

**REPORT OF EVALUATION OF PREVENTION, TREATMENT AND
REHABILITATION OF OBSTETRIC FISTULA IN NORTHERN
NIGERIA PROJECT (KANKARA AND NASSARAWA LGAs)**

SUBMITTED TO

UNFPA- NIGERIA

BY

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List of Abbreviations and Acronyms

ANC-Antenatal clinic

BCC-Behaviour Change Communication

EmOC-Emergency Obstetric Care

FGDs – Focused Group Discussions

FP-Family Planning

GOPD-General Out Patient Department

IDIs – In-depth Interviews

IM-Intramuscular

IV-Intravenous

LGA-Local Government Area

MCHC-Maternal and Child Health clinic

MVA-Manual Vacuum Aspiration

NURTW-National Union of Road Transport Workers

NGOs-Non-Governmental Organizations

PHC-Primary Health Care

PNC-Post natal care

SMOH – State Ministry of Health

SMWASD – State Ministry of Women Affairs and Social Development.

RH – Reproductive Health

RVF-Rectovaginal Fistula

VVF- Vesico Vaginal Fistula

UNFPA-United Nations Population Fund

EXECUTIVE SUMMARY

For every woman who dies (as a result of maternal complications) at least 20 others suffer morbidities such as Obstetric fistula (VVF), infections, and disabilities. Although the prevalence of VVF in Katsina and Kano states is not known, the burden of the condition (in these states) can be appreciated by the number of VVF and RVF repairs that have been done in the treatment facilities in those states. Considering Babbar Ruga Fistula Hospital (Katsina) from 1984 to 2005 Dr. Kees in his evaluation report XXII of the National VVF project reports a total of 10,034 repairs out of which 9,151 were VVFs and the remaining 883 were RVFs. In the same report the number of VVF and RVF repairs that have been done in Laure Fistula centre of Murtala Mohammed Specialist Hospital (Kano) from 1990 to 2005, is put at a total of 6,191 repairs out of which 5,599 were VVFs and the remaining 592 were RVFs.

In February 2005 a “Fistula Fortnight” was held in four states of northern Nigerian; – namely Kano, Katsina, Kebbi and Sokoto. The Fistula Fortnight was a two-week treatment, training and advocacy campaign executed by a collaboration of partners coordinated by UNFPA. Having sufficiently raised awareness on the problem while concurrently providing treatment for 556 fistula clients, it was thought that a need to consolidate the gain by follow-up activities with specific reference to community-based prevention, treatment and rehabilitation was evident. This informed the implementation of the “Prevention, treatment and rehabilitation of Obstetric fistula in northern Nigeria project supported by Virgin Unite in 2 communities; Kankara in Katsina state and Nassarawa in Katsina state. With the expiration of the project which lasted for 6 months, UNFPA commissioned a Consultant to evaluate the project with a view to ascertaining the appropriateness of strategies employed and the level of achievement of planned result noting lessons learnt and good practices if any to be taken into consideration in the scale up phase.

A cross sectional descriptive study was conducted in the two project LGAs vis Kankara and Nassarawa in Katsina and Kano states respectively. The study was conducted in April 2008. The study employed 2 approaches to data collection: qualitative and quantitative. The quantitative component was essentially record review of utilization and provision of maternal health services including maternal morbidity and mortality data in the health facilities in addition to unstructured observation. The qualitative component involved the use of In-depth interviews and Focus Group Discussions with women groups, VVF Clients, male and female Community Educators, LGA Policy makers, traditional and religious leaders including leaders of National Union of Road Transport Workers (NURTW).

MAJOR FINDINGS

1. The project has recorded success in the training and support for the activities of Community Educators in reaching the communities.
2. The project has succeeded in raising the awareness of community in appreciating the danger signs of pregnancy.
3. There is empirical evidence that males in the project communities are now more supportive of the pregnant women.
4. Even though extensive BCC has taken place at the community levels, absence of adequate quantities (and a broad range) of appropriate IEC materials has reduced its effectiveness.
5. The project has brought about increase awareness on VVF but reduction of stigma is still minimal.
6. Both the primary and secondary facilities designated by the project have met standard criteria for provision of EOC services.
7. There is anecdotal evidence of increase utilization of Family Planning service however complete and up to date data is not readily available.
8. The number of skilled attendant at birth has increased due to increasing number of women delivering in the health facilities.
9. Available information shows apparent decline in the number of caesarian sections.
10. The project has achieved 100% success in the area of training of health workers.
11. The transportation arrangement facilitated in the project communities by the project is yet to be as effective and extensive as described in the project document.
12. Information about women with complications reaching health facilities is unavailable due to weaknesses in the record keeping system.
13. An effective micro-credit scheme remains to be facilitated though some women received start up (financial) for economic activities in Kankara LGA.
14. The project has achieved 63% success rate based on the numbers of women that benefited from surgical repair.

