

PROMISING PRACTICES

FROM DIFFERENT COUNTRIES

This section of the Living Testimony Toolkit provides examples of promising practices that address obstetric fistula. Some of these practices focus on awareness about fistula and prevention strategies, while others are designed to improve treatment and reintegration of women into their communities.

The country strategies highlighted in this report address fistula from a range of approaches:

1. **PARTNERSHIPS**
2. **COMMUNITY MOBILISATION AND PARTICIPATION**
3. **WORKING WITH MEDIA**
4. **PREVENTION**
5. **TREATMENT**
6. **REINTEGRATION**



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This diversity of strategies highlights the complex, multidimensional nature of fistula—there are numerous interventions that can help combat fistula effectively. It is important to note that the practices included here have been chosen for their unique, innovative approaches to address fistula. They have not yet been rigorously evaluated—many, in fact, are only in pilot stages. This section of the toolkit is designed not to present programme models for replication, but to highlight emerging ideas and practices that may become proven, sustainable strategies in the years to come, and help to inspire innovative solutions in other countries.

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PARTNERSHIPS

Niger: Building a network of stakeholders for change

Background

Niger has the highest fertility rate in sub-Saharan Africa at seven births per woman (World Health Statistics 2009, WHO, p. 137). Forty-six per cent of women are illiterate (Statistics in Brief, UNESCO Institute for Statistics, 2007), use of modern contraceptives is low at 5% (Millennium Development Goals Indicators 2006, United Nations Statistics Division), and maternal mortality stands at 1,800 deaths per 100,000 live births (World Health Statistics 2009, WHO, p. 16). Eighty-four per cent of Niger's population lives in rural areas, and much of the landscape is desert, making access to health services a challenge (World Health Statistics 2009, WHO, p. 136). In addition, cultural norms that discourage women from seeking health care result in the vast majority of women delivering their babies at home, without the assistance of skilled attendants. The custom of early marriage and widespread practice of female genital mutilation (FGM) put women at further risk for obstetric fistula. Treatment for fistula is limited—few surgeons have the training to perform repairs.

Programme Description

Through a participatory process, a broad-based coalition of key stakeholders, called the Network for the Elimination of Fistula in Niger, was established in 2004 to address the problem of fistula. The network aims to coordinate stakeholders' interactions, share information, and facilitate joint planning and programming with the goal of achieving concerted action towards the elimination of fistula in Niger.

The objectives of the network are to:

- Ensure information sharing on issues related to obstetric fistula;



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- Ensure that interventions are complementary through effective multi-sectoral collaboration;
- Advocate for the cause of fistula and the promotion of emergency obstetric care (EmOC) services; and
- Mobilise political and financial support for fistula and EmOC programmes.

Several critical steps were taken in establishing the network:

1. **Lobbying:** The network created support and buy-in from potential stakeholders, including government, non-governmental organisations (NGOs), and health associations working on maternal health and fistula.
2. **Consensus building:** Once partners were identified and their commitment enlisted, a fistula workshop was organised to build national consensus on the framework of the network and its operating mechanisms. Network members agreed on a monitoring system and to hold meetings on a regular basis to follow-up on network activities.

3. **Official launch of the network:** The launch of the network was sanctioned by an official constitutive act passed by the government. An office was setup and the network became fully operational with a long-term strategic plan.

The membership of the network is comprised of representatives from the Ministry of Health, the Ministry of Social Development, and national NGOs and associations. A permanent council is charged with overseeing the day-to-day management of network activities. Every quarter, a plenary meeting is held to discuss strategic issues, planning, and monitoring and evaluation related to the network's activities. In addition, technical working groups focusing on research, communication, and training meet on an ad hoc basis. The United Nations Population Fund (UNFPA) and external partners provide technical assistance and financial support.

Since its establishment, the network has undertaken a range of programmatic activities, including a high-level advocacy campaign led by Niger's first lady and president; training of health care professionals on how to prevent and treat fistula, including the creation of dedicated surgical teams; and the introduction of a social reintegration programme for women.

Lessons Learned

- ▶ Information-sharing between partners working on fistula has led to improved coordination of activities.
- ▶ Involving the highest-level political figures (e.g. the president and first lady) and enlisting their support has galvanised national awareness of fistula.
- ▶ A comprehensive approach focusing on prevention, treatment, social integration, and political commitment is necessary for addressing the needs of women living with fistula.

Source: UNFPA Accra Regional Meeting Report, La mise en œuvre de la campagne Internationale de lutte contre la fistule obstétricale au Niger, Mme Mariama Moussa Permanente du REF et Dr Amoul Kinni Ghaichatou PF-Fistule.

COMMUNITY MOBILISATION AND PARTICIPATION

Eritrea: Engaging and mobilising communities on maternal health

Background

After years of conflict over the border with Ethiopia, severe drought, and food shortages, Eritrea struggles to reconstruct social services and economic stability and to reintegrate displaced populations. With a population of 4.9 million (World Health Statistics 2009, WHO, p. 134), Eritrea has a modern contraceptive prevalence of 5.1% (Millennium Development Goals Indicators 2002, United Nations Statistics Division). The total fertility rate has declined to 5.1 (World Health Statistics 2009, WHO, p. 135), though the ideal family size is slightly higher at 5.8 (Eritrea Demographic and Health Survey, National Statistics and Evaluation Office, 2002, p. 114). Maternal mortality is one of the highest globally, at 450 deaths per 100,000 live births (World Health Statistics 2009, WHO, p. 16). An estimated 41% of pregnant women receive antenatal care of at least four visits (World Health Statistics 2009, WHO, p. 74), and 28% of all births are attended by health personnel (World Health Statistics 2009, WHO, p. 17).

Programme Description

A pilot community mobilisation project aimed to promote community awareness and adoption of positive behaviours for maternal health, and the prevention of fistula was implemented in the town of Kamchewa in the Northern Red Sea Zone of Eritrea, with the neighbouring district of Haboro in Anseba Zone identified as a comparison area. The project is a partnership between the Eritrean Ministry of Health and the local community, with support from the United Nations Population Fund (UNFPA) and Stanford University's Eritrean Women's Health Project.

The project trained female and male Maternal Health Volunteers (MHVs) to lead a series of participatory sessions with community members on maternal health and obstetric fistula. Topics included in the sessions were: utilisation of antenatal care; malaria prevention; recognition of danger signs during pregnancy, labour, and delivery; the importance of prompt referral when complications occur; and the importance of using skilled birth attendants. The MHVs participated in a 10-day training course and were supervised and supported by local health centre staff. Particular importance was given to working with men, as they are often the primary decision makers for utilisation of health care services and they control household finances for services and transportation to health care facilities. The MHVs were provided with a reference manual, a field guide, and flipcharts on antenatal care, female genital mutilation, and maternal health in the local language (Tigre) to support their work. The maternal health volunteers were unpaid, but were reimbursed for expenses incurred during training.

The project also strengthened local health facilities, including training health workers in interpersonal communication and infrastructure improvements. By the end of the project, the MHVs were still active: 20 female and 19 male volunteers continued to hold discussion groups; a total of 32 groups (20-25 members in each group) had been organised by female volunteers; and 3 groups (total of 64 men) had been organised by male volunteers (the male MHVs had only recently been trained).

Evaluation of the project involved a quasi-experimental study design (non-equivalent group pretest-posttest) to assess whether the project improved the community's knowledge, attitudes, and practices related to maternal health and prevention/treatment of obstetric fistula.

