the ambulance. (She will accompany the ambulance in obstetric emergencies.) It will transport the patient to Tera, or to Niamey in case of unavailability of the surgeon at Tera.

  - If the patient has no access to the cellular telephone network:

  - In a village equipped with carts, transport the patient to the nearest health center, which will call the ambulance by radio
  - If there is no cart in the village, send someone to ask the nearest health center to call the ambulance, and send another person to find a cart in a nearby village, to transport the patient to the health center.

OBSTETRIC FISTULA - Sessions No. 6 to 9

Session No. 6:

The causes, and how obstetric fistula occurs

Objectives:

At the end of the session, each participant should be able to:

1. Define the obstetric fistula
2. Describe how obstetric fistula occurs
3. Give the causes of obstetric fistula
4. List the risk factors for obstetric fistula

Duration: 45 minutes

Contents of the session:

1. What is an obstetric fistula?
2. Who is at risk of developing an obstetric fistula?
3. How does a fistula occur?
4. What are the causes of the fistula?
5. What are risk factors for a fistula?

Progress of the session:

This session will be conducted in the form of a brainstorming (discussing ideas) using the experience of participants. The trainer will need to make the necessary clarifications to facilitate achievement of the objectives. To this end, he/she must proceed step by step.

Supporting Text No. 4

The obstetric fistula is a hole, a communication between the vagina and the bladder (VVF), the vagina and the rectum (RVF), or simultaneously between the vagina, the bladder and the rectum (RVVF). It is leakage of urine, intestinal contents or both, even at night while she sleeps, that began after a delivery.

The woman becomes incontinent, i.e. she loses urine and / or feces through the vagina. The condition is permanent unless corrected by surgery.

Mechanism of onset of the Fistula

During childbirth, the baby's head squeezes the walls of the vagina, bladder and rectum against the inside of the mother's pelvis, reducing the blood supply to the tissues that are in a squeeze. When labor takes too long (more than 24 hours), this compression causes so much disruption of blood supply (ischemia) that the squeezed tissue dies (becomes necrotic). The body effectively rids itself of the necrotic zone within 3 to 7 days, which leads to the formation of a large or small hole through which urine and/or feces flow into the vagina.

The compression can also damage nerves to the lower limbs, which leads to difficulty in walking.

The baby dies most of the time.

Risk factors in the birthing situation

- Every pregnant woman is at risk of experiencing obstructed labor
- No medical assistance, no detection of any abnormal situation
- In case of complications, delays in medical evacuation
- Limited access to Emergency Obstetric Care
- Delay in the evacuation decision
- No means of transportation or very slow or very expensive means
- Referral center too distant or not functioning

Biological risk factors

- First pregnancy
- Small size woman (height less than 150 cm)
- The woman was malnourished as a child
- Narrow pelvis, not large enough internal measurements
- Great number and closely spaced pregnancies
- Girl too young for a pregnancy, before the pelvis has adult form
- The body of the girl has not completed its development

Session No. 7:

THE CONSEQUENCES OF OBSTETRIC FISTULA

Objectives:

At the end of the session each participant should be able to:

state the consequences of obstetric fistula.

Duration: 45 minutes

Contents of the session:

What are the consequences of this disability?

1. Physical
2. Social
3. Economic

Progress of the session:

Brainstorm (discuss ideas) to help participants list all the consequences.
Note all the answers.

Conclude the session with a summary of the key points to remember.

Supporting Text No. 5

Physical Consequences of Obstetric Fistula

- Incontinence: Continuous flow of urine and sometimes feces
- Bad smell, difficulty maintaining good hygiene
- Frequent and repeated infections (urine, vagina)
- Risk of menstrual disorders
- Risk of infertility

Social Consequences

- Loss of dignity
- Social isolation: Divorce, repudiation, desertion by friends and sometimes family which difficult to bear
- Cannot engage in activity (economic activity, travel, public events, etc)
- Becomes a burden to her family and / or ends up a beggar
- Difficult psychological situation

Economic consequences

- Cannot engage in an economic activity to survive
- Has to face high health costs
- Becomes a burden to others
- Increased poverty

Session No. 8:

PREVENTION OF OBSTETRIC FISTULA

Objectives:

At the end of the session, each participant should be able to:

1. State the various measures used to prevent obstetric fistula
2. Identify the behaviors that help prevent obstetric fistula

Duration: 1 hour

Contents of the session:

- The various preventive measures
- Behavior conducive to the prevention of obstetric fistula
- Six rules to prevent the obstetric fistula

Progress of the session:

Use brainstorming to get participants to elicit the preventive measures they know.