15. Majority of the women who were able to access treatment passed through the government rehabilitation facilities in each of the states. However the rehabilitation process did not follow a uniform pattern in each state, while the women who received seed grants in Kankara were able to receive support for livelihood skills in tandem with their economic backgrounds.
16. Though there is participation of the local government officials in the project activities, the project implementation arrangement has not been fully integrated into the existing structure of the local government administration.

RECOMMENDATIONS

1. There is the need to define the management and delivery structure for the project with clear roles and responsibilities which should align with statutory responsibilities of government agencies especially with respect to Obstetric fistula interventions.
2. The roles and responsibility of the LGA should be clearly articulated by a Memorandum of understanding (MOU) signed by all the concerned parties.
3. In view of the successes recorded in the area of awareness creation, the strategy needs to purposefully sustained and consolidated.
4. To increase the effectiveness and efficiency of awareness creation, the projects needs to develop and produce appropriate and adequate quantities of BCC/IEC materials
5. In the project communities, the use of radio jingles, home videos, drama and posters is suggested in view of their popularity, acceptability and feasibility.
6. There is the need to evolve a more encompassing youth involvement strategy which would strengthen the community level activities to prevent the occurrence of VVF.
7. The project should adopt innovative approaches to strengthen its partnership with the fistula treatment centres especially the Murtala Mohammed Specialist Hospital to support the expansion of access to fistula repair services.
8. The project should facilitate an increase in the number of fistula treatment centres in its project location as a major strategy to increase access to treatment services for fistula clients.

9. The project should explore strategies to promote the availability of essential items at the labour wards/maternal health service delivery centres, such as maternity registers, parographs and essential drugs.
10. The project needs to support institutionalized mechanisms to improve the data management systems at the project locations and facilities. This should include the collection and collation data about the project activities at all levels.
11. The arrangement of transport system needs to be revisited and implemented taking due consideration of the physical and social realities at the community level while actively involving all stakeholders.
12. The facilitation of the entrepreneurial activities through various strategies including a micro-credit scheme need to be revisited and appropriately implemented in accordance to the economic realities of the communities.
13. Efforts should be geared towards the strengthening of the institutional capacity of the rehabilitation centres.

1.0 BACKGROUND

1.1 Introduction

Nigeria, with an estimated population of 140 million, is Africa's most populous nation. It is a country where high fertility rate is valued, and a woman's status is determined by her reproductive capacity. Consequently, the total fertility rate (TFR) has remained at a high rate of Six (6) children per woman. Unfortunately, reproduction occurs under conditions that threaten the life and well being of the women. For instance, skilled personnel attended to only 35.9% of births in 2003 as compared to 41.6% in 1999, while emergency obstetric care (EmOC) availability is 4.2% and only 1% of births are by caesarean section, far below the recommended minimum of 5%. This state of affairs results in very high levels of maternal deaths. Nigeria's maternal mortality ratio of 704/100, 000 is one of the highest in the world while for each maternal death that occurs, 15 to 20 other women suffer either short- or long-term maternal morbidities. Prominent among these morbidities is obstetric fistula.

Available information suggests that Nigeria is one of the countries with highest prevalence of fistula in Africa with wide regional variation showing the northern part of the country with the highest rates. The differential in rates have been attributed to regional differences in the distribution of risk factors such as low status of women, poverty, ignorance, availability, access and utilization of emergency obstetrics care coupled with the overwhelming resistance to operative deliveries and other cultural delivery practices inimical to safe motherhood.

To address this situation especially in the northern Nigeria, the UNFPA in February 2005, embarked on an aggressive treatment and awareness creation campaign tagged Fistula Fortnight in 4 states namely Kano, Katsina, Kebbi and Sokoto state as part of the global campaign to eliminate fistula along with partners. This programme was able to put obstetric fistula on the global agenda and was also aimed to convince people in areas with high prevalence that the condition is preventable and treatable.

