Prevention and Recognition of Obstetric Fistula Training Package: PARTICIPANT HANDBOOK

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ACRONYMS

AAFH	Addis Ababa Fistula Hospital
ANC	antenatal care
BDHFH	Bahir Dar Hamlin Fistula Hospital
BEmOC	basic emergency obstetric care
BMI	body mass index
BPM	beats per minute
CCT	Community Core Teams
CEmOC	comprehensive emergency obstetric care
cm	centimeters
CPD	cephalo-pelvic disproportion
DHHS	Demographic Health Survey
EmOC	emergency obstetric care
ESD	Extending Service Delivery (Project)
EUO	external urethral opening
FGM/C	female genital mutilation/cutting
FHR	fetal heart rate
HC	health center
HEW	Health Extension Workers
ICD-10	International Classification of Disease, 10th version
IMPAC	Integrated Management of Pregnancy and Childbirth
IPT	intermittent preventive treatment
ITN	insecticide treated nets
MMR	maternal mortality ratio
MNCH	maternal, neonatal and child health
OF	obstetric fistula
PMTCT	prevention of maternal to child transmission (of HIV)
PPT	PowerPoint
PRU	Pre-Repair Unit
RHB	Regional Health Bureau
RVF	recto-vaginal fistula
SBA	skilled birth attendant
SSA	sub-Saharan Africa
STI	sexually transmitted infection
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
UTI	urinary tract infection
VVF	vesico-vaginal fistula
WHO	World Health Organization

BACKGROUND INFORMATION

An obstetric fistula, one of the most devastating injuries of childbirth, is usually the result of a prolonged and/or obstructed labor when the tissues of the vagina, bladder and surrounding areas are damaged and a hole, or fistula, develops. Women with obstetric fistula leak urine (and sometimes stool if the fistula involves the rectum), develop associated physical and mental health problems, and are often abandoned by their husbands and families, becoming socially isolated.

The World Health Organization has said that fistula is "the single most dramatic aftermath of neglected childbirth". It is estimated that there are more than 100,000 women who develop fistula every year and the United Nations Population Fund (UNFPA) estimates that more than two million women are living with fistulas that have not been repaired. Both the prevention of obstetric fistula formation through safe motherhood practices and emergency obstetric care and referral for compassionate, competent surgical treatment of women with fistulas are critical steps in making a difference for women in Ethiopia.

The Hamlin Fistula Foundation, through the Addis Ababa Fistula Hospital (AAFH), has been providing holistic care to women with obstetric fistulas since 1974. In 2005, they expanded their services to reach more women in areas with a high prevalence of fistula in the Amhara region through the new Bahir Dar Hamlin Fistula Hospital (BDHFH). Since 2006, IntraHealth International – Ethiopia, with support from the USAID-funded EngenderHealth's ACQUIRE Project, Pathfinder's Extending Service Delivery Project (ESD), and EngenderHealth's Fistula Care Project, has partnered with BDHFH to work in three woredas (Adet, Dangla, and Woreta). More recently, IntraHealth has partnered with the Mekele Hamlin Fistula Center to work in Sekota woreda in East Amhara. The goals of this work are to:

- Increase community awareness of the causes of and prevention of obstetric fistula through community core teams (CCTs)
- Improve reproductive health and maternity care services aimed at preventing and recognizing cases of obstetric fistula in women
- Identify and refer women with obstetric fistula for surgical repair through pre-repair units affiliated with health centers
- Increase the access to treatment and care for fistula patients through various mechanisms, including specially trained nurses or "fistula mentors" who train health workers, and guide both the clinical and community aspects of the work.

IntraHealth works in close collaboration with the Hamlin Fistula Centers in both community mobilization and provision of care and treatment of fistula patients. While IntraHealth mainly focuses on improved access to and quality of emergency obstetric care to prevent obstetric fistula, fistula identification and pre/post repair services, the Hamlin Fistula Centers focus mainly on surgical repair services for women with obstetric fistula. In West Amhara, Pathfinder International and the Amhara Development Association are also involved in community mobilization in the prevention and recognition of fistula.

Course Description

This training is intended for health care workers (health officers, midwives, clinical nurses, maternal, neonatal and child health (MNCH) officers, managers and supervisors at woreda health office and health center levels) to build their knowledge base and capacity to provide care to women who are at risk of or who have developed obstetric fistula. In addition to this three day course, a one day obstetric fistula orientation for community volunteers and health extension workers (HEWs) has been developed.

Course Goals

The goals of this course are to build the capacity of health workers to provide:

- health education about obstetric fistula and the importance of antenatal care and skilled attendance at birth
- quality reproductive health and maternity care services for preventing, recognizing and providing pre-repair care for cases of obstetric fistula in women, referring women with obstetric fistula for surgical repair, and providing postoperative care and reintegration services for women with obstetric fistula

Participant Learning Objectives

By the end of the training, the participants will be able to:

- Provide health education to communities about safe motherhood, the importance of antenatal care and skilled attendance at birth, and fistula prevention, recognition and repair
- Demonstrate and train others in the use of the partograph to prevent prolonged/obstructed labor
- Identify and assess women who may have obstetric fistula
- Provide counseling and care for women with obstetric fistula during the pre-repair period
- Refer women to pre-repair unit (PRU) for ongoing care
- Provide support to women following repair during reintegration into communities

Participants

Mid-level Health Care Workers (health officers, midwives, clinical nurses at the primary health unit) and MNCH officers at woreda health office level, including supervisors and health center managers.

Facilitators

Fistula mentors and other health workers with experience in adult learning methodology and the clinical care of women at risk for obstetric fistula

Number of facilitators and participants

Maximum of 20 participants per session with 2-3 facilitators

Duration of Course

Three days

Venue

The training will take place at a health center or other similar venue where there is a room with adequate space for 23 participants and facilitators, and adequate light, ventilation, seating and tables. Participants may come from the health center where the training takes place and from nearby health centers.

Components of Learning Package

Facilitator materials

- **Facilitator's Manual** *(containing: background information, learning objectives and workshop schedule, session plans, pre- and post-course knowledge assessment answer key, pre and post-assessment score sheet, partograph exercises and answer key, role play exercises, counseling checklist, action plan form, and workshop evaluation form)*
- **Module 4 activity cards**
- **10 Modules in PowerPoint files** (see table of contents for module titles)

Participant materials

- **Participant's Handbook** *(containing: background information, learning objectives and workshop schedule, pre-course knowledge assessment, partograph exercises, role play exercises, counseling checklist, action plan form, and workshop evaluation form)*
- **PowerPoint module handout** (see table of contents for module titles)

Reference materials—for Facilitators and Participants

1. *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*. WHO/UNICEF/UNFPA/World Bank, 2004 (section C1-C3 –Rapid Initial Assessment).
2. Hancock, B and A Browning. *Practical Obstetric Fistula Surgery*. The Royal Society of Medicine Press Ltd. London: 2009 (Chapter 1: Obstetric Fistulae: Cause and Nature; The Obstetric Fistula Complex; Classification).
3. World Health Organization. *Obstetric Fistula: Guiding principles for clinical management and programme development.* Department of Making Pregnancy Safer. World Health Organization: Geneva, 2006.
4. Job Aid: Diagnosis of Obstetric Fistula (USAID/FistulaCare).
5. The Obstetric Fistula Pathway. Figure 3 in: *The Lancet* 2006; 368: 1201-1209.

Other materials needed for training:

Flipchart and markers, masking tape, pens and notepads for participants, laptop and LCD projector; large diagrams of female reproductive anatomy, participant name cards, video of A Walk to Beautiful, pelvic model and baby doll, and large laminated partograph with non-permanent markers.

Training/Learning Methods

- Illustrated lectures and group discussions including brainstorming and Q&A
- Case studies
- Role plays
- Small group and individual exercises
- Homework reading assignments

Evaluation Methods

Pre- and post-assessment questionnaires will be administered at the beginning and end of the training to assess baseline and change in knowledge of trainees. Skills will be assessed during the course of the training using case studies, exercises, and role plays.

Daily review sessions during opening and closing circles and an end of course evaluation questionnaire will be used to receive feedback from the participants on the effectiveness of the training and facilitators.

Schedule for Workshop on Prevention and Recognition of Obstetric Fistula

Day 1	Day 2	Day 3
1. Welcome and Introduction (8:30-10:30) Workshop Opening, Pre-course assessment, "Transfer-in", Hopes and Fears, learning objectives & schedule, participant materials Tea break (10:30 -10:45) **2. Overview of Safe Motherhood** (10:45-12:00) **3. Review of Female Reproductive System** (12:00-12:30)	**Opening Circle** (8:30-9:00) **5. Prevention of Prolonged and Obstructed Labor (cont'd)** (9:00 – 9:45) **6. Obstetric Fistula Causes & Factors** (9:45 – 10:30) Tea break (10:30 -10:45) **6. Obstetric Fistula Causes & Factors (cont'd)** (10:45-12:30)	**Opening Circle** (8:30-9:00) **8. Pre-repair Care and Referral (cont'd)** (9:00-9:50) **9. Principles of Postoperative Care and Reintegration** (9:50-10:30) Tea break (10:30 -10:45) **9. Principles of Postoperative Care and Reintegration (cont'd)** (10:45-12:30)
Lunch 12:30-1:45	***Lunch 12:30-1:45***	***Lunch 12:30-1:45***
4. Essential Components of ANC and EmOC (1:45-3:00) Tea break (3:00 - 3:15 pm) **5. Prevention of Prolonged and Obstructed Labor** (3:15-5:00) ***Homework assignment –*** Reading: - *IMPAC*: Managing Complications in Pregnancy and Childbirth, pages C1-C3 - Ch 1: *Obstetric Fistulae: Cause and Nature; the Obstetric Fistula Complex; Classification* **Closing Circle** (5:00-5:30)	**7. Identification of Obstetric Fistula** (1:45-3:00) Tea break (3:00 - 3:15) **7. Identification of Obstetric Fistula (cont'd)** (3:15-4:15) **8. Pre-repair Care and Referral** (4:15-5:00) ***Homework assignment –*** Reading - Ch 6 in *WHO Obstetric Fistula: Guiding principles for clinical management & programme development* - *Checklist for Obstetric Fistula Assessment and Counseling* **Closing Circle** (5:00-5:30)	**10. The Roles of Families, Community and the Health Care System in Obstetric Fistula** (1:45-3:00) Tea break (3:00 - 3:15) **Forward Planning** (3:15-4:15) **Post-course Assessment** (4:15-4:45) **Workshop Wrap-up, Evaluation, and Closure** (4:45-5:30)

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SESSION OBJECTIVES, EXERCISES AND HANDOUTS

DAY ONE

Day 1 Session Objectives

Module 1: Welcome and Introduction

At the end of the session, participants will be able to:

- Complete a pre-course assessment to identify current knowledge related to obstetric fistula
- Identify observations of participants about their work in safe motherhood
- Share their hopes and fears (and expectations) for the workshop, and compare with learning objectives
- Review participant materials, objectives and schedule for the workshop
- Begin contributing actively in the workshop

Module 2: *Overview of safe motherhood*

At the end of the session, participants will be able to:

- Define maternal mortality ratio
- Identify global causes of maternal mortality
- Distinguish between direct and indirect causes of maternal mortality
- Describe the global trends in maternal mortality and trends in Ethiopia
- Identify factors that contribute to maternal mortality and morbidity
- Describe strategies to prevent maternal mortality and morbidity including basics of Emergency Obstetric Care
- Develop health education messages about the importance of ANC and skilled attendance at birth