The evaluation design included:

- Baseline data collection in one intervention (Kamchewa) and one control community (Haboro);
- Implementation of project activities in the intervention community;
- A mid-intervention process evaluation; and
- Final assessment data collection in intervention and control communities one year after initiation of the intervention.

The evaluation revealed significant increases in knowledge and attitudes related to maternal health in Kamchewa. Although comparison with the control area indicates that there were general improvements in knowledge in other parts of Eritrea as well during this time period, the intervention did have a larger and significant positive effect on knowledge of pregnancy, recognition of birth danger signs, and birth preparedness. The evaluation results indicate that behaviour change in Kamchewa was greatest in the area of utilisation of antenatal care services, as indicated by more total visits during pregnancy, and first visits earlier in pregnancy, as compared to baseline. There were also significant increases in the number of women delivering in a health facility in Kamchewa, although the evaluation results are not conclusive. Findings from health centre statistics and focus groups also indicate that the quality of maternity care (based on women's assessments of the way they were treated by health workers during antenatal care and delivery) improved in the intervention area, but not in the control area.

Lessons Learned

- ▶ **Regular supportive supervisory visits** can provide ongoing support for the maternal health volunteers. Ideally, these visits can be integrated into the regular supervisory responsibilities of zonal or sub-zonal Ministry of Health (MOH) staff located near the community.
- ▶ More emphasis on **strengthening the role of male MHVs** may have good results, since they appear to be the key decision makers regarding whether or not women use health facilities for antenatal care and delivery. The female volunteers noted the importance of involving men as partners; it was observed that before men were trained as volunteers, many males in the community objected to the programme.
- ▶ **Improvements in the quality and availability of maternal health services** must accompany community mobilisation activities. As community members are made aware of the need to use health facility services, these services need to be available and of high-quality.
- ▶ Project efforts which **involve, empower, and mobilise communities** can prove to be a cornerstone in the reduction of obstetric fistula and result in the adoption of positive maternal health practices.

Source: Final report on the pilot community mobilisation/education project for promotion of safe motherhood and prevention of obstetric fistula in Eritrea. Prepared by Janet M. Turan, Ministry of Health/Eritrea, and UNFPA. November 2007.

Kenya: Working with religious leaders to reduce maternal mortality and morbidity

Background

Kenya's maternal mortality ratio is 560 per 100,000 live births according to 2005 estimates (World Health Statistics 2009, WHO, p. 16). While 52% of women receive the recommended four visits of antenatal care (World Health Statistics 2009, WHO, p.74), less than half (42%) of births are supervised by skilled attendants (World Health Statistics 2009, WHO, p. 17). Cultural norms strongly favour delivery at home, usually with a traditional birth attendant. There are an estimated 3,000 new cases of fistula every year in Kenya, and only 7.5% of those are treated annually ([Fistula Factsheet for Kenya, UNFPA Kenya](#)). Persistent poverty, poor education levels, and women's low status prevent women from gaining access to services to avert or cure the condition. In addition, cultural practices, such as early marriage and sexual debut, often mean that girls who are not fully developed get pregnant prematurely and face risky childbearing.

Programme Description

In the coastal region surrounding Mombasa, there is a high level of stigma associated with obstetric fistula. Coast General Hospital, one of four UNFPA-supported Obstetric Fistula Training Centres in the area, has pioneered two programmes aimed at increasing awareness of fistula and providing counselling to those affected.

The first programme utilises "Fistula Teams," which work in collaboration with community members to raise awareness of obstetric fistula. Hospital-based social workers form these teams and organise community meetings with participation from religious leaders and local chiefs. At meetings, teams respond to questions and concerns raised by community members about causes and consequences of fistula.

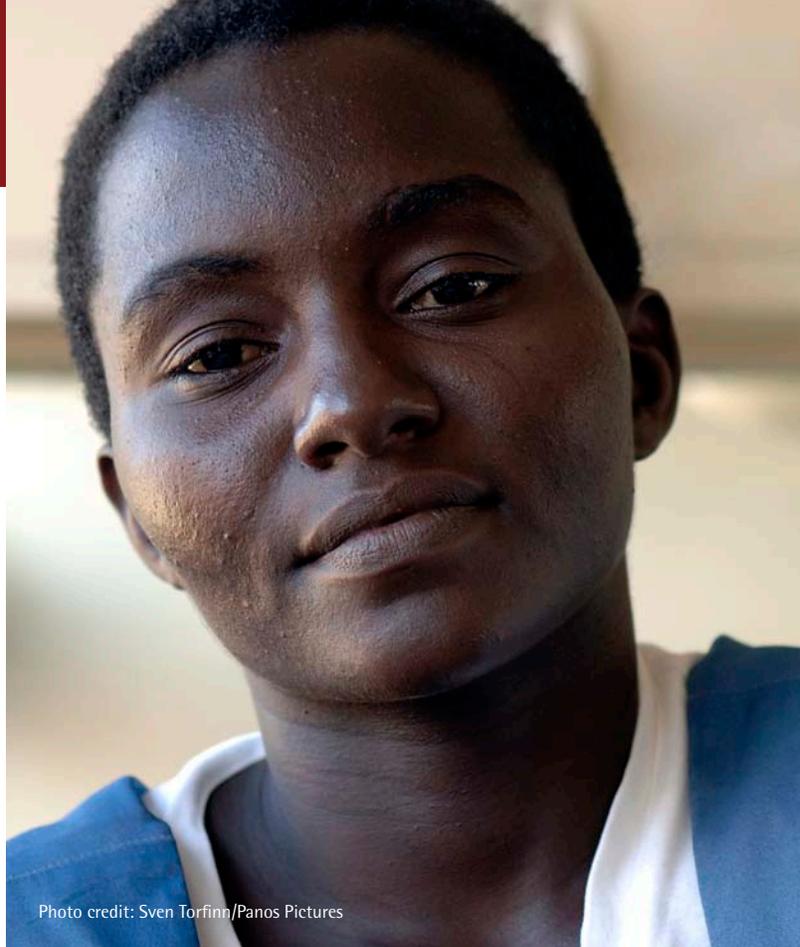


Photo credit: Sven Torfinn/Panos Pictures

The hospital's second programme aims to reintegrate women who have been treated successfully for fistula as community volunteers. These women then become "ambassadors," supporting Coast General's efforts by raising awareness, providing counselling to other women, and assisting with referrals and follow-ups for fistula patients. Through sharing their own experiences, ambassadors are able to gain the trust of other women living with fistula and encourage them to seek treatment. Currently, plans are underway to equip the ambassadors with mobile phones in order to facilitate communication with regional hospitals.

Lessons Learned

- ▶ Gaining entry to communities in which fistula is a significant health problem is central to preventing, as well as treating, the condition. Through outreach, health care facilities can promote dialogue and build trust with those communities. Participation of traditional leaders should be an integral part of outreach efforts, to ensure a strong reception and response.
- ▶ Holding meetings in the community has distinct advantages. Health professionals can reach a wider audience, and can use the visits to identify women who might be candidates for fistula treatment. Because community members will be at ease in their own villages, health workers are also more likely to hear questions and concerns.
- ▶ Training fistula patients as advocates empowers these women, helps to reintegrate them, and provides an important example to other women of how life after treatment can be different. Linking advocates to facilities with cellular phones may prove to be an effective way to improve access to treatment.

Source: UNFPA Needs Assessment of Obstetric Fistula in Kenya, Campaign to End Fistula, 2004.