Having sufficiently raised awareness on the problem, it was thought that, there was a need to consolidate the gain by follow-up activities with specific reference to community-based prevention, treatment and rehabilitation. This informed the implementation of the "Prevention, treatment and rehabilitation of Obstetric fistula in northern Nigeria project supported by Virgin Unite in 2 states.

The project which was implemented in Kankara LGA of Katsina state and Nassarawa LGA in Kano state had 3 main focus viz; **Preventing the harm** of fistula (prevention), **Healing the wounds** (treatment) and **Renewal of hope** (rehabilitation and reintegration) of the women affected by the fistula.

Under the first focus of the project which was the preventing the harm, the programme intended mobilize and sensitize the women, husbands and their families be able to address the social and cultural determinants that perpetuate the occurrence of fistula and

improve knowledge of pregnancy and its consequences. This objective was to be achieved through effective Behavioral Change Communication (BCC), which was to focus on promotion of family planning services, utilization of maternal health services, motivation of patients with fistula to seek care at repair centre, mobilization of community support and male participation. These components were to be achieved through amongst other strategies; the training of 60 volunteer community educators, training of 20 local health providers, facilitation of transport and referrals, advocacy and sensitization of community and religious leaders at each local government targeted.

The second components of the project focused on wound healing intended to provide free surgical treatment to approximately 200 women (100 per target local government council area) suffering from fistula in Babar Ruga Fistula Hospital in Katsina and Murtala Mohammed Specialist Hospital in Kano.

The third components of the project which has to do with renewing hope focused on removal of social, economic and psychological consequences through rehabilitation. This component was intended to be jointly achieved in collaboration with governmental agencies and other non-governmental organizations. The project was to ensure skills acquisition programme through provision of material, financial and other forms of support to the recovered women (economic empowerment).

Furthermore the project was designed to be implemented within the on-going UNFPA Rreproductive Health component of the Country Programme. In addition, the State Ministries of Health (SMOH) and, Women Affairs and Social Development (SMOWASD) were to be part of the multi-sectoral management team. Furthermore, the local technical team was to oversee day-to-day implementation. The project was to be conducted within 6 month and the sum of US\$ 221,080 was to be committed.

With the expiration of the 6 (six) months period of the implementation of the project the UNFPA commissioned a consultant to comprehensively evaluate the project in the 2 sites namely Nassarawa LGA in Kano state and Kankara LGA in Katsina state.

1.2 The Objective of the survey:

This is basically a comprehensive evaluation of the pilot phase of the project to ascertain the appropriateness of strategies employed and the level of achievement of planned result noting lessons learnt and good practices if any to be taken into consideration in the scale up phase.

1. 3 Specific Objectives:

- Evaluate the extent to which the community awareness activities of the project has contributed to improved knowledge of pregnancy, its complications and appropriate actions to take, reduction of stigma associated with obstetric fistula,

- reduction in the occurrence of obstetric fistula in the selected communities within the two LGAs
- Assess if the awareness creation has resulted in the improved utilization of maternal health services in general and emergency obstetric services in particular
 - Establish if the project has contributed to increased/improved involvement and participation of men in the maternal health related matters of women within the communities,
 - Community support for the transportation of pregnant women during in emergency
 - Establish if the project has contributed to improving the availability and quality of EmOC services in the selected health facilities
 - Establish if there has been any increase in the access to treatment and rehabilitation services for women with obstetric fistula
 - Establish the effectiveness of the rehabilitation services in improving livelihood skills of the women treated for fistula during the period.
 - Assess the effectiveness of the economic empowerment components of the project.
 - Make recommendations as appropriate for the scale-up phase of the project.

2.0 METHODOLOGY

2.1 Background information of study areas

The survey was conducted in the two project LGAs vis Kankara in Katsina state and Nassarawa in Kano state .These LGAs had been selected for the project because they contributed the highest number of fistula clients to the fistula fortnight in the two respective states.

2.2. Study Design

A cross-sectional descriptive study design using both qualitative and quantitative methods of data collection was employed in the study taking the set results in the project logical framework matrix as the point of departure. The quantitative component was essentially to generate data on the availability, utilization and quality of Emergency Obstetric Care. Both secondary and primary data were also collected from one PHC facility and one secondary health facility targeted for the survey. The qualitative component involved the use of Focused group discussions and In-depth Interviews. In addition on the ground observation of some of the inputs for the project was incorporated in to the study design.