Module 3: *Review of female reproductive system*

At the end of the session, participants will be able to:

- Identify the external and internal female reproductive organs
- Review the menstrual cycle process
- Identify the impact of poor nutrition on pregnancy and childbirth

Module 4: *Essential components of ANC and EmOC*

At the end of the session, participants will be able to:

- Define the basic components of evidence-based focused antenatal care
- Identify the importance of skilled attendance at birth
- Explain the levels of Emergency Obstetric Care
- Explain birth preparedness and complication readiness
- Identify and explain to others the key warning signs of complications in pregnancy and childbirth

Module 5: *Prevention of prolonged and obstructed labor*

At the end of the session, participants will be able to:

- Describe the potential complications of obstructed labor
- Identify how to recognize women who are at increased risk of obstructed labor
- Describe the purpose of using the partograph
- Describe the steps in using the partograph
- Practice using the partograph with case studies

Closing circle, Day 1

At the end of the session, participants will be able to:

- Express their thoughts about the day or what is in their minds, if they wish
- Respectfully listen to other participants' thoughts

PREVENTION AND RECOGNITION OF OBSTETRIC FISTULA

PRE-COURSE KNOWLEDGE ASSESSMENT

Participant code or name_____

Read carefully and circle the ONE BEST answer from the given options

1. Globally, the most common causes of DIRECT maternal mortality include:
   a. Infection, obstructed labor, severe anemia, and unsafe abortion
   b. HIV/AIDS, malaria, hemorrhage, and obstructed labor
   c. Obstructed labor, severe anemia, tuberculosis, and infection
   d. Hemorrhage, infection, eclampsia, and obstructed labor
   e. Obstructed labor, hemorrhage, malaria, and HIV/AIDS

2. Three of the common causes of INDIRECT obstetric death include:
   a. Infection, tuberculosis, and HIV/AIDS
   b. Unsafe abortion, severe anemia, and malaria
   c. Pre-eclampsia/eclampsia, hemorrhage, and obstructed labor
   d. Sexual violence, exacerbation of heart disease, and severe anemia
   e. Complications of surgery related to pregnancy, malaria, and severe anemia

3. Maternal mortality ratio is defined as:
   a. The death of a woman during pregnancy or within 42 days of childbirth
   b. The number of maternal deaths per 100,000 live births in the same time period
   c. The number of maternal deaths per 100,000 women of reproductive age in the same time period
   d. The probability of dying from a maternal cause during a woman's lifetime

4. In the last 20 years, maternal mortality has:
   a. Increased globally by 25%
   b. Resulted in more than 500,000 maternal deaths per year
   c. Decreased globally by 34%
   d. Increased in more than 147 countries

5. The estimated maternal mortality ratio in Ethiopia (estimated by WHO as of 2008) is:
   a. 360/100,000 live births
   b. 470/100,000 live births
   c. 820/100,000 live births
   d. 1,200/100,000 live births

6. Approximately what percentage of women worldwide will need emergency obstetric care?
   a. 2-5%
   b. 10%
   c. 15%
   d. 40%

7. Maternal deaths:
    a. Can usually be prevented with good antenatal care
    b. Most often occur 2-3 weeks after delivery when a woman is at home
    c. Often cannot be predicted or prevented so all women need access to emergency obstetric care
    d. Never occur in facilities but are very common when women deliver at home

8. Factors that contribute to maternal mortality and morbidity are:
    a. Lack of equipped health facilities and trained providers
    b. Low status of women
    c. Delay in decision to seek care, reaching care, and receiving care
    d. Geographic barriers and lack of transportation
    e. All of the above
    f. A, C, and D only

9. Inadequate nutrition can impact a woman's health by:
    a. Causing short stature and misshapen pelvic bones which put her at risk for prolonged and obstructed labor
    b. Increasing risk of anemia
    c. Interfering with reproductive hormones, her menstrual cycle and the health of pregnancies
    d. All of the above

10. Evidence-based focused antenatal care includes:
    a. At least four visits (confirmation of pregnancy, 20-28 weeks, after 36 weeks and before the expected date of delivery)
    b. Birth preparedness and complication readiness
    c. Measurement of weight/BMI and assessment of nutritional status
    d. Prevention and treatment of anemia and infections
    e. All of the above

11. Skilled attendance at birth is estimated to prevent what percentage of maternal deaths?
    a. <5%
    b. 50%
    c. 13-33%
    d. 65%

12. Warning signs of complications in pregnancy include:
    a. Swelling of hands and face
    b. Pale conjunctiva, tongue, palms and nail beds
    c. Increased fetal movement
    d. Bleeding from the vagina
    e. All of the above
    f. A, B and D only

13. Basic emergency obstetric care services include:
    a. Administration of antibiotics for infection
    b. Surgical skills including caesarian section
    c. Administration of antihypertensives and anticonvulsants for pre-eclampsia/eclampsia
    d. Manual removal of placenta
    e. All of the above
    f. A, C and D only

14. Birth preparedness and complication readiness include:
    a. Recognition of warning signs in pregnancy or childbirth
    b. Deciding on place of delivery
    c. Plan for rapid referral and transport to EmOC site
    d. Skilled attendant at birth
    e. Availability of clean items for mother and baby at birth
    f. All of the above
    g. A, C, and D only

15. An obstetric fistula is defined as:
    a. A tract between two areas of the reproductive system which interferes with a woman's capability to get pregnant and give birth
    b. An abnormal opening between two areas of the body (usually the bladder and the vagina, but can also be rectum and vagina) which develops during the course of a prolonged/obstructed labor and birth
    c. A hole in the uterus because of trauma
    d. An abnormal pathway between the uterus and vagina that can interfere with delivery

16. The most common reason women develop obstetric fistula is due to:
    a. Female genital mutilation
    b. Sexual violence
    c. Prolonged and/or obstructed labor
    d. Accidental injuries during surgery or episiotomy during childbirth

17. Some women with obstetric fistula also develop leg contractures because of:
    a. Injury to the peroneal nerves and/or lumbar plexus during prolonged/obstructed labor
    b. Weakness in lower legs because of nerve damage which results in difficulty walking
    c. Prolonged immobility due to depression, undernutrition, and poor care
    d. All of the above

18. If a woman develops a fistula during a prolonged or obstructed labor, the likelihood that she will also have had a stillbirth with that birth is:
    a. 60%
    b. 15%
    c. 95%
    d. 50%

19. Pathways to primary prevention of obstetric fistula include all of the following EXCEPT:
    a. Adolescent and maternal nutrition
    b. Education and empowerment for women
    c. Ready access to high quality emergency obstetric care
    d. Delaying marriage and child bearing

20. Most classification systems for describing obstetric fistula include all of the following EXCEPT:
    a. Size: large or >3 cm involves most of anterior vaginal wall and more difficult to repair
    b. Amount of scarring: fistulas with extensive scarring are more difficult to repair
    c. Whether or not the women also has foot drop and limb contractures
    d. Whether or not the fistula is circumferential
    e. Distance between fistula and the external urethral orifice (EUO or "opening" of the urethra): if this distance is >5cm it usually does NOT involve the neck of the bladder and is simpler to repair
    f. Estimation of bladder size

21. The most common place for a fistula to develop is:
    a. Between the rectum and the vagina
    b. Between the ureters and the vagina
    c. Between the bladder and the vagina
    d. Between the vagina and the uterus

22. Obstetric fistula can usually be diagnosed:
    a. Immediately postpartum (within 1-2 days) in all women
    b. By 1-2 weeks postpartum
    c. Not until three months after delivery
    d. Only if there is leakage of both stool and urine

23. Prognostic factors of whether or not fistula surgery will be successful include all of the following EXCEPT:
    a. Presence of associated complications such as malnutrition, chronic pelvic or bladder infections
    b. Size of fistula
    c. Degree of scarring and ease of access to the site of the fistula
    d. Young age (<20 years) of the woman with an obstetric fistula
    e. Whether this is the first attempt at surgical repair
    f. Proximity of the fistula to the urethra and neck of the bladder (where the trigone of bladder muscles are located)

24. The primary purpose of the partograph is to:
    a. Help women who are laboring at home recognize the warning signs of complications in pregnancy
    b. Assess the progress of normal labor at timely intervals in order to recognize and prevent prolonged or obstructed labor
    c. Help health workers keep accurate records of births at health centers
    d. Document all the important components of emergency obstetric care

25. The partograph should be used:
    a. Only by doctors with special training in Comprehensive EmOC
    b. By all health workers at all births
    c. Only by midwives working in rural areas who may need to transfer patients in labor
    d. Only for facility based deliveries

26. Common complications of prolonged and/or obstructed labor include:
    a. Avascular necrosis of the symphysis pubis leading to pelvic bone pain and abnormal gait
    b. Nerve compression which can result in foot drop and sometimes loss of feeling in the lower extremities
    c. Scarring in the vagina leading to vaginal stenosis, chronic pain with intercourse, amenorrhea, and secondary infertility
    d. Obstetric fistula
    e. All of the above

27. When completing the partograph for a woman in labor, if the second diagonal line or "action" line is crossed:
    a. Immediate referral to a site of CEmOC is recommended if the woman is laboring in a health center
    b. Operative delivery by caesarian section should be considered
    c. This represents prolonged and/or obstructed labor
    d. The risk of development of obstetric fistula is significant
    e. All of the above

28. If a woman has recently survived a prolonged/obstructed labor which of the following may help prevent development of a fistula or encourage spontaneous closing of a small fistula?
    a. Encouraging the woman to drink 4-5 liters of fluid per day
    b. Cleaning of the perineum and vagina with mild detergent and soap twice a day
    c. Indwelling urinary foley catheterization for at least 2 weeks
    d. IF there is an experienced clinician available, explore the vagina and gently excise any necrotic tissue
    e. All of the above
    f. A, B and C only

29. Pre-repair care for long standing obstetric fistulas (i.e., women not immediately postpartum) should include all of the following <u>EXCEPT</u>:
    a. Treatment for anemia with iron/folate supplements
    b. Psychological and emotional support
    c. Treatment for any infections – parasitic medication, antibiotics if any signs of UTI or STI
    d. Skin care for dermatitis including perineal care with mild detergent in water twice a day
    e. Continual drainage of bladder with a foley catheter until surgery can be scheduled
    f. Initiation of rehabilitation and physical therapy for foot drop or contractures

30. Women who are considering fistula repair surgery should be counseled that:
    a. Repair is sometimes more difficult when the fistula has been present for a long time
    b. Surgery is usually but not always successful
    c. Even if the fistula is closed, some women will still leak urine (15-25%) and most will have urinary frequency because of a smaller bladder
    d. Complications such as infertility, chronic pelvic pain and recurrent urinary tract infections will not likely be corrected with obstetric fistula surgery
    e. All of the above

31. Women should expect to stay at the fistula hospital after repair for:
    a. Up to one month
    b. 2-3 days only if the surgery goes well
    c. Approximately two weeks during which time they will have a urinary catheter
    d. 1 week

32. Possible complications of fistula surgery include all of the following EXCEPT:
    a. Anuria (absence of urine) because of accidental ligation of ureters or obstruction
    b. Breakdown of fistula repair due to infection or necrosis
    c. Development of bladder stones
    d. Dyspareunia (pain with intercourse), urethral or vaginal strictures, or infertility
    e. Secondary vaginal hemorrhage
    f. Foot drop
    g. Blockage of urinary catheter and distention of bladder

33. Post-repair counseling for women who have had fistula surgery includes recommendations to:
    a. Abstain from genital sexual relations for three months
    b. Do pelvic muscle exercises to regain strength in their bladder and pelvis
    c. Plan for caesarian section for the next birth
    d. Avoid pregnancy for at least one year
    e. All of the above

34. Important community messages about the prevention of obstetric fistula include:
    a. Educating girls and keeping them in school
    b. Assuring access to a skilled birth attendant at every delivery, and emergency obstetric care when needed
    c. Delaying marriage and first birth
    d. Eradicating harmful traditional practices such as female genital mutilation
    e. Promoting family planning to space births and limit the total number of births
    f. All of the above

35. The role of Health Extension Workers (HEWs) in the prevention of obstetric fistula includes:
    a. Providing health education to families on core topics such as family planning, antenatal care, institutional delivery, postnatal care, HIV and PMTCT
    b. Identifying obstetric fistula at the community level, counseling the woman and referring for care
    c. Referring women to health centers for antenatal care and following-up with information about birth preparedness, complication readiness and warning signs of problems in pregnancy and childbirth
    d. Assisting in normal deliveries when a woman cannot get to the health facility, even if they are not skilled attendants
    e. All of the above
    f. A, B and C only

PREVENTION AND RECOGNITION OF OBSTETRIC FISTULA
PARTOGRAPH EXERCISE

Purpose

The purpose of this exercise is to enable participants to practice using the partograph to manage labor.