Malawi: Empowering communities to strengthen maternal health care

Background

Malawi's maternal mortality ratio is one of the highest in sub-Saharan Africa, at 1,100 deaths per 100,000 live births (World Health Statistics 2009, WHO, p. 16). Some health indicators have shown improvement in recent years, such as contraceptive prevalence, which reached 38% for modern methods in 2006 (Millennium Development Goals Indicators 2008, United Nations Statistics Division). Skilled attendance at births is significantly higher than in neighbouring countries; however, women delivering for the first time are expected to do so at home. Despite the fact that 57% of women seek four or more antenatal care visits (World Health Statistics 2009, WHO, p. 76), maternal mortality remains high and is even rising, perhaps due to HIV prevalence. Obstetric fistula is associated with a number of cultural practices, including early marriage and early sexual initiation, and is thought to be a large and growing problem. The issue has not yet been addressed at the policy level.

Programme Description

In Malawi, UNFPA, the Ministry of Health and the Ministry of Gender have worked with communities through the Family and Reproductive Health (FARH) Project to increase utilisation and quality of reproductive health services. The project receives financing from the Canadian International Development Agency (CIDA) through the Canadian Public Health Association (CPHA).

Implemented in 232 villages in the rural Dedza, Mchinji, and Nkhata Bay districts, the FARH Project reaches a population of 900,000. Access to reproductive health services in these districts is limited—some communities are as far as 40 kilometres from a health facility. Furthermore, many providers cannot provide basic emergency obstetric services even if women are able to secure transport to health centres.

The FARH Project has implemented several complementary initiatives designed to empower communities and bolster involvement in reproductive health and maternal health:

- **Training for community members:** Community leaders, traditional authorities, and village heads received training in maternal health, pregnancy-related complications, and the importance of delivering at a health facility. All of the groups trained as part of the FARH project received information about the effects of gender inequality on the health of women and girls.
- **Establishing a framework:** Trainees enforced community maternal health bylaws, which stated that untrained traditional birth attendants should not conduct deliveries, and that first pregnancies should be delivered at health facilities. Penalties were established for those who break the bylaws, with severe penalties for maternal death.
- **Monitoring maternal health:** Maternal health task forces were established by trainees to follow pregnancy outcomes and record maternal deaths in the community.
- **Advocating for improved reproductive health:** Village Health Committees were formed by trainees to spread messages encouraging women to deliver at health facilities. The Committees presented this information using innovative means such as dramas, poems, and songs. Youth educators were also trained to provide counselling and to distribute condoms to peers. Family planning services were provided at the community level by trained local distributors.
- **Strengthening relationships with health care facilities:** Efforts have also been made to strengthen the referral system between communities and health care facilities. Bicycle ambulances improved transport from remote villages, and radio communication equipment at health centres facilitated referrals. Quarterly meetings between community members and health care providers were held to strengthen partnerships, and study tours between districts facilitated mutual learning.

Traditional leaders have been central to the FARH Project, offering guidance on how to approach the community and helping to open lines of communication. The project's strength lies in strong collaboration between community representatives and health service providers.

Evaluations have associated the FARH project with several positive outcomes:

- A reduction in maternal mortality and obstetric complications in all project areas. When the project began in 2001, there was an average of 12 maternal deaths in each health facility. During 2005, only one facility recorded a maternal death.
- An increase in service utilisation for antenatal care, family planning, and delivery.
- An increase in condom use among young people, which is associated with condom distribution by peer educators.
- An improved level of hygiene and sanitation within health care facilities as well as in communities.
- A greater overall level of trust between health care providers and community members.

Lessons Learned

- ▶ Community involvement in reproductive health programmes can help to reduce maternal mortality at the local level. Providing information and support to communities lays the foundation for such progress.
- ▶ Improving access to reproductive health services and overcoming potentially dangerous traditional practices are steps that depend on community involvement. Community members are well positioned to identify the major opportunities for and obstacles to addressing these local health issues.
- ▶ Collaboration with communities requires building trust between community members and health care providers. In areas where the relationship between these groups is weak and utilisation of skilled care is low, building trust calls for a significant time commitment that must be considered during project planning.

Source: The role of communities in increasing utilisation of reproductive health and maternal health services, UNFPA Campaign to End Fistula.

WORKING WITH MEDIA

Nigeria: Preventing fistula through serial dramas

Background

Maternal mortality in Nigeria is reported to be 1,100 deaths per 100,000 live births (World Health Statistics 2009, WHO, p. 16). The birth rate has dropped slightly, and knowledge of contraceptive methods has increased. In practice, however, only 12.6% of women use a contraceptive method (World Health Statistics 2009, WHO, p. 18), and 47% of women seek the recommended four antenatal care visits (World Health Statistics 2009, WHO, p.76). However, adolescent mothers and those who live in rural areas are particularly unlikely to receive care. There has been a promising increase in the percentage of births attended by skilled health personnel, from 30.8% in 1990 to 35.2% in 2003 (Millennium Development Goals Indicators, United Nations Statistics Division). Although data about the prevalence of fistula is difficult to obtain, it is clear that fistula is a large and growing problem in both the north and south of Nigeria. It is estimated that, nationwide, between 100,000 and 1,000,000 women live with the condition (Obstetric Fistula Needs Assessment Report: Findings from Nine African Countries, UNFPA/EngenderHealth, 2003, p. 57). To address fistula, the government has created a national task force and supported initiatives to train health care workers and develop advocacy programmes.

Programme Description

In June 2006, Population Media Center (PMC) began broadcasting a radio serial drama in Nigeria aimed at preventing obstetric fistula and encouraging women living with fistula to seek treatment.

PMC is a U.S.-based non-profit, non-governmental organisation specialising in the promotion of reproductive health issues through research-based entertainment-education media communication. Through current programmes in 12 countries



Photo credit: Micol Zarb/UNFPA

around the world, PMC collaborates with broadcasters, government ministries, UN agencies, and other non-governmental organisations to design and implement local media strategies that promoted healthy behaviours. Programming is designed and implemented with careful consideration of local values and attitudes about reproductive health.

The 70-episode radio serial created with PMC/Nigeria, *Gugar Goge* (“*Tell me Straight*” in Hausa) was written, produced, and acted by Nigerian radio and drama professionals. The programme targeted both men and women of reproductive age. Broadcasting to reach these millions of Nigerians was made possible with support from the Rotarian Action Group on Population and Development; the David and Lucile Packard Foundation; the Aventis Foundation; the Conservation, Food, and Health Foundation; and the German government.

Gugar Goge presented reproductive health information, including information about obstetric fistula, through the drama’s characters and plot development. Over the course of the series, actors modeled behaviour aimed at preventing obstetric fistula, such as delayed marriage and childbearing. Storylines educated listeners about the causes of fistula, and demonstrated that women living with the condition could get effective treatment and improve their quality of life.

Perhaps most importantly, the serial nature of Gugar Goge allowed listeners to develop emotional ties to characters as events unfolded. The programme showed characters' thoughts and behaviours evolve at a gradual, believable pace. This approach differs significantly from delivery of purely cognitive information usually provided in documentaries or "spots." The serial helped listeners to draw information about prevention, causes, and treatment of fistula themselves from a locally relevant, accessible, and engaging medium.

In August 2006, after two and a half months of broadcasting, PMC partnered with the Planned Parenthood Federation of Nigeria (PPFN) to do a preliminary evaluation of Gugar Goge's impact. The evaluation assessed demand for reproductive health services and vesicovaginal fistula (VVF) treatment among target audience members.

The monitoring report was based on 606 client exit interviews in three clinics, one hospital, and one basic health post in Kaduna and Kano states. Highlights of the findings include the following:

- Forty four percent of all clients interviewed at the facilities had listened to Gugar Goge.
- Thirty percent of the reproductive health clients and 47% of fistula repair clients indicated that the programme was their primary motivation for seeking treatment services.
- Most respondents indicated that they were motivated to seek health care services primarily by friends or neighbours, followed by radio programmes. Spouses and health workers were also cited as major influences in the decision to seek care.