2.3 Selection of health facilities

In each LGA one primary and one secondary health facility was selected for the evaluation. The selection was based on the fact that these were the health facilities where the main activities of the project were carried out. Thus in Kankara, General Hospital

Kankara and MCH (maternal and child health) centre Kankara were selected. In Kano, Murtala Mohammed Specialist Hospital and Gwagwarwa Clinic and Maternity were selected.

2.4 Sources of data

The following constituted the populations from which primary data was generated:

- Women of reproductive age group
- Male groups
- VVF Clients
- Male and female Community Educators
- Community leaders (religious and traditional)
- Leader of National Union of Transport workers Union (only in Kankara)
- Health care providers at both community and health facility levels
- Local Government (health) personnel

The table below gives a summary of the distribution of the various groups of respondents as well as the interview guide used. The various groups were selected based on their availability and willingness to participate in the evaluation. In all the FGDs the minimum number of respondents that constituted the groups was eight (8) participants. In total 5 FGDs were conducted at each survey site, 4 IDIs at Kankara and 3 IDIs at Nassarawa

Table 1 - Summary of the number of the various groups of respondents and interview guide used in the evaluation.

Target Groups	Number of respondents		Interview guide used
	Kankara	Nassarawa	
Focus Group Discussions			
Women of reproductive age	8	8	See appendix 1
Male and Female community educators	8 males and 8 females	8 males and 8 females	See appendix 2
Male groups aged 25 -40 years	10	8	See appendix 3
VVF Clients	8	8	See appendix 4
In Depth Interviews			
Religious Leaders	1	1	See appendix 5
Traditional Leaders	1	1	See appendix 6
NURTW	1	Nil	See appendix 7
MCH Coordinator	1	1	See appendix 8

2.5 Qualitative data

Convenient sampling was used to identify key informants representative of the various relevant stakeholders within the project communities. Key informant interviews and

focus group discussions were the methods of data collection used. Focus group discussion guides and interview guides were used for the conduct of the FGD and IDI respectively for qualitative data collection. There was approximately 8 respondents participating in each FGD session. The FGD were guided by a moderator and the interviews were recorded with a tape recorder. Additionally, for each session, a note taker took notes, including on non verbal communication. Each session lasted approximately one hour.

2. 6 Quantitative data

An adapted WHO/UNFPA checklist was used to collect data on availability and quality of emergency obstetric care services, maternal morbidity, mortality and availability of drugs, equipments and supplies.

2. 7 Data management and analysis

The quantitative data following analysis had the result presented in the form of frequency tables. For the qualitative data which were captured on tape and notes, the tapes were transcribed and reproduced in text. The transcripts were then content analyzed qualitatively around the main thematic areas of the research, identifying points of convergence and divergence in the responses of the different respondents. Triangulation of both the quantitative and qualitative data was undertaken.

3.0 FINDINGS

The findings from this evaluation are presented against the logical framework matrix contained in the project document

3.1 Improving knowledge of community members on pregnancy, its complications and actions to take in emergency.

3.1.1 Training and Functioning of Community Educators

The first strategy for improving knowledge of the community members as designed by the project was to train 60 volunteer Community Educators in each of the of the local government council areas (LGAs). The process commenced with identification of eligible female and male educators from the catchments communities. They were identified and selected in partnership with the traditional, religious leaders and other members of the community including the local government officials. Their previous participation in voluntary community-based activities was an important consideration in the selection. Furthermore, for the female educators, a preference was given to those who suffer from obstetric fistula and may or may not have been treated, so that they serve as role models.

Educators were trained on community entry approaches, the importance of ANC attendance, hospital delivery, care seeking and personal hygiene. They were also trained

on identification of fistula clients and linking them up with the PHC department for surgery and rehabilitation.

From this evaluation it was established that a total number of 123 (One hundred and twenty three) educators were trained this figure exceeded the target of set out by the project which was 120. Out the total number 57 were trained in Kankara while 66 in Nassarawa community. The ratio of female : male stands at 1:2 (as set out in the project plan).

Table 2 – Summary of the numbers of Community Educators trained

LGAS	Number of Community Educators trained		Total
	Male	Female	
Kankara	19	38	57
Nassarawa	22	44	66
Total	41	82	123

Following the successful completion of the 5-day training, the community educators immediately commenced activities in the community to sensitize and enlighten the women. The main activities of the community educators since the inception of the project centres round educating both male/female members of the community on VVF, safe motherhood, assisting women and educating members of the community on maternal health. This they have done with a lot of enthusiasm and commitment and through this process, they were able to reach communities and target groups. Some of the respondents had this to say about their activities:

“We go to nook and crannies to identify, record, encourage and mobilize them to come for treatment. We educate them on maternal health and personal hygiene.”