Instructions

The facilitator should review the partograph form with participants before beginning the exercise. Then participants can work through the cases, answer the questions, and plot the information on blank partograph forms. Then the facilitator and participants can discuss the answers to the questions and resolve any differences between the partographs completed by participants and the correctly completed partographs in the facilitator's manual. A discussion about what was challenging and useful about practicing partographs may be helpful at the conclusion of the session.

CASE 1

Step 1

- Amra, age 28, was admitted at 05.00 on 19.9.2009
- Membranes ruptured 04.00 with clear fluid
- Gravida 3, Para 2+0
- On admission the fetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

Q: What should be recorded on the partograph?
Amra is not in active labor. Record only the details of her history; not the descent and cervical dilation.

Step 2

09.00:

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

Q: What should you now record on the partograph?
Amra is now in the active phase of labor. Plot this and the following information on the partograph:

- 3 contractions in 10 minutes, each lasting 20–40 seconds
- Fetal heart rate (FHR) 120
- Membranes ruptured, amniotic fluid clear
- Sutures of the skull bones are apposed
- Blood pressure 120/70 mmHg
- Temperature 36.8°C
- Pulse 80/minute
- Urine output 200 mL; negative protein

Q: What steps should be taken?

Q: What do you expect to find at 13.00?

Step 3

Plot the following information on the partograph:

09.30 FHR 120, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.00 FHR 136, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.30 FHR 140, Contractions 3/10 each 35 seconds, Pulse 88/minute
11.00 FHR 130, Contractions 3/10 each 40 seconds, Pulse 88/minute, Temperature37°C
11.30 FHR 136, Contractions 4/10 each 40 seconds, Pulse 84/minute, Head is 2/5 palpable
12.00 FHR 140, Contractions 4/10 each 40 seconds, Pulse 88/minute
12.30 FHR 130, Contractions 4/10 each 45 seconds, Pulse 88/minute
13.00 FHR 140, Contractions 4/10 each 45 seconds, Pulse 90/minute, Temperature37°C

13.00:

- The fetal head is 0/5 palpable above the symphysis pubis
- The cervix is fully dilated
- Amniotic fluid clear
- Blood pressure 100/70 mmHg
- Urine output 150 mL; negative protein

Q: What steps should be taken?

Q: What do you expect to happen next?

Step 4

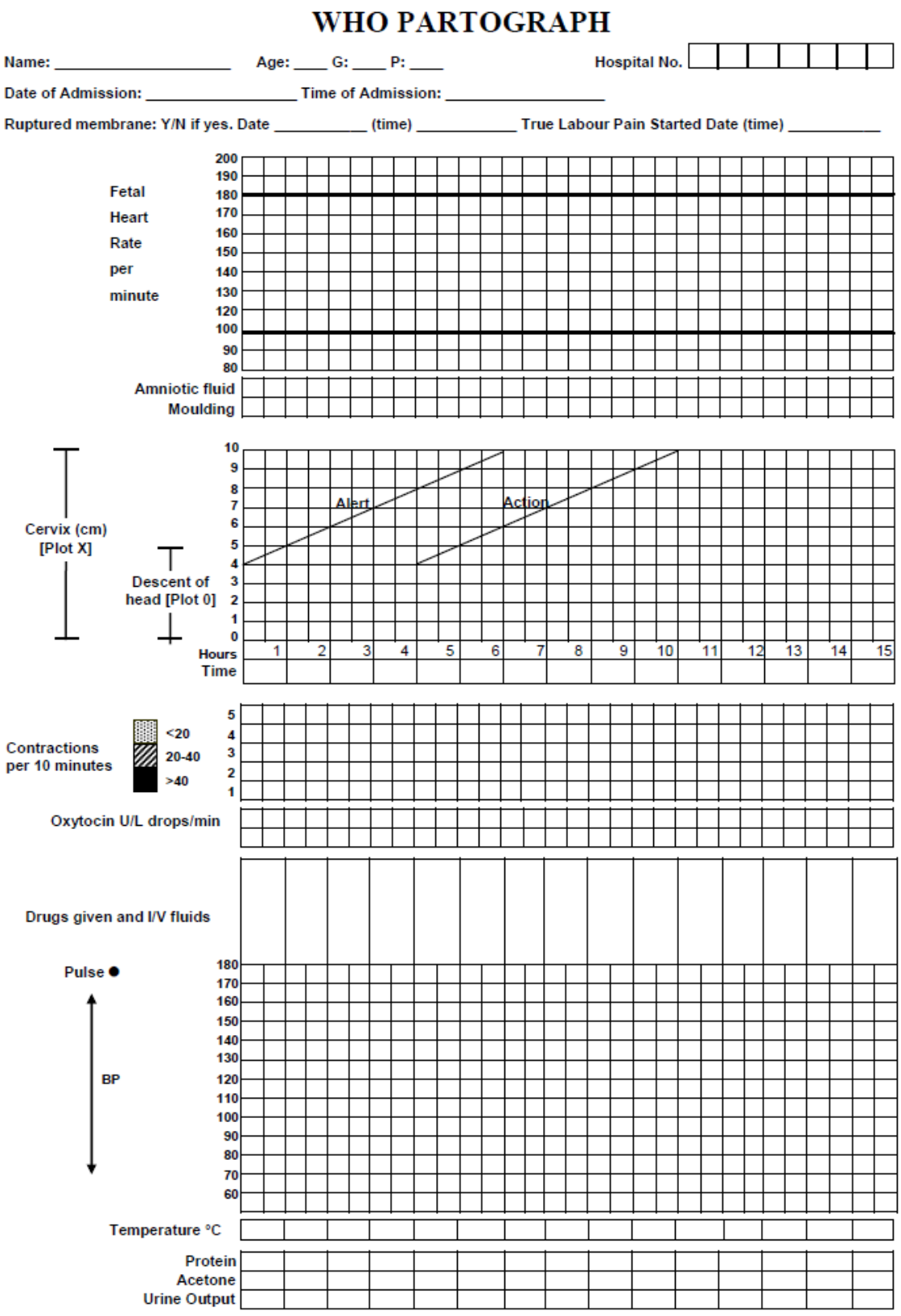
Record the following information on the partograph:

13.20: Spontaneous birth of a live female infant weighing 2,850 g

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

Q: How long was the second stage of labor?

Case 1


WHO PARTOGRAPH
Name: _____ Age: ____ G: ____ P: ____ Hospital No.
Date of Admission: _____ Time of Admission: _____
Ruptured membrane: Y/N if yes. Date _____ (time) _____ True Labour Pain Started Date (time) _____
Fetal Heart Rate per minute
200 190 180 170 160 150 140 130 120 100 90 80
Amniotic fluid
Moulding
Cervix (cm) [Plot X]
Descent of head [Plot 0]
10 9 8 7 6 5 4 3 2 1 0
Alert
Action
Hours
Time
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Contractions per 10 minutes
<20
20-40
>40
5 4 3 2 1
Oxytocin U/L drops/min
Drugs given and I/V fluids
Pulse ●
BP
180 170 160 150 140 130 120 110 100 90 80 70 60
Temperature °C
Protein
Acetone
Urine Output

CASE 2

Step 1

- Sumjana, age 21, was admitted at 10.00 on 19.9.2009
- Membranes intact
- Gravida 1, Para 0+0

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

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated
- 2 contractions in 10 minutes, each lasting less than 20 seconds
- FHR 140
- Membranes intact
- Blood pressure 100/70 mmHg
- Temperature 36.2°C
- Pulse 80/minute
- Urine output 400 mL; negative protein

Q: What is your diagnosis?

Q: What steps should be taken?

Step 2

Plot the following information on the partograph:

10.30 FHR 140, Contractions 2/10 each 15 sec, Pulse 90/minute
11.00 FHR 136, Contractions 2/10 each 15 sec, Pulse 88/minute
11.30 FHR 140, Contractions 2/10 each 20 sec, Pulse 84/minute

12.00:

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated, membranes intact

Q: What is your diagnosis?

Q: What action will you take?

Step 3

Plot the following information on the partograph:

12.30 FHR 136, Contractions 1/10 each 15 sec, Pulse 90/minute
13.00 FHR 140, Contractions 1/10 each 15 sec, Pulse 88/minute
13.30 FHR 130, Contractions 1/10 each 20 sec, Pulse 88/minute
14.00 FHR 140, Contractions 2/10 each 20 sec, Pulse 90/minute, Temperature 36.8°C, Blood pressure 100/70 mmHg

14:00:

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 5 cm dilated, and there is no moulding
- Urine output 300 mL; negative protein

Q: What action will you take?

Step 4

Plot the following information on the partograph:

14.30:

- 3 contractions in 10 minutes, each lasting 40 seconds
- FHR 140, Pulse 90/minute

15.00:

- 3 contractions in 10 minutes, each lasting 40 seconds
- FHR 140, Pulse 90/minute

15:30:

- 3 contractions in 10 minutes, each lasting 45 seconds
- FHR 140, Pulse 88/minute

16.00:

- Fetal head 2/5 palpable above the symphysis pubis
- Cervix 8 cm dilated; sutures apposed
- 3 contractions in 10 minutes, each lasting 45 seconds
- FHR 144, Pulse 92/minute
- Amniotic fluid clear

16.30:

- 3 contractions in 10 minutes, each lasting 45 seconds
- FHR 140, Pulse 90/minute
- Clear fluid noted

Q: What action will you take?