Lessons Learned

- ▶ Media programming allows for innovative presentation of information about reproductive health and can significantly affect the target population's behaviour. However, assessment data also point to the importance of families and communities in influencing women's choices.
- ▶ By forming alliances with local health providers and educational institutions, radio can serve as an effective medium to provide information about obstetric fistula prevention, causes, and treatment to a wide audience.
- ▶ Sound monitoring practices can be implemented to evaluate radio's effect on the demand for reproductive health services.

Source: UNFPA Nigeria, Campaign to End Fistula.

Senegal: Working with journalists to advocate for improved maternal health

Background

The maternal mortality ratio in Senegal is 980 deaths for every 100,000 live births (World Health Statistics 2009, WHO, p.16), and 52% of births are assisted by a skilled attendant (World Health Statistics 2009, WHO, p.17). Obstetric fistula is not well understood in Senegal, and the extent of the problem is unknown. However, given the weaknesses in the availability of emergency obstetric care and the low Caesarean rate—3% in 2005— (World Health Statistics 2009, WHO, p.76), it can be expected that prevalence is high, especially in isolated areas of outlying regions.

Programme Description

With UNFPA's support, a network of journalists on population and development was established in 1989 with the goal of improving the public's knowledge on issues related to population, reproductive health, and gender. Following the International Conference on Population and Development (ICPD) in 1994, the journalists' network has supported a major advocacy, information, and communications campaign which includes the following components:

- The development of audio-visual programmes, films, and documentaries on obstetric fistula to be broadcast on television, radio, and other outlets;
- Press articles and opinion pieces in large circulation newspapers.

UNFPA carried out a refresher workshop on reproductive health and obstetric fistula for members of the print, audio, and audiovisual media to strengthen their knowledge of reproductive health and obstetric fistula. Field missions were also held to visit women with obstetric fistula, as well as women who have been treated, for use in articles, broadcasts, and documentary films.

Key outcomes of the communications campaign included:

- Over a dozen audio-visual programmes, press articles, and documentaries on obstetric fistula have appeared on public and private, thematic and community radio stations, as well as in articles in national newspapers.
- An advocacy film on caring for women with obstetric fistula was produced with the involvement of the first lady.
- A television broadcast was produced with field reports of women affected by fistula.

One notable result of the campaign was the decision of Senegalese President Abdoulaye Wade to provide free fistula treatment services and support efforts to ban child marriages after having viewed an advocacy film developed by a television correspondent.

Lessons Learned

- ▶ Media can serve as a critical channel for communicating information to the general public, and to influence decision makers to make key policy decisions.
- ▶ The involvement of media and journalists is essential in raising awareness of obstetric fistula and can provide an entry point for discussion and debate on a range of sensitive issues, such as family planning, adolescent sexual health, early marriage, and other harmful cultural practices.

Source: *Evaluation des Stratégies de Réduction des Barrières Economiques, Socioculturelles, Sanitaires et Institutionnelles a l'Accès aux Soins Obstétricaux et Néonataux au Sénégal*. Prepared by UNFPA, MSPM, IMMPACT, and CEFORP.

Uganda: Digital storytelling for fistula

Background

Early marriage and childbearing is common in Uganda, generally due to social and religious customs. Civil war between the government and Lord's Resistance Army (LRA) rebels in northern and northeastern Uganda has also contributed to the phenomenon, as thousands of girls have been abducted over the course of the conflict, and many are forced to marry rebel commanders by early adolescence.

Nationally, 42% of births are supervised by skilled attendants (World Health Statistics 2009, WHO, p.17). The total fertility rate remains high, at seven children per woman (World Health Statistics 2009, WHO, p.139), and use of modern contraceptives stands at 18% ([Millennium Development Goals Indicators, United Nations Statistics Division](#)). Although the vast majority--94%--of pregnant women receive some level of antenatal care (World Health Statistics 2009, WHO, p.78), only 47% make the minimum four visits recommended by the Ministry of Health (World Health Statistics 2009, WHO p.78). Reliable data on the number of obstetric fistula cases are difficult to gather, but it is clear that demand for fistula repair services far outstrips the health sector's current supply of personnel and facilities. The need to raise awareness about risks associated with pregnancy and to increase relevant training for healthcare workers is increasingly recognised at the government level.

Programme Description

Despite the devastating impact of obstetric fistula on the lives of thousands of women and girls each year, the international health community has tended largely to neglect the problem. The ACQUIRE programme has responded to this gap by working with national governments and other local partners to strengthen and/or implement comprehensive fistula initiatives. The ACQUIRE approach to fistula is holistic; the programme works with stakeholders at the facility and community levels to collaborate on the development of strategies that can prevent fistula from occurring, increase women's access to clinical treatment and counselling, and

provide rehabilitation services to help affected women reintegrate into their communities.

Lessons from successful public health campaigns have shown that visual media can play a key role in educating communities and policy makers about a range of important health and wellness issues. The highly sensitive nature of obstetric fistula suggests the need to develop alternatives to traditional methods, which can be inappropriately intrusive and leave people with a sense of having been exploited for the sake of capturing their lives on video. Digital storytelling, with its unique ability to open people up to sharing intimate, relevant, and accessible details about their experiences, is an ideal method for creating compelling visual tools and offering a form of group counselling, as women tell and bear witness to stories in a safe, supportive environment. Rather than feeling exploited, digital storytelling participants come away with a clear sense of individual achievement, group solidarity, and a final product of which they can be proud.

In 2007, ACQUIRE partnered with the Center for Digital Storytelling (CDS) to carry out a four-day digital storytelling workshop that would gather stories of Ugandan fistula patients and service providers; develop a series of video interviews with fistula providers; and produce a DVD featuring these various media pieces.

The Digital Storytelling Workshop

After weeks of dedicated outreach, a group of 11 participants assembled in the town of Masaka, Uganda for an orientation session of the digital storytelling process. They viewed digital stories created in CDS workshops by women and men from Swaziland, Zambia, and South Africa and talked about the purpose of the fistula workshop. Next, they were given disposable cameras, taught how to use them, and asked to take photos of their homes and villages. One month later, they traveled again to Masaka for the four-day workshop. Over the course of the session, the women shared their fistula stories with one another in a carefully-structured group Story Circle process, recorded voiceover narration, and drew pictures to illustrate their lives. The photos they had taken in their villages were developed, scanned, and combined by CDS facilitators with images and video shot on location to create the final

stories. While editing was underway, the women visited the local hospital where they had been treated and offered advice and support to women awaiting fistula treatment. The workshop ended with a celebratory screening of the digital stories.

Themes raised in these powerful media pieces address topics such as:

- How women develop fistula in the first place (delays in accessing quality prenatal care, traditions of home birth, difficulty raising funds for transport, living long distances away from health facilities);
- How they are received by their families and communities once they have the condition (experiences of being shunned, experiences of being supported, myths about what has caused fistula and what can be done about it);
- How they seek and receive fistula treatment (sources of information about services; experiences of overcoming financial, geographic, and cultural barriers; quality of care in medical facilities); and
- What their lives are like in the aftermath (elation over successful surgeries, resignation about ongoing fistula symptoms, acceptance and family/community reintegration, desire to spread the word about prevention options and treatment services).