- The trainer makes a good summary of the correct responses, emphasizing the key points
- Any woman in labor for nearly 12 hours must be evacuated directly to a location where emergency surgery can be performed at any time of day or night

In addition, use the opportunity to encourage behavior that reduces other risks:

- It is important to go to prenatal consultation and postnatal consultation
- It is important to deliver under medical assistance (e.g. at the health center)
- Encourage the population to avoid deliveries at a young age (<18)

Supporting Text No. 6

Obstetric fistula can be prevented by complying with the following behavior:

Go to PRENATAL CONSULTATIONS

- These consultations can help detect and prevent other dangerous risks
- Postnatal consultations are also to be encouraged

Know the RISKS

- First pregnancy
- Small size girl (height shorter than 150 cm)
- Narrow pelvis
- Great number and closely spaced pregnancies
- Early pregnancies occurring before the age of 18 (A girl aged 15 is 25 times more likely to have complications during delivery than a girl 20 years old).

Opt for ASSISTED DELIVERIES

- A much better chance of survival for women and children
- A better way to handle complications
- Reduced risk

Follow the medical EVACUATION PLAN

Do not leave a woman in labor for over 12 hours without evacuating her to an appropriate health facility.

Follow the evacuation plan

The sun must NEVER rise twice over a woman in childbirth!!!!

Practice FAMILY PLANNING It is one way of delaying the risk of early pregnancy and closely spaced pregnancies.

RULES FOR THE PREVENTION of fistulas and other obstetric disasters

1. *Any woman in labor for nearly 12 hours should be evacuated by ambulance*
2. *Deliveries should be attended by health professionals*
3. *Regular antenatal and postnatal consultations*
4. *Risk detection*
5. *Adequate family planning*
6. *Prevention of teen pregnancy*

Session No. 9

REFERRAL AND TREATMENT OF OBSTETRIC FISTULAS

Objectives:

At the end of the session each participant should be able to:

1. Refer every woman who has obstetric fistula
2. Know that an obstetric fistula is curable
3. State at least 2 precautions to be taken to prevent recurrence. Advise patients.

Duration: 30 minutes

Contents of the session:

1. Where to refer women victims of an obstetric fistula?
2. How to treat the fistula
3. Factors favoring the success of the surgery.

Progress of the session:

Use brainstorming to get participants to elicit the preventive measures they know

The trainer makes a good summary of the correct responses emphasizing the key points:

- Where to refer women with an obstetric fistula?
  - Nearest Health Center
  - National Hospital in Niamey
  - Lamordé Hospital in Niamey

If the woman is in great social distress

- Contact the Social Services
- Contact the Obstetric Fistula Center (formerly “Dimol”) in Niamey
- Contact CONIPRAT
- Contact REF

Obstetric fistulas can usually be repaired by surgery, and the treatment is free.

The post-operative care takes three (3) weeks in hospital, minimum, which is free.

The woman should not have sex for six (6) months after the operation and must not become pregnant again in the first year following the surgery.

A woman healed from an obstetric fistula should ALWAYS give birth in a reference health facility to avoid the risk of recurrence.

Session No. 10

STRATEGY FOR EARLY PREVENTION OF OBSTETRIC FISTULA

Introduction

The diagnosis of a woman in labor is the same regardless of the location where it is performed (health facility or not) or the person (doctor or other) who performs it. And it requires no instrument or test. Anyone who knows the criteria can do it, and anyone can measure the duration of the labor. Also, clinical experience has shown that most cases of obstetric fistula appear only after 24 hours or more of childbirth labor.

Obstetric fistula could therefore be eliminated if all women in labor for 12 hours or longer were referred quickly to a specialized health facility that can do surgery day or night.