Female Community Educator (Kankara LGA)

“We organize community group health education. I talk to them on ANC attendance, early care seeking, danger signs in labour and informing their husbands when they are in labour.”

Female Community Educator (Nassarawa LGA)

“I educate them on importance of ANC (both male and female), environmental sanitation, use of good water and HIV/AIDS. I concentrate on those men who are newly married”

Male Community Educator (Nassarawa LGA)

The exact figure of the total number of the communities and persons reached cannot be ascertained due to the fact that not all trained educators participated in this survey. However 7 (seven) of the female respondents that participated in the FGD have been able to reach to 35 communities and more than 1100 clients.

The male educators also conducted community mobilization and sensitization activities while 8 (eight) male respondents reported that they had covered 52 communities. However, when further probed none of them could confirm the actual number of people reached and none had identified any fistula client. The inability to provide the number of people reached by the male educators signified poor record keeping whereas the inability of to identify cases might not be unconnected with the religious cum cultural barriers inherent in a typical Hausa Fulani community.

3.1.2. Knowledge on danger signs of pregnancy

Knowledge on danger signs of pregnancy is an indication of impact of BCC (behaviour change communication) activities on knowledge and care seeking on maternal health and obstetric fistula. Although the survey could not determine the exact proportion of women who know at least three (3) danger signs, the responses from qualitative discussions (FGDs and IDIs) with women of reproductive age suggested increased in knowledge. Based on the aggregate of information given by the various groups in the 2 project sites there is increasing knowledge on the importance of attending ANC, the relevance of regular visit, ability to identify danger signs in pregnancy and importance of hospital as against home delivery. Some of the respondents from Kankara LGA (in Katsina state) had this to say:

“We now know the importance of ANC (early booking) and regular visit.”

Woman of reproductive age (Kankara LGA)

“We know about early booking for ANC and we are able to recognize danger signs such as leg swelling. We also appreciate the importance of hospital delivery.”

Woman of reproductive age (Nassarawa LGA)

In addition to the responses from the women of reproductive age groups almost all the respondents interviewed attested to this increasing knowledge. For instance the community educators have alluded to the fact that, the women now have better understanding of rational for ANC attendance, importance of family planning, ability of

women to recognizing danger signs such as anaemia, loss of appetite, easy fatigue, avoidance of delay at home in case labour to mention just but few. More so the Traditional Ruler in Kankara asserted that the programme has brought about reduction of pregnancy related problems; below are some of the responses of the respondents

“The women now have better understanding of family planning; husbands now encourage and take their wives for family planning.”

Female Community Educator (Kankara LGA)

“Women now recognize anaemia due to weakness, loss of appetite and easy tiredness. More women now ask questions about pregnancy, delay at home is decreasing and women are able to detect pregnancy early.”

Female Community Educator (Nassarawa LGA)

“It helps some in understanding family planning as most see family planning as a new thing alien to their culture.”

Male Community Educator. (Kankara LGA)

“It has improved in ANC attendance among all age group of reproductive age.”

Male Community Educator (Nassarawa LGA)

“It (the project) educate us on importance of ANC, avoiding protracted labour.”

Male group respondent (Kankara LGA)

“There is provision of ambulance to carry women in labour to hospital”

Male group respondent (Nassarawa LGA)

“As a result of the programme, there is reduction in the number of pregnancy related problems.”

Traditional ruler (Kankara LGA)

3.1.3. Male supporting pregnant women

Male participation is an important element of any quality reproductive health programme. Considering the socio-cultural set up of the project communities, where male dominance is the norm rather than the exception, the need for men to play important roles is buttressed. Though we can not adduced the exact proportion of male supporting pregnant women for the reason advanced earlier, however there is overwhelming consensus of improvement of male participation in maternity health services. In all the project sites Kankara and Nassarawa, the religious leaders, women of reproductive age, male respondents, fistula clients and Community Educators have acknowledged this fact; Below are some of the responses of the different groups in the 2 project sites;

“The programme has improved the participation of males in maternal health issues. The males allow their women to attend ANC and they pay their transport services.”

Religious leader, Kankara

“I think it will take time, some are beginning to be cooperative. Let us continue the efforts, more men will get involved. We thank God”.

Religious leader, Nassarawa

“Gradually, gradually, the men are getting involved.”