Research has demonstrated the significant therapeutic benefits of storytelling, which enables people to give voice to previously silenced experiences. The ACQUIRE digital storytelling workshop was no exception. On the last day, the staff facilitated a debriefing session with the women to discuss their feelings about the workshop, and they were unanimous in reporting their appreciation.

In addition to the clear, transformative benefits of the process, the project resulted in the creation of a set of visual media tools that are being integrated into ACQUIRE's ongoing fistula provider training activities. The programme is also exploring ways to share the stories in local settings, in order to educate rural women and support them in seeking fistula care.

Lessons Learned

- ▶ Adequate resources and planning for a project of this nature are essential. The time, thoughtfulness, and dedication of everyone involved with creating outreach materials; recruiting participants; organizing logistics; and facilitating a meaningful workshop were crucial to the success of this ACQUIRE/CDS partnership.
- ▶ Participation must be defined realistically and on local terms. The work of digital storytelling emphasises process as much as end media product. Strategies can be developed to accommodate multiple languages and literacy levels and ensure that participants are engaged but not tyrannised by technology.

Digital storytelling processes can be effective for peer health education. An unexpected outcome of the project was the degree of learning it offered to the participants, specifically about why fistula occurs and how it can be prevented. Future efforts would benefit from making this component more explicit, and to continue developing the skills of workshop participants as community health outreach workers.

Source: "Learn From My Story": Digital Storytelling for Fistula. Prepared by EngenderHealth.

PREVENTION

Burkina Faso: Redefining roles for Traditional Birth Attendants

Background

Maternal mortality in Burkina Faso is among the highest globally, with the maternal mortality ratio at 700 deaths per 100,000 live births (World Health Statistics 2009, WHO p.16). The Demographic and Health Surveys from 1998 and 1999 show that 39% of pregnant women receive no antenatal care and births are attended primarily by traditional birth attendants (42%), health personnel (31%), and family members (20%) (Living Testimony, UNFPA/FCI, 2007, p.18). Only 18% of women receive antenatal care of at least four visits (World Health Statistics 2009, WHO, p.72).

Programme Description

In 2004, with collaboration from UNFPA and financing from the European Union, Burkina Faso developed a National Strategy for the Eradication of Fistula that addresses prevention, treatment, and rehabilitation. The strategy is part of a broader effort to reduce maternal mortality, which has been implemented by the Office of Family Health.

One of the key components of the plan involves re-framing the role of traditional birth attendants (TBAs) as a means to improve maternal health. At the national level, a study on the role and impact of TBAs was conducted, and a national workshop analysing the position of TBAs in the context of maternal mortality was held. Health professionals from all levels, administrators, financial partners, and TBAs themselves attended.

The workshop highlighted the limits of a maternal health strategy based on the idea that some pregnancies can be identified as “high-risk”—evidence increasingly points to the fact that all pregnancies involve risk, and that most obstetric complications are neither foreseeable nor avoidable. These



Photo credit: SMB Akash/Panos Pictures

complications can, however, be treated. For that reason, a reduction in maternal mortality calls for efforts to promote skilled care at delivery.

The workshop went on to analyse the roles and limits of TBAs, defining specific activities that they should and should not perform based on their skill levels, and discussing when referrals to health care facilities need to be made. The next step was to continue the process of redefining the TBA's position at the community level. The Zabré district, in the Central East Health Region, has been the site of a pilot implementation of this process of reframing.

In Zabré, several measures were taken to facilitate the process. A new strategy for defining the role of TBAs reoriented their activities and reinforced the importance of collaboration with healthcare facilities. Bi-annual meetings between health professionals and TBAs were established, providing opportunities to discuss the importance of traditional birthing practices in communities, but also to address the negative health outcomes that can result from those practices. The first meeting was attended by 187 TBAs from all over the district. Through the dialogue, participants developed a strategy to create financial incentives for TBAs to make referrals to health facilities.

Workshops were also set up in Zabré to educate TBAs on safe delivery techniques, risk factors, and signs of danger in pregnant women and newborns. Health workers monitored delivery outcomes in communities, promoting incorporation of these techniques into practice. TBAs were also incorporated into the monitoring system: they took an active role in tracking pregnancies in their communities and encouraging women to seek antenatal care at a facility. To facilitate this process and gauge effectiveness, each TBA was given a notebook to keep a formal record of all women consulted and their outcomes.

These initiatives served to reinforce social dialogue between health workers and communities, increase utilisation of maternal health services, and reduce the number of delayed referrals. The Zabré team demonstrated that even in a remote district where access to care is limited and cultural barriers are high, it is possible to promote maternal health by working directly with community members and promoting open dialogue with health professionals. Currently, there is a plan to document the experiences in Zabré and disseminate the report to other districts in the hopes of scaling up the programme.

Lessons Learned

- ▶ Efforts to incorporate TBAs as part of a maternal mortality reduction strategy can greatly improve access to rural, remote populations that lack trust in the health care system.
- ▶ While TBAs are respected and important members of their communities, the dangers of delivery without skilled care must be addressed. By defining the role of TBAs clearly, a programme can both empower them as key actors in the healthcare system and also limit their activities to reduce risk.
- ▶ If TBAs are recognised and incorporated into a maternal mortality reduction strategy, they can contribute tremendously to efforts to strengthen education about maternal health in communities, as well as encourage women to seek skilled care at a facility. Programmes should aim to leverage the influence of TBAs and seek their guidance on how to best reach community members.
- ▶ Timely referrals in cases of obstructed or prolonged labour are key to preventing obstetric fistula. TBAs are well positioned to make those referrals, and to convince community members to seek care when necessary.

Source: UNFPA Burkina Faso, Campaign to End Fistula.

Mauritania: Using micro-health insurance to improve access to maternal health services

Background

The maternal mortality ratio in Mauritania is high, at 820 deaths per 100,000 live births (World Health Statistics 2009, WHO, p.16). Skilled birth attendance is estimated at 61% (World Health Statistics 2009, WHO, p.17) and antenatal coverage that meets WHO recommendations is at 16% (World Health Statistics 2009, WHO p.72). The proportion of women with obstetric complications who receive EmOC is low, at 35% (Making safe motherhood a reality in West Africa, UNFPA/AMDD, 2003, p.8). The proportion of births delivered by Caesarean section is 3% (World Health Statistics, WHO, 2009 p.76), well below the World Health Organization-recommended minimum of 5%. Health providers are scarce and inequitably distributed between rural and urban regions as well as between high and low income groups.

Programme Description

The cost of health services is a significant barrier to access for low-income people in Mauritania. Various cost recovery systems are used in the public health system, but are not always uniformly or equitably applied. The cost of a normal delivery in rural health clinics ranges from US\$5 to US\$10, in health centres in urban and semi-urban areas from US\$12 to US\$25, and at hospitals in the larger urban areas it may be as high as US\$50. Caesarean sections in public hospitals cost between \$150 and \$200. Costs of care in private facilities are significantly higher. With nearly 26% of the population living on less than \$1 a day, maternal health costs are unaffordable for a significant portion of the population (WHO Statistical Information System, 2000 data).

Beginning in 2002, with financial support from the French Ministry for Foreign Affairs, the Ministry of Health instituted the Obstetric Risk Insurance (ORI) plan to allow obstetric risk sharing across communities on a voluntary basis. A fixed premium entitled women to an obstetric package, including emergency obstetric care, hospital care, and postnatal care.

The poorest were permitted to enroll at no charge.