Step 5

17.00 FHR 138, Pulse 92/minute, Contractions 3/10 each 45 sec
17.30 FHR 140, Pulse 94/minute, Contractions 3/10 each 45 sec
18.00 FHR 140, Pulse 96/minute, Contractions 4/10 each 50 sec
18.30 FHR 144, Pulse 94/minute, Contractions 4/10 each 50 sec

Step 6

Plot the following information on the partograph:
19.00:

- Fetal head 0/5 palpable above the symphysis pubis
- 4 contractions in 10 minutes, each lasting 50 seconds
- FHR 144, Pulse 90/minute
- Cervix fully dilated and patient pushing

Step 7

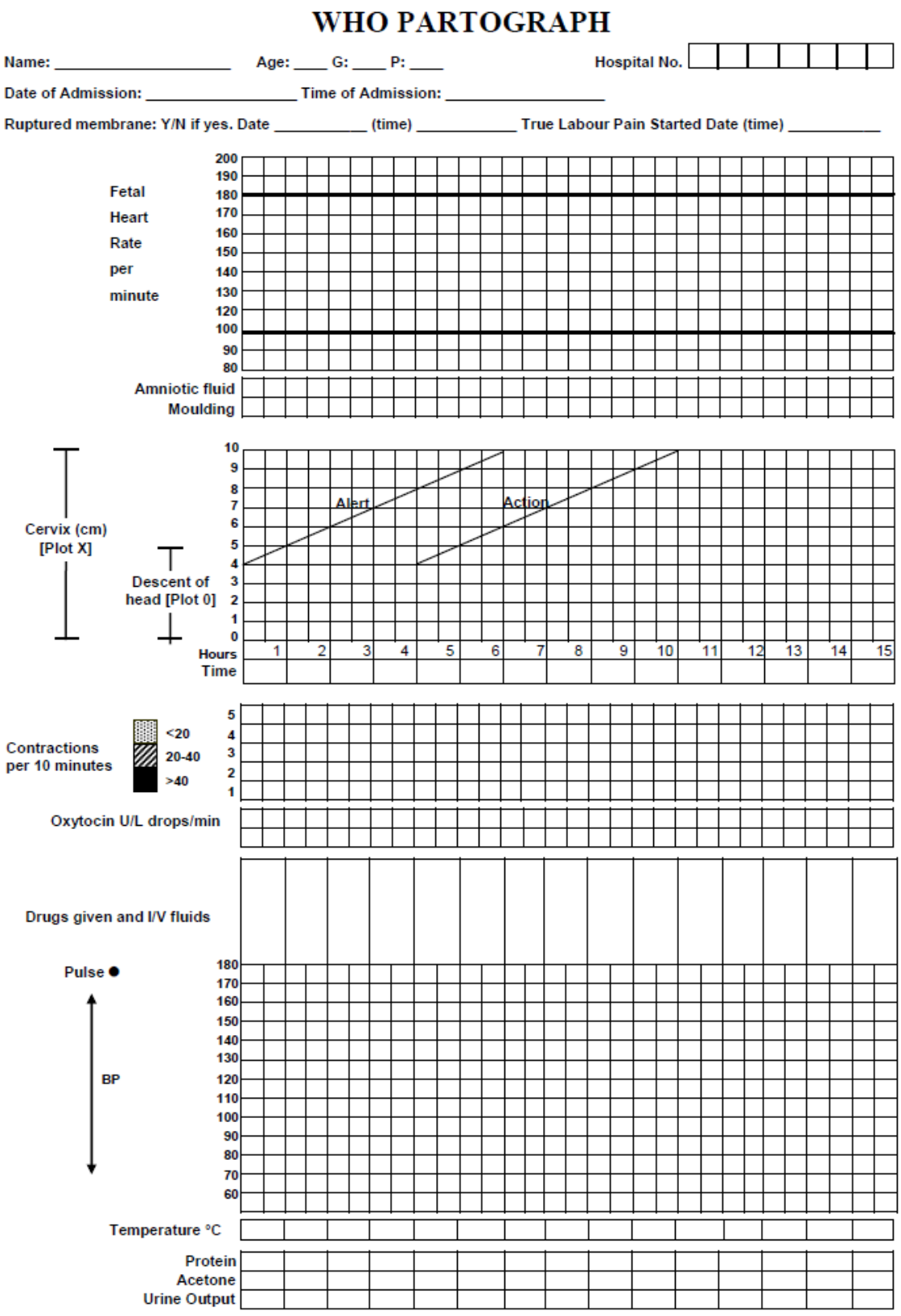
Record the following information on the partograph:
19.30:

- Spontaneous birth of a live male infant weighing 2,650 g

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

Q: How long was the second stage of labor?

Case 2


WHO PARTOGRAPH
Name: _____ Age: ____ G: ____ P: ____ Hospital No.
Date of Admission: _____ Time of Admission: _____
Ruptured membrane: Y/N if yes. Date _____ (time) _____ True Labour Pain Started Date (time) _____
Fetal Heart Rate per minute
200 190 180 170 160 150 140 130 120 100 90 80
Amniotic fluid
Moulding
Cervix (cm) [Plot X]
Descent of head [Plot 0]
10 9 8 7 6 5 4 3 2 1 0
Alert
Action
Hours
Time
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Contractions per 10 minutes
<20
20-40
>40
5 4 3 2 1
Oxytocin U/L drops/min
Drugs given and I/V fluids
Pulse ●
BP
180 170 160 150 140 130 120 110 100 90 80 70 60
Temperature °C
Protein
Acetone
Urine Output

CASE 3

Step 1

- Bibhu, age 32, was admitted at 10.00 on 19.9.2003
- Membranes ruptured 09.00
- Gravida 4, Para 3+0

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

- Fetal head 3/5 palpable above the symphysis pubis
- Cervix 4 cm dilated
- 3 contractions in 10 minutes, each lasting 30 seconds
- FHR 140
- Amniotic fluid clear
- Blood pressure 120/70 mmHg
- Temperature 36.8°C
- Pulse 80/minute
- Urine output 200 mL; negative protein

Step 2

Plot the following information in the partograph:

10.30 FHR 130, Contractions 3/10 each 35 sec, Pulse 80/minute
11.00 FHR 136, Contractions 3/10 each 40 sec, Pulse 90/minute
11.30 FHR 140, Contractions 3/10 each 40 sec, Pulse 88/minute
12.00 FHR 140, Contractions 3/10 each 40 sec, Pulse 90/minute, Temperature37°C, Head 3/5 palpable
12.30 FHR 130, Contractions 3/10 each 40 sec, Pulse 90/minute
13.00 FHR 130, Contractions 3/10 each 45 sec, Pulse 88/minute
13.30 FHR 120, Contractions 3/10 each 45 sec, Pulse 88/minute
14.00 FHR 130, Contractions 4/10 each 45 sec, Pulse 90/minute, Temperature37°C, Blood pressure 100/70 mmHg

14:00:

- Fetal head 3/5 palpable above the symphysis pubis
- Cervix 7 cm dilated, amniotic fluid clear
- Sutures overlapped, molding

Q: What is your diagnosis?

Q: What steps should be taken?

Step 3

14.30 FHR 120, Contractions 4/10 each 45 sec, Pulse 90/minute, Clear fluid
15.00 FHR 120, Contractions 4/10 each 45 sec, Pulse 88/minute
15.30 FHR 100, Contractions 4/10 each 45 sec, Pulse 100/minute
16.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 100/minute, Temperature37°C
16.30 FHR 96, Contractions 4/10 each 50 sec, Pulse 100/minute
17.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 110/minute

17:00:

- Fetal head 3/5 palpable above the symphysis pubis
- Cervix 7 cm dilated
- Amniotic fluid meconium stained
- Sutures overlapped with molding
- Urine output 100 mL; protein negative

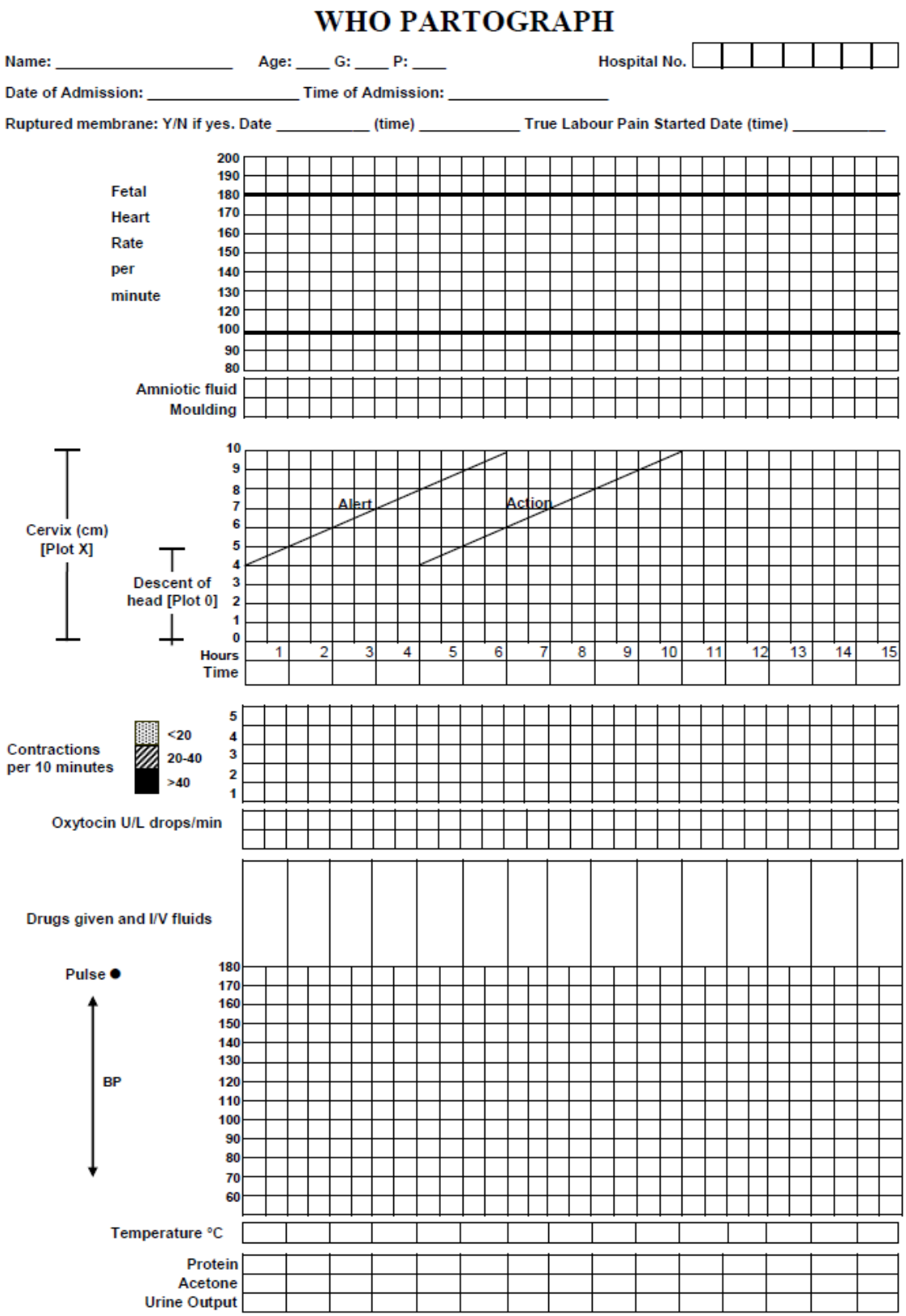
Step 4

Q: What is the diagnosis now?

Q: What action is indicated?

Q: What complications may be likely for this mother and newborn?