However, women in labor are subject to a number of cultural and economic barriers that can be responsible for sub-optimal management of the delivery. These barriers are mainly socio-economic. This project is based on the idea that community-based activities can greatly and rapidly reduce the number of new obstetric fistulas and the number of women who die in childbirth.

Referral of every woman who is in labor for 12 hours or more could have a major impact.

The medical evacuation of all pregnant women is totally free in Niger

The proposed strategy is therefore to train and annually retrain community volunteers in the field, and equip them to perform the following tasks:

1. Detection of pregnancies

- Record all new pregnancies
- Explain to mothers the importance of prenatal consultations
- Explain to community members, the appropriate measures to put in place for the quick evacuation of women in labor:
    - Phone the Bankilare ambulance if in an area with telephone access
    - **Bring her to the health center by donkey cart if in an area without phone access**
    - Get permission in advance from the family members, for evacuation of the pregnant woman in case of complications during delivery
    - It is important to explain the risk of obstructed childbirth to every pregnant woman and to the decision makers in her family. Make a delivery and evacuation plan in case of an emergency. Permission in advance is important, in case the family's main decision maker happens to be absent when the woman needs to be evacuated.

- Record and monitor all pregnancies:
  - In the monitoring book
  - On the pregnancy registration form

2. Interview of the pregnant woman

Why the female community volunteer should interview the woman:

- To familiarize herself and build trust with the pregnant woman
- To confirm the presence of a pregnancy
- To seek permission for the adoption of an evacuation plan
- To look for risk factors of occurrence of a fistula and strongly encourage birth in a health center if she sees risk factors
- To sensitize on the importance of prenatal and postnatal consultations

3. Home visits

Why should the female community volunteer make home visits?

- To confirm the pregnancy
- To build awareness and a good relationship
- To educate on compliance with the evacuation plan
- To educate on the importance of medical assistance during delivery

4. Follow the local evacuation plan

Session No. 11:
POST PARTUM HEMORRHAGE (PPH)

Objectives:

- To know what post partum hemorrhage is
- To understand the causes and consequences of post partum hemorrhage
- To know the ways to prevent PPH and lessen its consequences
- To know the steps to be taken in the presence of a PPH

Contents:

- **Definition**

  Post partum hemorrhage consists of a loss of blood, which can be very abundant and deadly, occurring after the baby is born. It is different from bleeding in the 3rd trimester of the pregnancy which is linked to a complication of the pregnancy, such as placenta preavia or retro placental hematoma.

- **The Causes of PPH**
  - The leading cause of post partum hemorrhage is a greater or lesser degree of placental retention (the placenta remains in the womb of the mother several hours after the baby is born).
  - The 2nd most common cause is linked to an incomplete separation of the placenta which, after its expulsion, can leave some debris in the uterus (womb) of the mother and continue to cause abundant bleeding.
  - Sometimes, even after the complete exit of the placenta, a woman continues to lose blood, sometimes even profusely, due to an atony of the uterine muscle that is unable to contract to stop the bleeding.
  - Finally, the cause may (rarely), be deficiency of the coagulation system.

- **The Consequences of PPH**
  - PPH most often results in the rapid death of the mother, within 24 to 72 hours. PPH deaths may be more frequent in rural areas where the overwhelming majority of deliveries occur at home.
  - Sometimes even if the woman survives this emergency situation, she later dies (a few days or weeks later) from the effects of anemia,

especially if she is not receiving any replacement feeding.
- The newborn being unable to feed properly (if the mother is between life and death, or even deceased) sees its chances of survival greatly diminished.

NB: Today, around the world, PPH alone is responsible for nearly one third (1 / 3) of maternal deaths, i.e. 140 000 to 150 000 deaths each year.

How to prevent and minimize blood loss?

- The first rule is to deliver in a health facility
- If the delivery is to take place at home, make arrangements to evacuate any woman whose placenta is not expelled from the womb 30 minutes after delivery of the baby (see "preparation for delivery and possible complications" and "compliance with the evacuation plan")
- Urgently evacuate any woman who is bleeding heavily after delivery (see "preparation for delivery and its possible complications" and "compliance with the evacuation plan")
- If delivery takes place in a health facility, immediately administer to the mother after the baby is born one dose of synthocynon if available
- In case of delivery at home, administering 2 tablets of cytotec (400 µg) to the woman in a **SINGLE DOSE** immediately after the baby is born reduces the risk of PPH.