The project began with preliminary briefings with the Ministry of Health and its partners, including donors, civil society groups, and NGOs. *A technical committee was established to coordinate the implementation of the project, including:*

- **Gathering preliminary data:** The committee conducted a baseline survey on community experiences with health insurance and health care.
- **Building a pool of advocates:** Initial training focused on creating a pool of advocates to educate civil society groups on micro-health insurance.
- **Sensitising community members and health care providers:** Local organisations were responsible for sensitising communities on micro-health insurance, the role of the community in improving access to health care, and the quality of care on micro-health insurance and health care issues. Health care providers were sensitised on the importance of patients' rights within a quality of care framework as well as gender issues.
- **Implementing insurance programmes at the local level:** Local NGOs were contracted and trained to implement the insurance programmes at the community level. Communities raised funds generally through individual contributions of less than US\$1 per month for six months.
- **Monitoring and evaluation:** Pilot versions of the insurance programme began in three communities before extension to five other zones. The committee designed specific metrics to measure outcomes during these early phases.

In all, micro-health insurance programmes were established in three rural and five urban communities throughout the country. Members of the programmes were covered at 50% for curative consultations. They were guaranteed 100% coverage for antenatal and postnatal care, skilled delivery, and emergency transport.

The Direction of Social Affairs and Access to Care is the government agency responsible for monitoring the project.

Evaluations indicate that implementation of the insurance programmes improved financial access to reproductive health services for poor people in the catchment areas.

By the end of the project in 2003, approximately 9,000 people in five urban communities (primarily Nouakchott) and 2,000 people in three rural areas were reached by micro- health insurance programmes. Coverage rates greatly improved access to health services for the poorest, who were required to pay less than US\$1 a month for their insurance plans. In Nouakchott, 95% of pregnant women in the project's catchment area chose to enrol in the insurance programme (representing 48% of the city's deliveries). Utilisation rates increased over the three-year period of project implementation.

In evaluations of the first three pilot programmes, slight improvements in utilisation of maternal health services were observed: antenatal and postnatal coverage increased 3- 7% and the skilled attendance rate increased 2-3%. The programme generated significant revenues—more than twice as much as user fees. Notable qualitative outcomes include improved community awareness regarding the role of insurance, and increased commitment by the government to improve reproductive health. This shift is evidenced by the fact that between 2004 and 2006, the Ministry of Health supported the scale-up of micro-health insurance programmes to three more districts.

Lessons Learned

- ▶ Establishing micro-health insurance programmes in rural and urban settings can increase access to reproductive health services by reducing financial barriers.
- ▶ Health insurance plans can generate substantial revenues, and contribute to improved organisation and delivery of reproductive health services.
- ▶ Health plan administrators can facilitate dialogue between health service providers and their clients and increase demand for services by making an effort to sensitise stakeholders.
- ▶ Sensitising a population largely unfamiliar with health insurance is a challenge. Working with locally based NGOs to deliver information about health care plans is one of the ways to bridge gaps and ensure community buy-in.

Source: "Mauritania: Micro health insurance schemes contributed to improved financial accessibility of maternal health services." Submitted by Thierno Coulibaly, UNFPA National Programme Officer, Mauritania.

Ghana: Implementing quality client- and community-friendly services

Background

A predominantly agricultural country rich in natural resources, Ghana has a per capita output roughly twice that of its neighbours in West Africa. Cultural norms in Ghana include a preference for large families, even when poverty makes it difficult to educate or feed children. Ghana has one of the highest maternal mortality rates in the West African region, with 560 deaths per 100,000 live births (World Health Statistics 2009, WHO, p.16). According to World Health Organization and United Nations Children's Fund (UNICEF) estimates, a Ghanaian woman has a 1 in 45 chance of dying from a pregnancy-related cause during her lifetime (World Population Data Sheet 2008, Population Reference Bureau, p.7). According to several hospital-based studies, it is estimated that complications from unsafe abortion cause 22-30% of maternal deaths.

Programme description

In the Bongo district of the Upper East Region of Ghana, where the rates of skilled care are among the poorest in the country, the health district implemented a programme to provide high quality, client-focused, and community-friendly maternal health services. Following a needs assessment, a midwife posted to the sub-district health centre worked with the district health administration to implement community-friendly interventions to increase skilled care during birth.

The needs assessment revealed the concerns of community members in the quality of care available in the health facility, including the periodic absence of the midwife, poor staff attitudes, and the absence of two very important traditional practices: no millet water (*zomkoom*) to drink after delivery and no hot water for bathing shortly after birth. It also indicated that pregnant women often had limited say in determining the place of delivery and that delivering at home was viewed by the community as a sign of bravery. Other findings included long distances to the health facility and the prohibitive cost of services.

Beginning in 2003, the district implemented a number of measures to increase the number of women delivering at the health facility. A highly motivated midwife was posted at the health centre to ensure round-the-clock emergency obstetric care. A vehicle and a regular supply of fuel were made available to transport women to the health centre or to the district hospital for referral. Where communities were severely isolated due to poor roads, the midwife traveled to these villages by motorcycle to deliver at home or transport women back to the health centre if necessary. For women delivering at the health centre, the midwife provided hot water for bathing as well as *zomkoom* for drinking after delivery. Monthly campaigns were conducted in the community to improve attitudes regarding the health facility.

In order to improve staff morale and attitudes towards clients, the midwife organised regular meetings with health staff to underscore the importance of client-friendliness as part of high-quality care and to encourage them to change the poor perceptions in the community regarding the health centre. Staff members used these events as an opportunity to discuss work-related problems and develop solutions. In addition, the staff established a suggestion box for addressing concerns during the monthly social event.

As a result of the midwife's efforts, the rate of skilled delivery in the Zorkor sub-district, Bongo, increased from 14% in 2003 to 66% in 2006.

Lessons learned

- ▶ Skilled and motivated health professionals can contribute to improved quality of care and increased institutional delivery. In Zorkor, the midwife integrated non-harmful traditional delivery practices into the health centre, motivated health centre staff to adopt a client-friendly approach to service provision, and established regular dialogue with community members concerning the functioning of the health centre.
- ▶ Community mobilisation activities should be maintained in order to ensure the acceptability and quality of health services.
- ▶ Efforts should be made to document the Zorkor experience and disseminate best practices among other regions along with recommendations for possible replication.

Source: Dr. Sebastian Eliason, UNFPA National Programme Officer, Ghana.

TREATMENT

Ethiopia: Providing comprehensive care for fistula patients

Background

Over 83% of Ethiopia's population lives in rural areas (World Health Statistics 2009, WHO, p.134). Approximately 12% of women receive the recommended four antenatal care visits (World Health Statistics 2009, WHO, p.74), and only 6% of deliveries are attended by health personnel (World Health Statistics 2009, WHO, p.17). The birth rate is high: most women average 5.4 children over their lifetimes (Ethiopia Demographic and Health Survey 2005, Central Statistical Agency, p. 47). The maternal mortality is one of the highest globally at 720 deaths per 100,000 live births (World Health Statistics 2009, WHO, p.16), and there are an estimated 100,000 women living with fistula. Another 9,000 women develop fistula each year ([Fistula Fast Facts and Recently Asked Questions, The Fistula Foundation](#)).

Programme Description

The Addis Ababa Fistula Hospital was established in 1974 by Drs. Reginald and Catherine Hamlin, pioneers in surgical fistula treatment, who recognised a tremendous need among Ethiopian women. The hospital provides free treatment for its patients, most of whom live in extreme poverty and social isolation as a result of having fistula.

The hospital's goals are to:

- Provide physical, social, and spiritual assistance to patients with obstetric fistula disabilities.
- Build capacity among health care providers to handle fistula cases.

- Increase international awareness of the plight of women in the developing world suffering from childbirth injuries.
- Improve the capacity of the hospital to meet the needs of patients.