Case 3

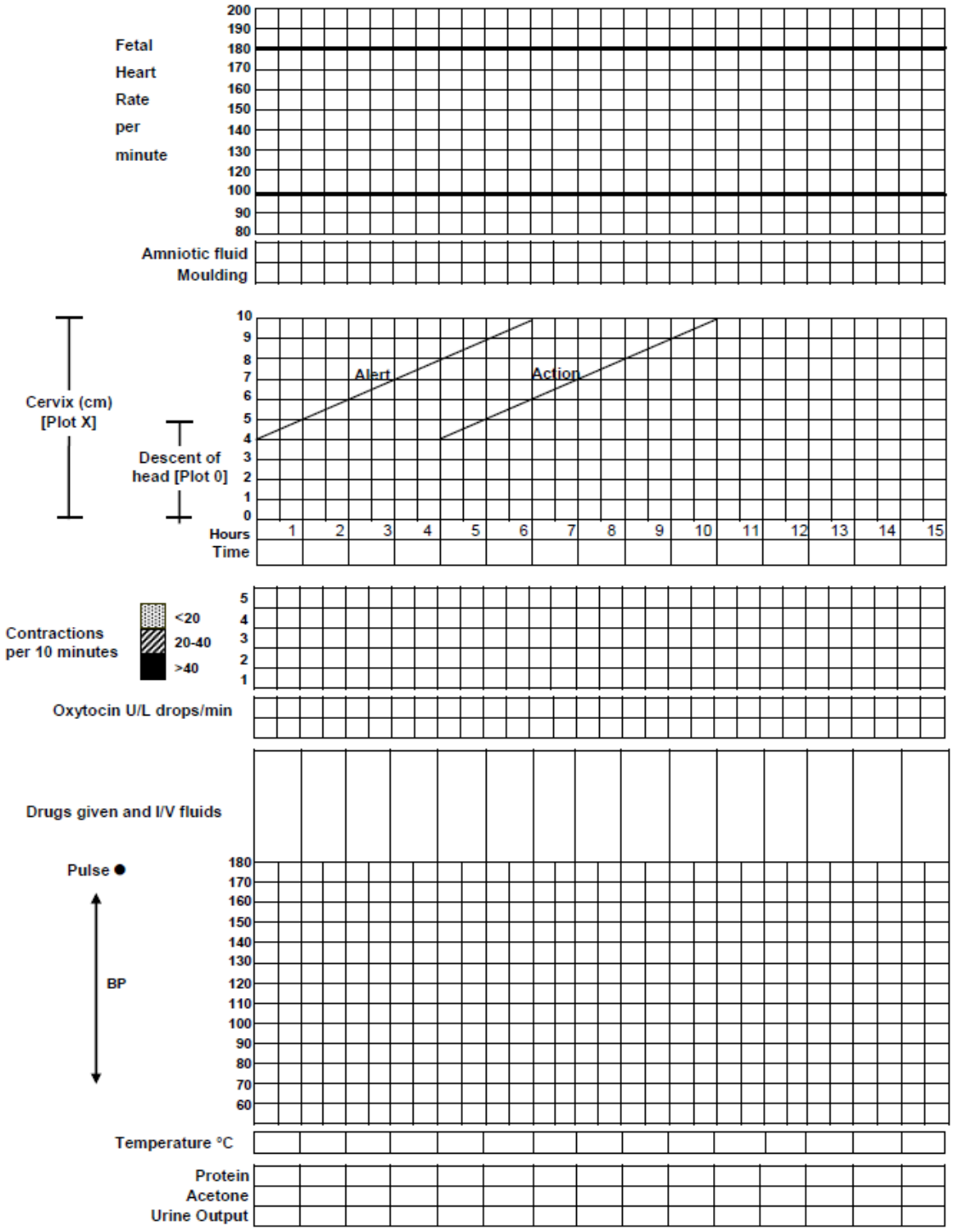

WHO PARTOGRAPH
Name: _____ Age: ____ G: ____ P: ____ Hospital No.
Date of Admission: _____ Time of Admission: _____
Ruptured membrane: Y/N if yes. Date _____ (time) _____ True Labour Pain Started Date (time) _____
Fetal Heart Rate per minute
200 190 180 170 160 150 140 130 120 100 90 80
Amniotic fluid
Moulding
Cervix (cm) [Plot X]
Descent of head [Plot 0]
10 9 8 7 6 5 4 3 2 1 0
Alert
Action
Hours
Time
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Contractions per 10 minutes
<20
20-40
>40
5 4 3 2 1
Oxytocin U/L drops/min
Drugs given and I/V fluids
Pulse ●
BP
180 170 160 150 140 130 120 110 100 90 80 70 60
Temperature °C
Protein
Acetone
Urine Output

WHO PARTOGRAPH

Name: _____ Age: ____ G: ____ P: ____ Hospital No. | | | | | | | |

Date of Admission: _____ Time of Admission: _____

Ruptured membrane: Y/N if yes. Date _____ (time) _____ True Labour Pain Started Date (time) _____



SESSION OBJECTIVES, EXERCISES AND HANDOUTS

DAY TWO

Day 2 Session Objectives

Opening Circle, Day 2

At the end of the session, participants will be able to:

- Express their thoughts about the workshop, if they wish
- Respectfully listen to other participants' thoughts

Module 5: *Prevention of prolonged and obstructed labor (continued)*

At the end of the session, participants will be able to:

- Practice using the partograph with case studies
- Identify how they will share their knowledge about the partograph with other health workers in their facility

Module 6: *Obstetric fistula causes and factors*

At the end of the session, participants will be able to:

- Define obstetric fistula
- Describe the causes and development of obstetric fistula
- Identify contributing factors of obstetric fistula
- Identify complications of obstetric fistula
- Explain the relationship between obstetric fistula and stillbirth
- Identify how obstetric fistula can be prevented
- Develop health education messages about obstetric fistula and its prevention

Module 7: *Identification of obstetric fistula*

At the end of the session, participants will be able to:

- Identify the different types of obstetric fistula
- List the basic components of classification systems for describing obstetric fistula
- Describe the most common symptoms for diagnosing obstetric fistula
- Use the job aid for Diagnosis of Obstetric Fistula
- Identify the factors determining the prognosis of success of fistula repair

Module 8: *Pre-repair care and referral*

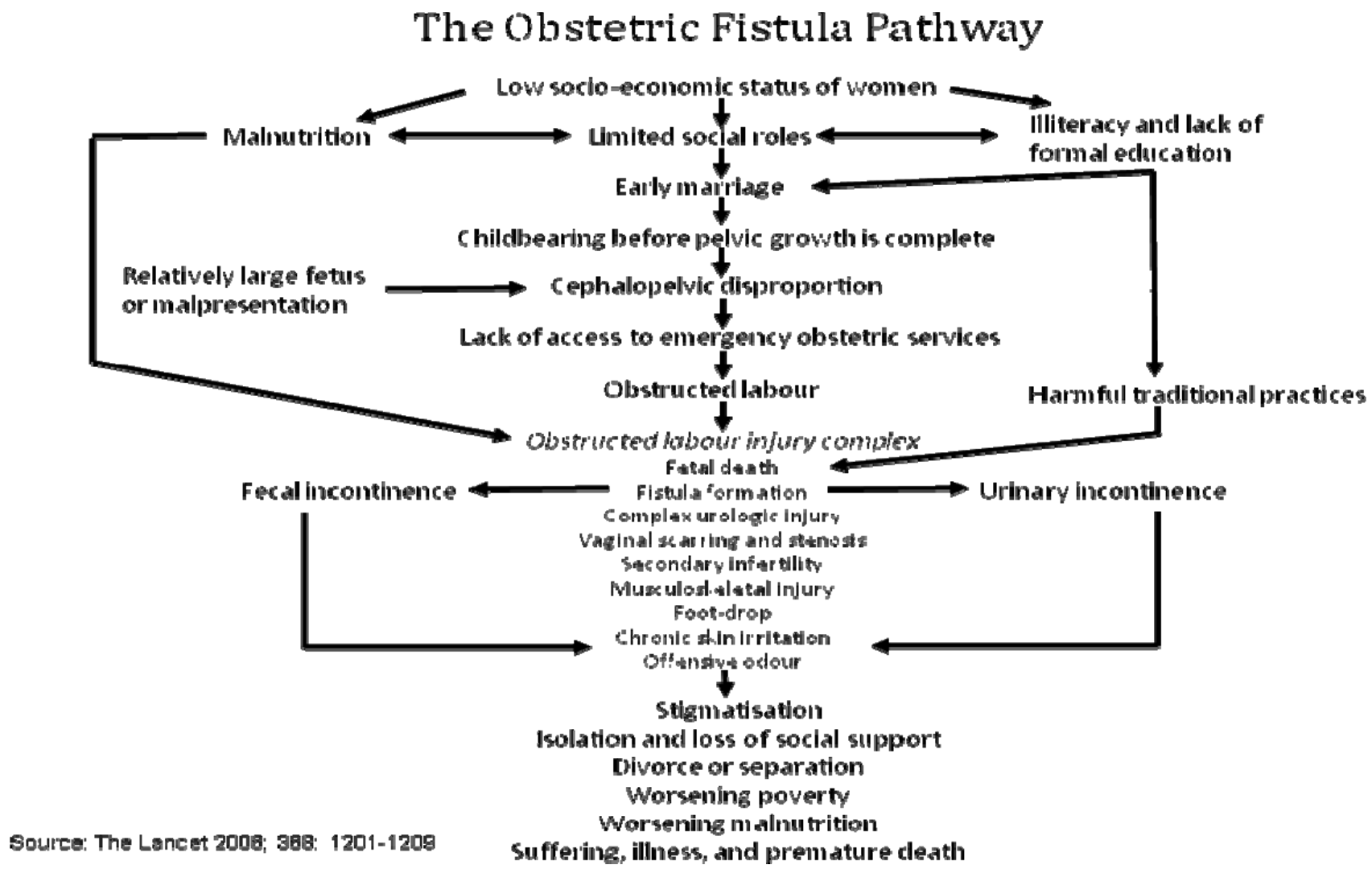
At the end of the session, participants will be able to:

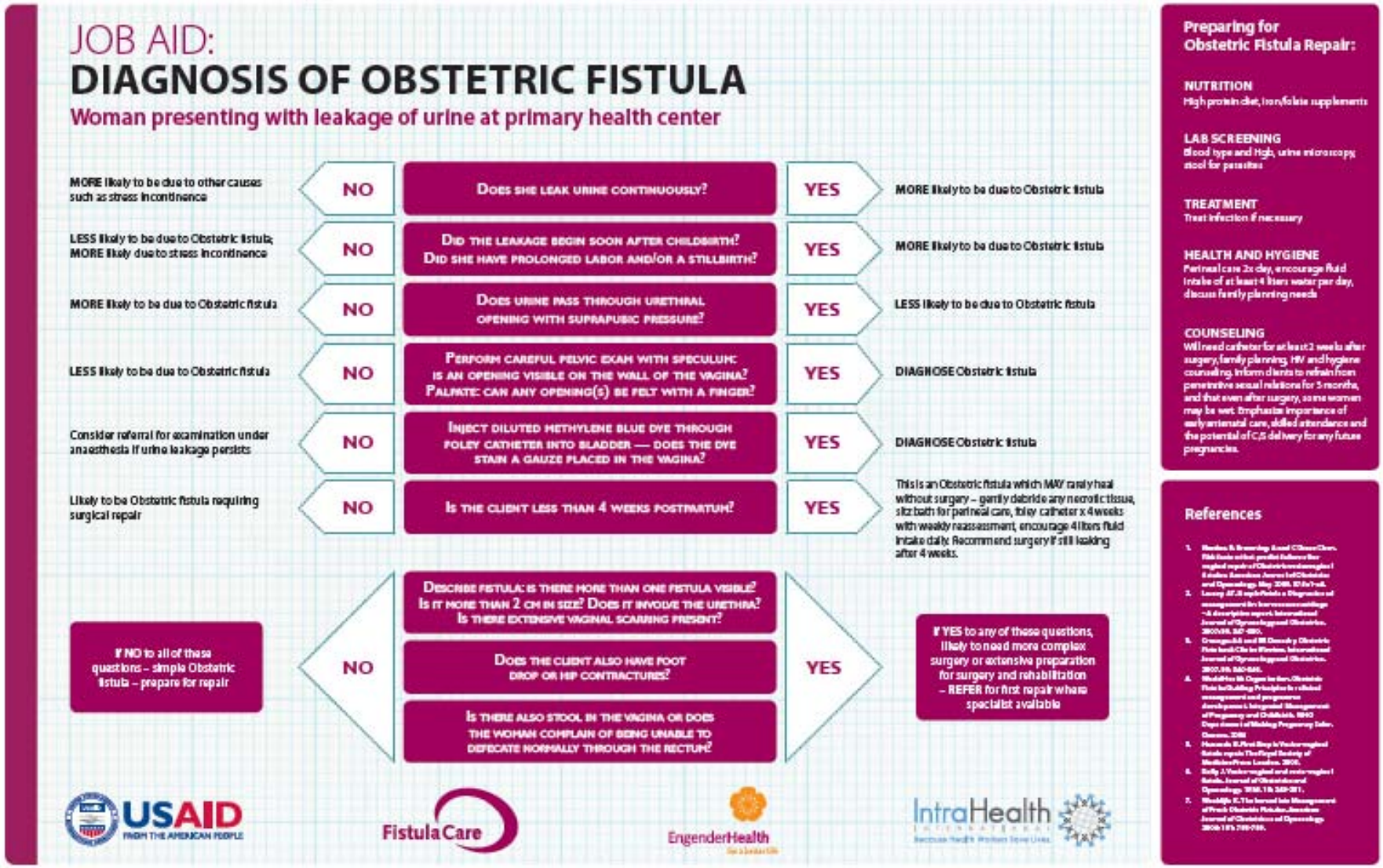
- Describe steps for early detection and management of obstetric fistula
- Explain procedures for history-taking, physical and pelvic exam, and lab tests for assessing the woman with possible obstetric fistula
- Describe the components of pre-repair care of the woman with possible obstetric fistula
- Identify fistula surgery counseling messages for the woman with obstetric fistula
- Describe steps for fistula referral to the pre-repair unit and back

Closing circle, Day 2

At the end of the session, participants will be able to:

- Express their thoughts about the day or what is in their minds, if they wish
- Respectfully listen to other participants' thoughts


The Obstetric Fistula Pathway
Low socio-economic status of women
Malnutrition
Limited social roles
Illiteracy and lack of formal education
Early marriage
Childbearing before pelvic growth is complete
Relatively large fetus or malpresentation
Cephalopelvic disproportion
Lack of access to emergency obstetric services
Obstructed labour
Harmful traditional practices
Obstructed labour injury complex
Fatal death
Fecal incontinence
Fistula formation
Urinary incontinence
Complex urologic injury
Vaginal scarring and stenosis
Secondary infertility
Musculoskeletal injury
Foot-drop
Chronic skin irritation
Offensive odour
Stigmatisation
Isolation and loss of social support
Divorce or separation
Worsening poverty
Worsening malnutrition
Suffering, illness, and premature death
Source: The Lancet 2006; 368: 1201-1209


JOB AID:
DIAGNOSIS OF OBSTETRIC FISTULA
Woman presenting with leakage of urine at primary health center
MORE likely to be due to other causes such as stress incontinence
NO
DOES SHE LEAK URINE CONTINUOUSLY?
YES
MORE likely to be due to Obstetric fistula
LESS likely to be due to Obstetric fistula; MORE likely due to stress incontinence
NO
DID THE LEAKAGE BEGIN SOON AFTER CHILDBIRTH? DID SHE HAVE PROLONGED LABOR AND/OR A STILLBIRTH?
YES
MORE likely to be due to Obstetric fistula
MORE likely to be due to Obstetric fistula
NO
DOES URINE PASS THROUGH URETHRAL OPENING WITH SUPRAPUBIC PRESSURE?
YES
LESS likely to be due to Obstetric fistula
LESS likely to be due to Obstetric fistula
NO
PERFORM CAREFUL PELVIC EXAM WITH SPECULUM: IS AN OPENING VISIBLE ON THE WALL OF THE VAGINA? PALPATE: CAN ANY OPENING(S) BE FELT WITH A FINGER?
YES
DIAGNOSE Obstetric fistula
Consider referral for examination under anaesthesia if urine leakage persists
NO
INJECT DILUTED METHYLENE BLUE DYE THROUGH FOLEY CATHETER INTO BLADDER — DOES THE DYE STAIN A GAUZE PLACED IN THE VAGINA?
YES
DIAGNOSE Obstetric fistula
Likely to be Obstetric fistula requiring surgical repair
NO
IS THE CLIENT LESS THAN 4 WEEKS POSTPARTUM?
YES
This is an Obstetric fistula which MAY rarely heal without surgery – gently debride any necrotic tissue, sitz bath for perineal care, foley catheter x 4 weeks with weekly reassessment, encourage 4 liters fluid intake daily. Recommend surgery if still leaking after 4 weeks.
If NO to all of these questions – simple Obstetric fistula – prepare for repair
NO
DESCRIBE FISTULA: IS THERE MORE THAN ONE FISTULA VISIBLE? IS IT MORE THAN 2 CM IN SIZE? DOES IT INVOLVE THE URETHRA? IS THERE EXTENSIVE VAGINAL SCARRING PRESENT?
DOES THE CLIENT ALSO HAVE FOOT DROP OR HIP CONTRACTURES?
IS THERE ALSO STOOL IN THE VAGINA OR DOES THE WOMAN COMPLAIN OF BEING UNABLE TO DEFECATE NORMALLY THROUGH THE RECTUM?
YES
If YES to any of these questions, likely to need more complex surgery or extensive preparation for surgery and rehabilitation – REFER for first repair where specialist available
USAID
FROM THE AMERICAN PEOPLE
Fistula Care
EngenderHealth
IntraHealth
Preparing for Obstetric Fistula Repair:
NUTRITION
High protein diet, iron/folate supplements
LAB SCREENING
Blood type and Hgb, urine microscopy, stool for parasites
TREATMENT
Treat infection if necessary
HEALTH AND HYGIENE
Perineal care 2x day, encourage fluid intake of at least 4 liters water per day, discuss family planning needs
COUNSELING
Will need catheter for at least 2 weeks after surgery, family planning, HIV and hygiene counseling. Inform clients to refrain from penetrative sexual relations for 3 months, and that even after surgery, some women may be wet. Emphasize importance of early antenatal care, skilled attendance and the potential of C/S delivery for any future pregnancies.
References

Role play for Module 7: Using the Diagnosis of Obstetric Fistula Job Aid

Ayana is a 22 year old woman from a village 6 hours walk away from the nearest health center. She got married when she was 18 years old and during her first birth at 21 she pushed for 12 hours before delivering a male baby who was stillborn. A few weeks after the delivery, Ayana began to leak urine all the time and she stopped going to collect water and to the market because of the smell. Her husband suggested that she should sleep in the smaller house in the yard in order to not offend other members of the family. A HEW who works in a nearby village heard about Ayana and brought her to the health center to see if maybe she had an obstetric fistula and could be helped.

In your small group, role play the steps you would go through in welcoming Ayana to the health center, using the job aid to determine if she is likely to have an obstetric fistula and preparing her for obstetric fistula repair. One group member could play Ayana, another a HEW or nurse doing the initial assessment and counseling, and a third could be the midwife and describe the steps in the physical examination. (resource: Diagnosis of Obstetric Fistula Job Aid)

IntraHealth Fistula Patients Referral Form

Ref.No……..

Name of Patient…… Age……

Address: Woreda……Kebele……..PA……H.No……

Referred from community/health post on……Arrived at health facility on(date)…….

Came health facility by (transport)……

Stayed in the health center for……days

Treatment/Care given in the health center

……

……

Reason for referral

……

……

Referred by……

Signature……..

Date……

……Feedback……

Name of Patient……Age……Address…….

Referred from……Health Center H.Center Ref.No……

Referred on (date)……Came to B.Dar/Mekele Fistula Hospital on (date)……

Reason for referral was……

Patient condition on arrival……

Intervention at B.Dar/Mekele Fistula Hospital……..

……

Patient stayed in Hospital for……days/ weeks

Follow up recommendation……

……

Feed back by……Date……

SESSION OBJECTIVES, EXERCISES AND HANDOUTS

DAY THREE

Day 3 Session Objectives

Opening Circle, Day 3

At the end of the session, participants will be able to:

- Express their thoughts about the workshop, if they wish
- Respectfully listen to other participants' thoughts

Module 8: *Pre-repair care and referral (cont'd)*

At the end of the session, participants will be able to:

- Describe steps for early detection and management of obstetric fistula
- Explain procedures for history-taking, physical and pelvic exam, and lab tests for assessing the woman with possible obstetric fistula
- Describe the components of pre-repair care of the woman with possible obstetric fistula
- Identify fistula surgery counseling messages for the woman with obstetric fistula
- Describe steps for fistula referral to the pre-repair unit and back

Module 9: *Principles of postoperative care and reintegration*

At the end of the session, participants will be able to:

- Describe elements of postoperative care for the woman after obstetric fistula surgery
- Identify possible post-operative complications from fistula surgery
- Identify post-repair counseling messages regarding sexual relations, pregnancy, and reintegration into the community
- Outline what a woman may need when she returns to her community after repair of obstetric fistula

Module 10: *Roles of families, community and the health care system*

At the end of the session, participants will be able to:

- Identify messages for the community about prevention of obstetric fistula
- Identify the roles of families, communities, and health workers in preventing and treating obstetric fistula

Forward planning

At the end of the session, participants will be able to:

- Develop an individual action plan for how they are going to apply the skills and knowledge learned in the workshop

Post-course assessment

At the end of the session, participants will be able to:

- Complete a post-course assessment to determine their level of knowledge about the workshop content

Workshop wrap-up, evaluation, and closure

At the end of the session, participants will be able to:

- Compare participant expectations with workshop objectives
- Provide written evaluations of the workshop
- Provide one-sentence vision of their workplace's future initiatives in obstetric fistula prevention and care

Checklist for Obstetric Fistula Assessment and Counseling

Instructions: Evaluate the performance of the provider in implementing each task or activity, using the following codes: **S = Satisfactory** **U= Unsatisfactory** **N/O = Not observed**

Name: _____ **Service site:** _____

Observer: _____ **Date** _____

Task/Activity	Rating per patient/provider interaction				
Greets and welcomes patient					
Welcomes the patient with respect, kindness, and reassurance. Introduces himself or herself, and offers the patient a seat					
Ensures comfort and privacy in the consultation room					
Assures the patient of the confidentiality of all information that is shared					
Indicates throughout the consultation that she is listening to the patient (e.g., culturally appropriate eye contact, smiling and nodding, refraining from doing other tasks)					
Encourages and responds to the patient's questions					
Asks patient about herself and her concerns					
Assists the patient in clarifying her health needs, concerns, and problems					
Assists the patient in determining decisions or actions that the she needs or wants to make during this visit					
Explains the purpose of the questions (as appropriate)					
Uses simple and clear language that the patient can understand					
Explains terms as needed					
Obtains the patient's medical and social history (using the Outpatient Card for Fistula Patient, or other guidelines)					
• Age, parity and past obstetric history					
• Any history of FGM or other genital or sexual trauma					
• Description of last labor and birth, including whether the infant was born live or stillborn and mode of delivery					
• Duration of symptoms of urinary or fecal incontinence					
• Any problems with mobility or walking					
• Other past medical history including any illnesses, other surgery or allergies					
• Social history, including marital history and any problems which have arisen due to consequences of obstetric fistula					
Asks about the patient's:					
• Reproductive health plans (desired number of children, spacing of births, etc.)					
• Perception of risk (regarding pregnancy or STIs, including HIV/AIDS)					
• Risk behaviors as pertinent to the patient's concerns (e.g., pregnancy and STIs, including HIV)					
Encourages and responds to the patient's questions					