Session No. 12:
EPIDEMIOLOGICAL SURVEILLANCE

Objectives:

At the end of the session, each participant should be able to:

Fill the epidemiological surveillance notebook and the Epidemiological Surveillance Record Book (supervisors);

Duration: 2 hours

Materials: Epidemiological surveillance register and Record Book, pen, pencil, eraser, sharpener

Content of the session:

Filling in the monthly epidemiological surveillance form

Progress of the session:

Divide participants into small groups of four (4) to five (5) persons. Give everyone a sheet of the data registry notebook and ask them to fill in the sheet based on the following exercise.

Exercise: Hamissou is the community worker of Bangou Kaina and Gnali the TBA (female community volunteer in the project) of the village. During the month of July, Gnali has identified 12 pregnant women in her village and 3 others at a nearby farming hamlet. Hamissou has made home visits. He was able to meet 20 people to advise them individually and, with Gnali, he also held 2 sensitization meetings in different neighborhoods of his village: one (1) with the men and one (1) with the women. Based on this information, fill the form for that month for the community of Bangou Kaina.

- After the group work, ask each group's representative to present the results of their work. The correction will be done in plenary.
- Emphasize the other activities that the community worker should record in his/her notebook for the purpose of integration of activities.

At the end of the session, make a summary recalling:

- What a fistula is and its consequences for women
- The evacuation plan and the importance of having permission in advance to evacuate the woman, just in case it becomes necessary
- The registration of information (how to mark items on the form).

Session No. 13:
COMMUNICATION

Objectives:

At the end of the session, each participant should:

- know the different types of communication used in health education
- know the different educational materials used in sensitization about the early prevention of obstetric fistulas.

Duration: 45 minutes

Contents of the session:

- the different types of communication;
- the qualities of a good facilitator;
- the various educational materials used.

Progress of the session:

The trainer conducts a brainstorming session to identify all the types of communication known by the participants. Summarize and complement their responses.

The trainer does the same for the discussion on the qualities of a good facilitator and the discussion on the various educational materials used. He/she must complement the answers with the supporting texts and make use of the educational materials for the rapid prevention of obstetric fistula.

SUPPORTING TEXT N ° 8
The Qualities of a Good Facilitator

A good facilitator should encourage participants to speak. He/she should collaborate with participants to seek practical solutions to the problems identified.

In terms of knowledge, he/she must:

- have a good grasp of the subject (he/she does not need to be an expert)
- know the community
- know the different steps

In terms of training-session technique, he/she must:

- ask clear questions
- listen
- give the floor to participants
- use teaching aids
- go through the different steps
- take into account the availability of the villagers

In terms of interpersonal skills, he/she must be:

- welcoming
- nice
- friendly
- patient
- courteous
- respectful

He/she must:

- use plain language
- dress simple
- know how to put people at ease and not judge
- ask open questions
- accept all responses
- not guide or influence the listener to give answers
- not distract
- rephrase the answers for the understanding of other group members.

Session No. 14

EXPLANATION OF MESSAGES AND USE OF VISUAL AIDS

Objectives:

At the end of the session, each participant should :

1. know the key messages
2. know how to use a visual aid correctly.

Duration: 1 hour 30 minutes

Materials:

- Cotton cloth flip-chart (pagivoltes) on obstetric fistula for each village
- (Posters)

Content of the session:

- What is a visual aid?
- Characteristics of a visual aid
- Method and technique of using visual aids in face-to-face and group communication (pagivoltes, posters)
- Messages

Progress of the session:

- Using question and answer quizzes, participants define what a visual aid is. Show some examples.
- Show different visuals and the messages that accompany them
- Show participants how to use a pagivolte of the obstetric fistula

At the end of the session, the trainer must draw conclusions by highlighting the importance of visual aids for the sensitization of the population.

Supporting text No. 9

THE CLOTH FLIP-CHART / PAGIVOLTE

1. Definition:

The cotton cloth flip-chart (pagivolte) is a visual aid consisting of a series of images printed on fabric, and whose aim is to focus the attention of an audience on specific aspects of a message.