Many patients at the Addis Ababa Fistula Hospital are young women who have recently developed fistula. The majority of these women spend three weeks at the facility. The hospital also serves women who have suffered severe physical damage, are unable to walk, and require tremendous moral and psychological support. A physiotherapy department helps to address the needs of these patients, but the women also offer each other significant support during their stays in group houses on the property.

The hospital has comprehensive facilities including an outpatient department, preoperative accommodation, inpatient facilities, an operating theatre, facilities for autoclaving and sterilising, pharmacy, physiotherapy unit, X-ray department, kitchen, laundry, doctor's office, nurse's station, canteen, changing rooms, and an administration department.

Addis Ababa Fistula Hospital goes beyond offering standard fistula surgery to provide comprehensive support to women, including counselling and rehabilitation. *The hospital has taken several initiatives that demonstrate its commitment to addressing the range of clients' needs, including the following:*

- **Training in new surgical techniques:** Staff members were trained to perform an operation to address stress incontinence, a condition that sometimes affects women even once they have had their fistula repaired.
- **Support for mid-level health workers:** With support from the Australian High Commission in Nairobi, the hospital has also initiated a "Training of Trainers" programme for mid-level health professionals. The programme is

designed to strengthen nurses' knowledge of fistula patient care in every region of Ethiopia.

- **Provision of long-term care:** The facility is being expanded to include a village where patients who require continued care can live permanently. For many women who suffer debilitating physical consequences from fistula and who are unable to return to their villages, housing at Addis Ababa Fistula Hospital is an important option. The hospital recognises that not all patients will be able to reintegrate themselves into the communities they came from, and provides them with a safe haven and continued rehabilitation.
- **Reintegration and rehabilitation through productive activities:** In collaboration with the Rotary Club, the hospital is developing its own farm. The farm will be an integral part of the rehabilitation process, encouraging women to engage in productive activities and thereby regain their sense of self-worth. Women can participate in simple chores to help them integrate back into the working population.
- **Attention to cultural preferences and psychological well-being:** Most women who visit the hospital are from rural communities. Small, one-story buildings are most familiar and comfortable for them, so the facility has been designed accordingly. The clinic, treatment facilities, and dormitories are surrounded by trees and grass, which also helps the women to feel at home. The building plan and outdoor areas also function to bolster women's morale: the lawns absorb urine without leaving a visible puddle, and small, separate buildings lessen the smell of urine that typically follows women living with fistula.
- **Investment in personnel:** Addis Ababa Fistula Hospital recognises the need to employ a diverse group of professionals at the facility in order to meet its institutional goals. Obstetric gynaecologists, surgeons with special training in obstetric fistula repair, nurses, nursing aides, technicians and a large support staff allow the hospital to offer repairs, rehabilitation, counselling, and housing for patients all under one roof.

- **Advocacy through involvement:** Addis Ababa Fistula Hospital's support network is made up of a diverse group of individuals and organisations in Ethiopia as well as several in the United Kingdom, Australia, the United States, Canada, Sweden, and the Netherlands. By building these relationships, the hospital is able to fundraise internationally and raise awareness about obstetric fistula. Ties are cultivated through special initiatives, a steady flow of visiting professionals from abroad, and institutional partnerships.

Lessons Learned

- ▶ Ideally, fistula treatment is provided in a setting that addresses the multi-dimensional needs of patients. A fistula hospital with surgical, nursing, laboratory, counselling, and housing services is well positioned to meet those needs. In some settings, this may be a unit in an existing hospital rather than a freestanding centre.
- ▶ Offering fistula surgery alone will not be sufficient to rehabilitate and reintegrate many women living with the condition. Psychological consequences, stigma, and cultural norms may serve to keep women isolated even once their physical condition has improved. Care for some patients may require a longer-term investment.
- ▶ Partnerships with medical institutions abroad, multilateral organisations, charity organisations, land developers, architects, and physiotherapists are an integral part of building a model fistula hospital. Such alliances are important to increase awareness of the condition, particularly in developed countries that lack direct experience with fistula.

Sudan: Coordinating national surgery fistula campaigns

Background

Early marriage and early pregnancy are common across all of Sudan; more than 40% of girls are married by the age of 18 (Living Testimony, UNFPA/FCI, 2007, p.24). Use of any contraceptive method is low across the country—around 8% — and even less for modern methods (World Health Statistics 2009, WHO, p.18). There are also wide variations in contraceptive use throughout the country, with some states having rates of less than 1% (Living Testimony, UNFPA/FCI, 2007, p.24). Obstructed labour is considered a major health problem leading to maternal morbidity and mortality in Sudan, especially in regions of civil conflict.

Civil conflict has created major barriers to accessing sexual and reproductive health in the Darfur region. In West Darfur, 85% of deliveries occur at home with traditional birth attendants, midwives, or family members (Living Testimony, UNFPA/FCI, 2007, p.24). Obstructed labour is prevalent due to the lack of available, accessible, and affordable emergency obstetric services. The extent of fistula is unknown but is suspected to be high considering the many risk factors present.

Programme Description

Beginning in 2001, and later expanding in 2004, annual fistula campaigns have been carried out in the Darfur region to provide free surgical treatment to women living with fistula. The campaigns are conducted at one of Sudan's three fistula centres (El-Fasher, El-Genaina, and Zalingi). The treatment campaigns are combined with advocacy activities, training of fistula surgery teams, and community education and awareness-raising of obstetric fistula, as well as reintegration strategies. The campaigns are implemented in coordination with a range of partners, including NGOs, to identify and register women with fistula; health care providers, to carry out awareness-raising activities; and international partners, to provide in-kind support, such as food, health supplies, and other materials.



During May 2007, an obstetric fistula campaign was held at the Zalingi fistula centre. Staff trained in fistula surgery arrived at Zalingi from other facilities to participate in the campaign. *Its aims were to:*

- Raise awareness about fistula and its links to maternal health;
- Provide surgical treatment for at least 40 fistula cases;
- Train fistula surgery teams and build capacity of the Zalingi surgical team.

In total, 47 patients were treated for fistula during the campaign, with women arriving from different regions of Darfur. Advocacy and information-sharing activities to raise awareness of fistula and the availability of free surgical treatment began several months prior to the start of the campaign.

A subsequent fistula surgery campaign was held between February–March 2008 at the El-Fasher Maternity Hospital in North Darfur. A total of 40 women were surgically treated for fistula during the campaign. Mass media community mobilisation strategies carried out in advance of the campaign resulted in a high turn-out, including women with complex forms of fistula and of long duration. Following surgery,

women received psychosocial support and counselling on reintegration strategies. Women were also provided with information and training on income-generating activities and counselling on family planning and prevention of HIV. The centre has also trained women following surgery as village midwives, and they have been posted to remote areas to serve as community advocates for fistula prevention and to identify and refer women needing treatment.

Lessons Learned

- ▶ Effective coordination between a range of partners was critical for the successful implementation of the campaign; these included health providers, NGOs, international agencies, and female fistula advocates working at the community level.
- ▶ Community mobilisation activities carried out in advance of the surgery campaigns were effective in raising awareness about fistula, and resulted in a high turn-out for the surgery campaigns.
- ▶ Social and physical rehabilitation should be integrated following surgery, and continue after discharge to facilitate women's self-sufficiency and reintegration in the family and community.
- ▶ Training fistula patients as midwives may be an important element of rehabilitation and social reintegration.