Task/Activity	Rating per patient/provider interaction				
Performs physical exam:					
Assures a private place for the examination and cleanliness of exam room, necessary equipment and supplies, and appropriate infection prevention					
Explains the exam to the patient.					
Offers that a support person or nurse can also accompany the patient for the exam if desired					
Performs complete physical examination, with attention to:					
• Fever and signs of infection					
• Anemia					
• Nutrition					
• Dermatitis					
• Lower limb weakness and contractures					
• Bed sores or ulcers					
Performs a genitourinary exam:					
• Careful and sensitive examination of external and internal genitals					
• Methylene blue injection through foley catheter in bladder to determine the size, location and number of fistulas					
• Careful recto-vaginal examination for recto-vaginal fistulas and any involvement of the anal sphincter or presence of rectal strictures					
Performs laboratory examination. Depending on local resources and condition of patient, includes:					
• Blood type and hemoglobin					
• HIV test					
• Stool for parasites					
• Evaluation for urinary tract infection					
• Evaluation for sexually transmitted diseases					
Reviews the results of the physical examination with the patient, answering any questions					
For Obstetric Fistula PRE-repair Counseling:					
Counsels patient on information appropriate to pre-repair for obstetric fistula					
Begins the discussion with the patient's preference or most urgent need					
Asks what the patient already understands about her health situation and desired course of action					
Tailors information to the patient's need, knowledge, and personal situation					
Uses words familiar to the patient					
Uses appropriate information, education, and communication materials in an effective manner					
Asks open-ended questions to verify the patient's understanding of important information					
Encourages and responds to the patient's questions					
Corrects false information and rumors, as needed					

Task/Activity	Rating per patient/provider interaction				
Counsels patients who will be referred for obstetric fistula repair about pre-repair care including:					
• Treatment for anemia with iron/folate supplements					
• High protein diet					
• Treatment for any infections – parasitic medication, antibiotics if any signs of UTI or STI					
• Skin care for dermatitis					
• Perineal care with mild detergent in water twice a day					
• Initiation of rehabilitation and physical therapy for foot drop or contractures					
• Psychological and emotional support					
• After complete evaluation, explanation of treatment options to the woman and family including recommendations for surgery and obtaining consent					
Explains to patient what to expect during referral care for fistula surgery including:					
• Most fistulas can be repaired with surgery, especially if: – they are small – they are not associated with other complications – they have not been present for a long time AND – this is the first attempt at repair					
• Women need to know that the surgery is not always successful					
• Even if the fistula is closed, some women will still leak urine (15-20%) and most will have urinary frequency because of a smaller bladder					
• Complications such as infertility, chronic pelvic pain and infections will not likely be corrected with obstetric fistula surgery					
Explains referral process to patient:					
• Women with acute obstetric fistulas are currently encouraged to wait for three months before surgical repair at AAFH					
• Women with chronic obstetric fistulas should be referred from health centers to the nearest PRU as soon as possible					
• Women are cared for at the PRU for rehabilitation and pre-repair care for approximately one week and then referred to the fistula hospital					
•Most women will stay at the fistula hospital for two weeks (with a urinary catheter) and after discharge will return to the PRU for 2-5 days for follow-up and post-repair care before returning to their homes					
• The cost of transportation to/from the fistula hospital is covered by the project. It is not necessary for family to accompany the patient to the hospital					
• The cost of surgical repair is covered by funding through the fistula hospital					
Counsels patient about surgery:					
• The woman will not be restricted from eating and drinking the day before surgery. Usually she will be given a enema in preparation for surgery					
• Surgery takes 60 minutes on average for uncomplicated fistula, but can be as long as 3-4 hours if complicated					
• The usual approach for repair is through the vagina, but occasionally an abdominal incision is needed					

Task/Activity	Rating per patient/provider interaction				
• Usually performed under spinal anesthesia					
• Most women will receive antibiotics before and after the surgery to prevent infection					
• Usually the woman will need to admitted to the fistula hospital for two weeks and may need help with dressing changes, eating, bathing, etc.					
Helps patient to make decisions to meet her health needs					
Asks open ended questions to make certain patient understands her problem and the risks and benefits of fistula surgery as well as what steps are needed for preparation					
Asks patient if she is ready to make a decision to proceed with referral for fistula surgery. If she is not able to decide, make a return appointment to talk about this further and encourage her to discuss the decision with family and friends					
Explains instructions for managing health problem/implementing decisions					
Asks open-ended questions to verify the patient's understanding of important information					
Encourages and responds to questions from the patient					
Plans next steps / Return visit / Referral					
Sets up follow-up visit or time for referral, as needed, if patient is able to make a decision to proceed with fistula surgery repair					
Invites the patient to come back at any time for any reason					
Refers the patient for needed or requested services unavailable on-site					
Encourages and responds to questions from the patient					
Thanks the patient for coming					
For Obstetric Fistula POST-repair Counseling:					
Counsels patient on information appropriate to obstetric fistula post-repair after she has returned to the health center/pre-repair unit following surgery					
Discusses family planning: • ask client whether she wishes to become pregnant again • recommend that all women should abstain from genital sexual relations for three months after repair • recommend that pregnancy should be delayed for at least one year • ask client about her past experience with family planning and assess her knowledge about methods • offer or arrange for FP method of choice, considering client and partners situation and desire for spacing or limiting births					
Advises patient that many women will need to do pelvic muscle exercises to regain strength in their bladder and pelvis, and explains how to do these exercises					
Advises about delivery of next child: • should be at a hospital with emergency obstetric care • in most cases, cesarean birth is recommended. Obstetric fistulas may reopen during a subsequent vaginal birth					

Task/Activity	Rating per patient/provider interaction				
Talks with patient about • what she may need when she returns to her home community • resources and support available, including follow-up at the health center or Pre-repair unit and home visits by a fistula mentor					
Explains instructions for managing health problem/implementing decisions					
Asks open-ended questions to verify the patient's understanding of important information					
Encourages and responds to questions from the patient					
Plans next steps / Return visit / Referral					
Sets up follow-up visit or time for referral, as needed					
Invites the patient to come back at any time for any reason					
Refers the patient for needed or requested services unavailable on-site					
Encourages and responds to questions from the patient					
Thanks the patient for coming					

Role play for Module 8: Pre-repair counseling

Abeba was referred to the PRU unit where your team works after having been diagnosed with a likely obstetric fistula at a nearby health center. She had three normal births and three living children, but during her fourth delivery three years ago the baby was in a transverse position. Abeba was in labor for 2 days before her sister finally convinced the family to take her to the hospital. She had a caesarian section but the baby was already dead. Abeba developed an infection and anemia and spent two weeks in the hospital, and she has been leaking urine since that time. She has come with her sister to the PRU after referral, and hopes that surgery will be able to restore her to health.

In your small group, role play the steps in pre-repair care and counseling for Abeba. Answer her questions about what she needs to do to get ready for fistula surgery repair and what to expect during and after surgery. (resources: Module 8 PPT: Pre-repair care and referral and *Checklist for Obstetric Fistula Assessment and Counseling*)

Role play for Module 9: Post-repair counseling

Makda has returned to your health center after spending two weeks at the fistula hospital undergoing obstetric fistula repair. Prior to this, she had lived for many years by herself in a small house behind her brother and family. Her husband had abandoned her and taken another wife after her second stillborn. Makda is encouraged that her life may now improve, but she is also worried about how she will care for herself and make enough money for food and clothing.

In your small group, role play the steps in post-repair counseling for Makda. Counsel her on caring for herself, what she may expect as she recovers from the surgery, and things she needs to consider for the future. Answer her questions about what support might be available to her in her community. (resources: Module 9: Principles of post-repair counseling and reintegration and *Checklist for Obstetric Fistula Assessment and Counseling*)

Action Plan for Applying Skills in Prevention and Recognition of Obstetric Fistula

Use this form to:

- plan how you will continue to improve your knowledge and skills in prevention, recognition, and care of obstetric fistula
- share what you have learned with others at your worksite
- improve the quality of maternal health and obstetric care services for clients in your community

1. My name: _____ 2. Name of health centre: _____

3. District: _____ 4. Date I completed this form: _____

Activities and steps	Person(s) responsible	Resources and assistance needed	Time period (from _____ to _____)

Activities and steps	Person(s) responsible	Resources and assistance needed	Time period (from _____ to _____)

PREVENTION AND RECOGNITION OF OBSTETRIC FISTULA

WORKSHOP EVALUATION

Items 1–4: Please rate the following on a scale of 1 to 5: **1** = you **strongly disagree**

5 = you **strongly agree**

		1	2	3	4	5
1	As a result of this workshop I am more confident in my knowledge about prevention and recognition of obstetric fistula, and care of patients pre/post fistula repair.					
2	The objectives were met through the presentations and activities used in this workshop.					
3	The facilitators were knowledgeable and kept the activities interesting.					
4	The training room facilitated a learning environment.					
5	The training materials and resources provided will be useful to me after the workshop.					

Items 6–28: Please rate the following workshop sessions and training activities on a scale from 1–5:

1 = you were **very dissatisfied** with the topic or the way it was presented

5 = you were **very satisfied** with the topic or the way it was presented

		1	2	3	4	5
6	Day 1, Opening Circle, Welcome and Introduction					
7	*Module 2*: Overview of Safe Motherhood					
8	Developing health education messages about importance of ANC and skilled attendance at birth					
9	*Module 3*: Review of Female Reproductive System—quick review of female anatomy and menstrual cycle					
10	*Module 4*: Essential Components of ANC and EmOC					
11	Identifying components of Focused ANC					
12	Identifying warning signs of complications in pregnancy and postpartum					
13	*Module 5:* Prevention of prolonged and obstructed labor					
14	Case studies to practice using the partograph					
15	Closing Circles, Days 1-3					
16	Homework reading assignments					
17	Opening Circles Days 2-3					
18	*Module 6*: Obstetric fistula causes and factors					
19	Developing health education messages about obstetric fistula and its causes					
20	Gallery walk and selecting best health education messages developed by participants on safe motherhood and obstetric fistula					
21	*Module 7*: Identification of obstetric fistula					
22	Role play using the Diagnosis of Obstetric Fistula job aid					

		1	2	3	4	5
23	*Module 8*: Pre-repair and referral					
24	Role play counseling a woman with OF about the pre-repair care she will receive and what to expect with the surgery					
25	*Module 9*: Principles of postoperative care and reintegration					
26	Role play counseling a woman recovering from OF surgery about planning for reintegration into her community					
27	*Module 10*: Roles of families, community and the health care system					
28	Developing individual action plans for how you will apply your new skills and knowledge to improve maternal health care and fistula care services					