2. The advantages of using images:

- We assimilate better when we see images to complement the words
- The image gives a good starting point for discussion
- The image induces a reaction from participants
- The image facilitates understanding and ensures remembering

3. The disadvantages of using images:

- Sometimes the images are not tailored to each locality, to each audience
- Do not use the pagivolte like a movie: the spoken word remains the most important

4. Role of the facilitator in the use of the pagivolte:

The facilitator's role is that of a guide, not a teacher.

Therefore, he/she gives the floor to the audience and does not simply explain.
To fulfill this role properly, he/she must:

- know the subject
- know the audience
- ask simple and open questions
- prepare the meeting
- adapt his/her language to the group
- try to draw real examples from the experiences of the audience.

5. Some conditions for using a pagivolte correctly:

- The location of the pagivolte should allow all participants to follow the images and the discussion
- Give participants enough time to observe the images
- Do not give full attention to the images; they are only used to facilitate speaking

6. Description of the image:

Questions to be asked with each image

What do you see?

Ask the audience to describe the image. This way you ensure that the image is correctly interpreted and that everyone speaks about the same thing; discuss the subject.

First analysis: what does the image refer to?

What's happening?

When you finish talking about what is seen in the picture, you go to the discussion phase on the action that the image shows.

Problems raised: you go deeper into the subject:

Does it cause problems?

If yes what are the problems?

What are the solutions proposed?

What action does the image show you?

Session No. 15

INTERPERSONAL OR FACE TO FACE COMMUNICATION TECHNIQUE

Objective:

At the end of the session, each participant should be able to:

Apply the technique of interpersonal communication to disseminate messages on the prevention of obstetric fistulas in his/her village, or to be understood when talking with development partners involved in his/her village.

Duration: 1 hour 30 minutes

Contents of the session:

- What is face-to-face communication?

- In which case should the face-to-face communication technique be used?

- What are techniques for conducting effective face-to-face communication?

Progress of the session:

Recall the different aspects relating to the quality of a good facilitator for effective communication

Involve participants by referring to their personal experiences

Engage in simulation exercises, so that each participant has a chance to practice face-to-face communication. To this end, organize role-play exercises using visual aids on the prevention of obstetric fistulas

At the end of the session, draw conclusions making a link between this session and the participants' role once they return to their villages

Supporting text No. 10:

INTERPERSONAL OR FACE TO FACE COMMUNICATION

Definition:

Interpersonal communication is an exchange between two people facing each other, centered on a question of specific concern for one of the two.

The goals of interpersonal communication:

- Complement a group discussion by establishing a dialogue with someone who does not want to expose some of his/her problems in a group
- Create an opportunity for a shy person to express his/her views on an issue
- Encourage individuals to reflect on particular problems and to gain a deeper understanding of the causes of these problems
- Help individuals find solutions to their problems
- Consolidate the information given by the media or in a group for its better understanding and exploitation
- Adapt the message to a particular individual in order to better identify his/her needs

The Requirements for effective interpersonal communication:

- Create the conditions for good listening
- Make an effort to understand
- Make no value judgments
- Provide systematic feedback
- Demonstrate availability

Session No. 16
GROUP DISCUSSION TECHNIQUE

Objective:

At the end of this session, each participant should be able to:

Effectively lead a group discussion, to deliver messages to his/her community.

Duration: 1 hour 30 minutes

Materials: Printed cotton cloth flip-charts (pagivoltes)

Content of the session:

- What is a group discussion?
- When to use a group discussion?
- The methods and techniques to use, to properly conduct a group discussion

Progress of the session:

- Call upon the experience of participants, to obtain their full participation in the session
- Organize participants into groups and make them role-play the holding of a group discussion using visual aids
- Make sure that everyone has the opportunity to play the role of facilitator
- Draw conclusions on the experience of participants during this practice exercise and highlight the relationship with their future roles in the village