Source: Campaign to end fistula, by Yusuf Lawal, RH Coordinator/ Team Leader, UNFPA Field Unit- West Darfur; Technical Report, Fistula Campaign, El Fasher, North Darfur, Sudan. Report on Obstetric Fistulae Campaign, Zalingi-West Darfur, May 2007.

Tanzania: Treating fistula through a tiered system of care

Background

Maternal mortality and morbidity are significant problems in Tanzania: the maternal mortality ratio is estimated at 950 deaths per 100,000 live births (World Health Statistics 2009, WHO, p.16) and only 46% of women deliver with a skilled attendant (World Health Statistics 2009, WHO, p.17). While antenatal care coverage meeting WHO recommendations is high at 62% (World Health Statistics 2009, WHO, p.78), care after delivery is virtually non-existent. Tanzanian women's literacy levels are measurably lower than men's (66% and 79% respectively) (UNESCO Institute for Statistics 2007). Statistics indicate that women constitute 51% of the economically-active labour force in Tanzania (Tanzania Strategic Gender Assessment, World Bank 2004, p.7), with women performing the bulk of agricultural work in the country (UNSD Gender Info 2007).

Programme Description

In 2005, a National Fistula Programme was established with the aim of strengthening the prevention and management of fistula and promoting women's right to health. The Programme trains doctors and nurses in fistula care; facilitates referral of women for fistula treatment; educates communities about fistula and where services are available; and conducts research and advocacy on fistula prevention and treatment and maternal health. The National Programme is implemented by the Women's Dignity Project, the Ministry of Health and Social Welfare, and African Medical and Research Foundation/Tanzania.

In an effort to expand fistula care as widely as possible through an integrated approach, treatment services are provided at general, rather than dedicated, fistula facilities. Care is provided through a three-tiered system, in which different types of services are provided at differing levels of the health system:

Level 3 (few specialist hospitals) provide:

- Complicated and simple repairs
- Repairs available on a regular basis
- Repairs conducted primarily by trained Tanzanian surgeons

Level 2 (general hospitals) provide:

- Simple repairs
- Repairs available on regular basis at some hospitals, and according to predictable schedule of visiting surgeons at other hospitals
- Repairs conducted by both trained Tanzanian surgeons, as well as Tanzanian and expatriate visiting surgeons

Level 1 (primary health facilities) provide:

- Prevention of fistula in primary facilities through support of national maternal health efforts

A referral system links these lower- and higher-level health facilities. The referral system seeks to identify girls and women living with fistula at the community level and who visit primary facilities, and support them to reach the nearest hospital providing treatment. If the hospital is not able to help the woman, she is referred 'up' the system to the next level of care. Community-based organisations support the referral system by identifying and referring girls and women with fistula to appropriate treatment services.

The referral system is supported by an information campaign which targets girls and women in remote areas, and involves men, mothers-in-law, and the community in supporting access to fistula treatment. The campaign provides information about the causes, context, and prevention of fistula, as well as the location and availability of fistula services. Radio is the primary vehicle for the information campaign: three radio spots are continuously aired on national and regional/local radio stations, with the local radio spots carrying specific information on the location and timing of fistula services. Printed leaflets with this information are also available at health facilities and shared with other partners for distribution.

Lessons Learned

As a result of the National Programme, the number of fistula surgeries increased from 712 repairs in 2001 to 1,069 repairs in 2007. Two districts in approximately half the regions in Tanzania have participated in the pilot stage, and the lessons learned from the pilot are being replicated in other districts.

- ▶ Access to fistula treatment can be expanded by integrating service delivery into existing hospitals. As with all fistula care, a decentralised system requires that trained surgeons and nurses are available, and that they have the necessary caseload to provide high-quality care.
- ▶ Fistula providers need to be linked in a streamlined partnership so women with complicated fistula can be referred 'up' the system for treatment at hospitals with adequately trained providers.
- ▶ Building capacity of local surgeons, and decreasing reliance on expatriate surgeons, requires a long-term commitment to pre- and in-service training in fistula repair. However, in many countries with fistula, support from expatriate surgeons may be required in both the short and the long term given severely limited human resource capacity.
- ▶ Effective referrals through systems need to build on existing structures. In many cases, no additional funding is required for efforts which can be integrated with, or piggy-backed onto, other local systems.
- ▶ Service delivery must go hand-in-hand with access to information. Women will access services once they know such services exist; without access to information, services cannot be fully utilised.
- ▶ Information campaigns should identify the primary routes through which women and families get information—most likely radio and word of mouth in remote areas. These should be localised so communities hear about the services available near them.

Source: Tanzania National Fistula Programme, submitted by Maggie Bangser, 2008.

REINTEGRATION

Bangladesh: *Rehabilitating and training women with fistula*

Background

In Bangladesh, 40% of people live in poverty and the status of women is low (Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth, 2003, p.8). The average age of marriage is 15 years (Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth, 2003, p.8); motherhood and early childbirth are considered extremely important cultural obligations. Eighty-four percent of pregnant women do not receive the recommended four antenatal care visits (World Health Statistics 2009, WHO, p.72), and 92% of births occur at home, primarily with the assistance of untrained traditional birth attendants, relatives, or friends (Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth, 2003, p.8). The maternal mortality ratio, one of the highest outside sub-Saharan Africa, is estimated at 570 per 100,000 live births (World Health Statistics 2009, WHO, p.16). In this context, the likelihood of a woman developing fistula is high. The first situation analysis of fistula estimated that at least 416,000 women are currently living with fistula in Bangladesh (Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth, 2003, p.10).

Programme Description

In November 2006, the Bangladesh Women's Health Coalition (BWHC) established a fistula patient treatment, recovery, and rehabilitation centre in Dhaka in partnership with the national government and UNFPA. Employing both a residential- and community-based approach, the training and rehabilitation programme provided fistula patients with shelter and accommodation during the recovery and rehabilitation period. In addition to providing patients with a place to stay, meals, and psychosocial counselling services, the centre offers literacy training, information on general health and hygiene, income-



Photo credit: GMB Akash/Panos Pictures

generation skills, and courses in home gardening, cooking, animal husbandry, and sewing. The centre works closely with the National Fistula Centre at Dhaka Medical Hospital to coordinate patients' physiotherapy treatment, and follow-up visits with medical personnel. The duration of patients' stay in the rehabilitation centre varies from ten days to eight months, depending on individual patients' needs and circumstances.

BWHC's community-based programme works with fistula patients in the communities where they live to:

- Conduct behaviour change communication activities with community members;
- Carry-out follow-up visits with fistula patients to identify any issues needing reinforcement or additional support;
- Provide counselling with family members to help facilitate reintegration; and
- Identify community-based fistula advocates to raise awareness and support other women with fistula.

Between November 2006–March 2008, some of the notable results achieved by the rehabilitation programme included:

- 102 fistula patients were admitted to the rehabilitation centre;
- 39 behaviour change meetings were held in patients' communities;
- 47 follow-up visits were made to patients' homes;
- 30 community fistula advocates were trained in advocacy and awareness-raising.

Lessons Learned

- ▶ The term “fistula” is still not well understood within communities, nor are the consequences for women who are living with fistula.
- ▶ Additional follow-up visits are needed with rehabilitated fistula patients to reinforce literacy training and animal husbandry skills, but these visits can be expensive and human-resource intensive when organised from the capital city.
- ▶ Further community involvement and support is needed to facilitate fistula patients' access to credit and income-generating activities through the local agricultural and social welfare offices.
- ▶ Operations research should be carried out to understand the impact of the programme strategies, and to make subsequent improvements and adjustments.

Source: *Fistula Patients Training and Rehabilitation Center*, submitted by Afroze Deel.

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