26. Which activities did you enjoy the most or learn the most from?

27. Which activities could be improved upon and how?

28. Please write any additional comments you may have:

PREVENTION AND RECOGNITION OF OBSTETRIC FISTULA
POST-COURSE KNOWLEDGE ASSESSMENT

Participant code or name_____

Read carefully and circle the ONE BEST answer from the given options

1. Globally, the most common causes of DIRECT maternal mortality include:
   a. Infection, obstructed labor, severe anemia, and unsafe abortion
   b. HIV/AIDS, malaria, hemorrhage, and obstructed labor
   c. Obstructed labor, severe anemia, tuberculosis, and infection
   d. Hemorrhage, infection, eclampsia, and obstructed labor
   e. Obstructed labor, hemorrhage, malaria, and HIV/AIDS

2. Three of the common causes of INDIRECT obstetric death include:
   a. Infection, tuberculosis, and HIV/AIDS
   b. Unsafe abortion, severe anemia, and malaria
   c. Pre-eclampsia/eclampsia, hemorrhage, and obstructed labor
   d. Sexual violence, exacerbation of heart disease, and severe anemia
   e. Complications of surgery related to pregnancy, malaria, and severe anemia

3. Maternal mortality ratio is defined as:
   a. The death of a woman during pregnancy or within 42 days of childbirth
   b. The number of maternal deaths per 100,000 live births in the same time period
   c. The number of maternal deaths per 100,000 women of reproductive age in the same time period
   d. The probability of dying from a maternal cause during a woman's lifetime

4. In the last 20 years, maternal mortality has:
   a. Increased globally by 25%
   b. Resulted in more than 500,000 maternal deaths per year
   c. Decreased globally by 34%
   d. Increased in more than 147 countries

5. The estimated maternal mortality ratio in Ethiopia (estimated by WHO as of 2008) is:
   a. 360/100,000 live births
   b. 470/100,000 live births
   c. 820/100,000 live births
   d. 1,200/100,000 live births

6. Approximately what percentage of women worldwide will need emergency obstetric care?
   a. 2-5%
   b. 10%
   c. 15%
   d. 40%

7. Maternal deaths:
    a. Can usually be prevented with good antenatal care
    b. Most often occur 2-3 weeks after delivery when a woman is at home
    c. Often cannot be predicted or prevented so all women need access to emergency obstetric care
    d. Never occur in facilities but are very common when women deliver at home

8. Factors that contribute to maternal mortality and morbidity are:
    a. Lack of equipped health facilities and trained providers
    b. Low status of women
    c. Delay in decision to seek care, reaching care, and receiving care
    d. Geographic barriers and lack of transportation
    e. All of the above
    f. A, C, and D only

9. Inadequate nutrition can impact a woman's health by:
    a. Causing short stature and misshapen pelvic bones which put her at risk for prolonged and obstructed labor
    b. Increasing risk of anemia
    c. Interfering with reproductive hormones, her menstrual cycle and the health of pregnancies
    d. All of the above

10. Evidence-based focused antenatal care includes:
    a. At least four visits (confirmation of pregnancy, 20-28 weeks, after 36 weeks and before the expected date of delivery)
    b. Birth preparedness and complication readiness
    c. Measurement of weight/BMI and assessment of nutritional status
    d. Prevention and treatment of anemia and infections
    e. All of the above

11. Skilled attendance at birth is estimated to prevent what percentage of maternal deaths?
    a. <5%
    b. 50%
    c. 13-33%
    d. 65%

12. Warning signs of complications in pregnancy include:
    a. Swelling of hands and face
    b. Pale conjunctiva, tongue, palms and nail beds
    c. Increased fetal movement
    d. Bleeding from the vagina
    e. All of the above
    f. A, B and D only

13. Basic emergency obstetric care services include:
    a. Administration of antibiotics for infection
    b. Surgical skills including caesarian section
    c. Administration of antihypertensives and anticonvulsants for pre-eclampsia/eclampsia
    d. Manual removal of placenta
    e. All of the above
    f. A, C and D only

14. Birth preparedness and complication readiness include:
    a. Recognition of warning signs in pregnancy or childbirth
    b. Deciding on place of delivery
    c. Plan for rapid referral and transport to EmOC site
    d. Skilled attendant at birth
    e. Availability of clean items for mother and baby at birth
    f. All of the above
    g. A, C, and D only

15. An obstetric fistula is defined as:
    a. A tract between two areas of the reproductive system which interferes with a woman's capability to get pregnant and give birth
    b. An abnormal opening between two areas of the body (usually the bladder and the vagina, but can also be rectum and vagina) which develops during the course of a prolonged/obstructed labor and birth
    c. A hole in the uterus because of trauma
    d. An abnormal pathway between the uterus and vagina that can interfere with delivery

16. The most common reason women develop obstetric fistula is due to:
    a. Female genital mutilation
    b. Sexual violence
    c. Prolonged and/or obstructed labor
    d. Accidental injuries during surgery or episiotomy during childbirth

17. Some women with obstetric fistula also develop leg contractures because of:
    a. Injury to the peroneal nerves and/or lumbar plexus during prolonged/obstructed labor
    b. Weakness in lower legs because of nerve damage which results in difficulty walking
    c. Prolonged immobility due to depression, undernutrition, and poor care
    d. All of the above

18. If a woman develops a fistula during a prolonged or obstructed labor, the likelihood that she will also have had a stillbirth with that birth is:
    a. 60%
    b. 15%
    c. 95%
    d. 50%

19. Pathways to primary prevention of obstetric fistula include all of the following EXCEPT:
    a. Adolescent and maternal nutrition
    b. Education and empowerment for women
    c. Ready access to high quality emergency obstetric care
    d. Delaying marriage and child bearing

20. Most classification systems for describing obstetric fistula include all of the following EXCEPT:
    a. Size: large or >3 cm involves most of anterior vaginal wall and more difficult to repair
    b. Amount of scarring: fistulas with extensive scarring are more difficult to repair
    c. Whether or not the women also has foot drop and limb contractures
    d. Whether or not the fistula is circumferential
    e. Distance between fistula and the external urethral orifice (EUO or "opening" of the urethra): if this distance is >5cm it usually does NOT involve the neck of the bladder and is simpler to repair
    f. Estimation of bladder size

21. The most common place for a fistula to develop is:
    a. Between the rectum and the vagina
    b. Between the ureters and the vagina
    c. Between the bladder and the vagina
    d. Between the vagina and the uterus

22. Obstetric fistula can usually be diagnosed:
    a. Immediately postpartum (within 1-2 days) in all women
    b. By 1-2 weeks postpartum
    c. Not until three months after delivery
    d. Only if there is leakage of both stool and urine

23. Prognostic factors of whether or not fistula surgery will be successful include all of the following EXCEPT:
    a. Presence of associated complications such as malnutrition, chronic pelvic or bladder infections
    b. Size of fistula
    c. Degree of scarring and ease of access to the site of the fistula
    d. Young age (<20 years) of the woman with an obstetric fistula
    e. Whether this is the first attempt at surgical repair
    f. Proximity of the fistula to the urethra and neck of the bladder (where the trigone of bladder muscles are located)

24. The primary purpose of the partograph is to:
    a. Help women who are laboring at home recognize the warning signs of complications in pregnancy
    b. Assess the progress of normal labor at timely intervals in order to recognize and prevent prolonged or obstructed labor
    c. Help health workers keep accurate records of births at health centers
    d. Document all the important components of emergency obstetric care

25. The partograph should be used:
    a. Only by doctors with special training in Comprehensive EmOC
    b. By all health workers at all births
    c. Only by midwives working in rural areas who may need to transfer patients in labor
    d. Only for facility based deliveries

26. Common complications of prolonged and/or obstructed labor include:
    a. Avascular necrosis of the symphysis pubis leading to pelvic bone pain and abnormal gait
    b. Nerve compression which can result in foot drop and sometimes loss of feeling in the lower extremities
    c. Scarring in the vagina leading to vaginal stenosis, chronic pain with intercourse, amenorrhea, and secondary infertility
    d. Obstetric fistula
    e. All of the above

27. When completing the partograph for a woman in labor, if the second diagonal line or "action" line is crossed:
    a. Immediate referral to a site of CEmOC is recommended if the woman is laboring in a health center
    b. Operative delivery by caesarian section should be considered
    c. This represents prolonged and/or obstructed labor
    d. The risk of development of obstetric fistula is significant
    e. All of the above

28. If a woman has recently survived a prolonged/obstructed labor which of the following may help prevent development of a fistula or encourage spontaneous closing of a small fistula?
    a. Encouraging the woman to drink 4-5 liters of fluid per day
    b. Cleaning of the perineum and vagina with mild detergent and soap twice a day
    c. Indwelling urinary foley catheterization for at least 2 weeks
    d. IF there is an experienced clinician available, explore the vagina and gently excise any necrotic tissue
    e. All of the above
    f. A, B and C only

29. Pre-repair care for long standing obstetric fistulas (i.e., not immediately postpartum) should include all of the following EXCEPT:
    a. Treatment for anemia with iron/folate supplements
    b. Psychological and emotional support
    c. Treatment for any infections – parasitic medication, antibiotics if any signs of UTI or STI
    d. Skin care for dermatitis including perineal care with mild detergent in water twice a day
    e. Continual drainage of bladder with a foley catheter until surgery can be scheduled
    f. Initiation of rehabilitation and physical therapy for foot drop or contractures

30. Women who are considering fistula repair surgery should be counseled that:
    a. Repair is sometimes more difficult when the fistula has been present for a long time
    b. Surgery is usually but not always successful
    c. Even if the fistula is closed, some women will still leak urine (15-25%) and most will have urinary frequency because of a smaller bladder
    d. Complications such as infertility, chronic pelvic pain and recurrent urinary tract infections will not likely be corrected with obstetric fistula surgery
    e. All of the above

31. Women should expect to stay at the fistula hospital after repair for:
    a. Up to one month
    b. 2-3 days only if the surgery goes well
    c. Approximately two weeks during which time they will have a urinary catheter
    d. 1 week

32. Possible complications of fistula surgery include all of the following EXCEPT:
    a. Anuria (absence of urine) because of accidental ligation of ureters or obstruction
    b. Breakdown of fistula repair due to infection or necrosis
    c. Development of bladder stones
    d. Dyspareunia (pain with intercourse), urethral or vaginal strictures, or infertility
    e. Secondary vaginal hemorrhage
    f. Foot drop
    g. Blockage of urinary catheter and distention of bladder

33. Post-repair counseling for women who have had fistula surgery includes recommendations to:
    a. Abstain from genital sexual relations for three months
    b. Do pelvic muscle exercises to regain strength in their bladder and pelvis
    c. Plan for caesarian section for the next birth
    d. Avoid pregnancy for at least one year
    e. All of the above

34. Important community messages about the prevention of obstetric fistula include:
    a. Educating girls and keeping them in school
    b. Assuring access to a skilled birth attendant at every delivery, and emergency obstetric care when needed
    c. Delaying marriage and first birth
    d. Eradicating harmful traditional practices such as female genital mutilation
    e. Promoting family planning to space births and limit the total number of births
    f. All of the above

35. The role of Health Extension Workers (HEWs) in the prevention of obstetric fistula includes:
    a. Providing health education to families on core topics such as family planning, antenatal care, institutional delivery, postnatal care, HIV and PMTCT
    b. Identifying obstetric fistula at the community level, counseling the woman and referring for care
    c. Referring women to health centers for antenatal care and following-up with information about birth preparedness, complication readiness and warning signs of problems in pregnancy and childbirth
    d. Assisting in normal deliveries when a woman cannot get to the health facility, even if they are not skilled attendants
    e. All of the above
    f. A, B and C only