SUPPORTING TEXT No. 11
THE STAGES OF A GROUP DISCUSSION

1. Preparation:

1.1. What are you going to talk about and with whom?

- Select the topic
- Identify the target population

1.2. What do you need to know and to prepare? You need to:

- Know the community and the environment (food availability, habits and beliefs of the people, busiest times of people, ...)
- Master the topic to be discussed from the technical point of view
- Prepare your materials; identify the main ideas of the topic
- Specify what the group should remember after the discussion
- Identify the methods that will be used to highlight these ideas
- Prepare the questions, the visual aids and the evaluation method

1.3. From a practical standpoint, what other preparations do you need to make?

- Choose and prepare the venue of the session (meeting)
- Schedule the meeting with the population: set the date and time of the session in full agreement with community leaders

2. Conduct of the group discussion:

2.1. Greeting participants and introducing the topic

- Put participants at ease; install the benches in a way that facilitates communication, sit participants in a “U” shaped arrangement
- Welcome participants; greet them and get them seated, introduce yourself
- Introduce the topic
- Ask participants their views on the topic

2.2. Developing the topic

- Identify the problems in the community in relation to the topic
- Elicit the causes of these problems
- Investigate the possible solutions
- Complement the information if necessary
- Whenever possible, support the discussion with visual aids or demonstration
- Give the floor to the audience to ask questions

3. Evaluation of the session:

3.1. Did the audience get the message?

Several methods of assessing the effectiveness of a group discussion may be used, but the most common and most practical method is the "question and answer" method.

- Ask participants what they have learned
- Ask participants what advice they can give to others after this discussion.

3.2. Reinforce the main ideas

Make a summary of the main ideas developed during the session, and re-emphasize them if necessary

3.3. Closing of the session

- Thank participants for their participation, their patience and their contributions
- If possible, make an appointment for another upcoming meeting, and possibly announce the topic for this next discussion.

Topics for the group discussion practice exercises

Group N ° 1 Topic: The Evacuation Plan

Group N ° 2 Topic: Medically assisted delivery

Group N ° 3 Topic: Prenatal consultations

Group N ° 4 Topic: Request for permission to evacuate

Session No. 17

THE ROLE-PLAY TECHNIQUE

Objective:

At the end of this session, each participant should be able to:
Use the role-play technique to disseminate educational messages to different social groups in his/her village.

Duration: 2 hours

Content of the session:

- What is role-play?
- What kinds of message can be disseminated using role-play?
- What are the requirements for implementing role-play?
- Methods and techniques of role-play

Progress of the session:

- Brainstorm on role-play and complement with a brief presentation
- This session will largely be based on practice exercises using visual aids

The trainers will focus on helping participants choose topics and messages relevant to the rapid prevention of obstetric fistulas.

Some examples of topics for practice exercises:

Situation I:

Sipti is a young woman aged 15; it is her first pregnancy and when she goes into labor, she does not say anything to any one until nightfall, when her mother finds her in pain.

Mother advises her to be patient. The next day, the pain is more intense but she is once more advised to be patient. On the third day, exhausted, she collapses, unconscious.

She is then transported to the Health Center which evacuates her to the district hospital which, in turn, refers her to the maternity hospital of Niamey. Upon her arrival at the hospital, the medical staff notes the death of the child, which has already started to rot in her womb. Sipti is then delivered and cared for.

A week later she observes that she loses urine when making an effort, when she sleeps or talks, and even when she sits. She therefore leaves her community and returns to the hospital to try to get treatment. All of this at her own expenses when she has so little money ....

Situation II:

Agaicha has five (5) children. When she goes into labor, she thinks she has enough experience with childbirth, and she just has to be patient; everything will be fine. But this time the child is too big, and the labor drags on. Finally on the fourth (4) day she is evacuated to the district hospital. The child dies on the way and she herself, exhausted, survives for only a few hours in the hospital.

Session No. 18:
EVALUATION OF THE TRAINING

Objectives:

At the end of the session, each participant should be able to:

- state all the topics discussed during the training
- summarize the key points about the rapid prevention of obstetric fistulas

Duration: 30 minutes

Contents of the session:

- Review of all the chapters covered
- Recall of the main points of the strategy to rapidly prevent obstetric fistulas

Progress of the session

The trainer initiates a question and answer exercise during which the participants add to each other's answers. And if necessary, the trainer provides clarifications.