Traditional ruler, Nassarawa

“This mobilization makes male (fathers) avoid early marriage for their children. They play important role in avoiding protracted labour”

Male group respondent, Kankara

“They discourage practices of traditional birth attendants who cut the female genitals”

Male group respondent, Kankara

“Yes, now I accompany my wife several times to the clinic.”

Male group respondent, Kankara

“In fact I had experience of a neighbour who was in services labour and her husband was not around, we liaised with the community educator we took her to hospital before the arrival of her husband and she delivered safely.”

Male group respondent, Nassarawa

“Yes I have accompanied my wife to hospital especially in her second delivery and it is born by the work of the educators.”

Male group respondent, Nassarawa

“Before this project, male participation is low, but it is now high. Men allow women for ANC. They also give permission for children to be immunized.”

Woman of reproductive age, Kankara

“The men are now more enlightened, yes they are supporting us!”

Woman of reproductive age, Nassarawa

“The result of our work in this project has made males to release their affected wives for treatment; before they were hiding the cases because of stigma.”

Male Community Educator, Kankara

“My experience is that males are contributing a lot, a man whose mother benefited from Project intervention has now turned to mobilizer on VVF.”

Male Community Educator, Nassarawa

“After my last visit, my husband allowed all my patients that I have seen to come to my house.”

Female Community Educator, Kankara

“The males are participating more as evidenced by giving permission to their wives to go to hospital.”

Female Community Educator, Kankara

“The men are now receptive, they listen to us and encourage us even though some men prevent their wives from coming out.”

Female Community Educator, Kankara

“The level of male participation is on the increase, our male parents are giving us support.”

Fistula client, Nassarawa

3.1.4. IEC and BCC materials

For effective awareness creation, the project envisaged that there would be sufficient tailored-made IEC/ materials on safe motherhood and fistula prevention. However in this evaluation it can be established that some posters were developed and disseminated but these were limited in coverage to the health care centres and immediate surroundings. There was no evidence that other multi-media materials were developed under the project especially those for use by the Community Educators such as pamphlets e.t.c. The community educators confirm the absence of these IEC materials; they further reiterated that the availability of these materials would have gone along way in increasing the effectiveness of their campaigns.

However some fistula clients were trained as part of UNFPA’s fistula programme as “fistula voices” – community based fistula advocates and they reinforced the BCC activities at the community level through songs and other forms of oral rendition and campaigns.

3.1.5. VVF Awareness and Stigma Reduction

Responses from the FGDs and IDIs suggest significant improvement in the community’s awareness about Vesico Vaginal Fistula with respect to its cause, treatment/cure and rehabilitation. However, stigmatization of fistula clients remains significant though with some minimal reduction. Some of the respondents were quoted as saying:

“It has helped in reducing the extent to which the VVF patients are rejected”. The community education has helped in reduction in the number of cases in my ward”

Male Community Educator, Kankara

“When they came to my house I enjoyed the session I also told my neighbour about their activities. We helped them in the identification of fistula patient.s”

Woman of reproductive age, Kankara

“We use our self as role models, we are now cured, and stigma is reducing. The evidence of reduction is that more women are coming up with the condition. Some even come to me at night. There are plenty now awaiting surgery. They even beg us to be included in the list of those to be operated upon.”

Female Community Educator, Kankara

“Somebody (fistula patient) spent 20 years with disease not knowing where to go, with the activities of the educators, the patient was identified and repaired.”

Male group respondent Kankara

“Now there is no stigma, even the men no longer stigmatize us. Stigma is gone. We thank God.”

Woman of reproductive age, Kankara

“They (community educators) go to bring about awareness on maternal health and VVF at different occasion like naming and wedding ceremonies.”

Woman of reproductive age Nassarawa

“They (community educators) educate us about VVF and how to get treatment for it.”

Woman of reproductive age Nassarawa

“It changed my behaviour personally, I make sure my wife attended ANC during her last pregnancy and during labour I immediately conveyed her to hospital to avoid prolong labour and I am happy with the outcome.”

Male group respondent Nassarawa

“They (community educators) enlighten us an importance of attending ANC, discouraging under age marriage, those that have the VVF should attend hospital.”

Male group respondent Nassarawa

“I am aware of a colleague, we are working together in the same place, initially nobody relates to her, nobody takes anything from her. I personally linked her to the education and through this programme, she was treated and the stigma is not their any more.”

Male group respondent, Nassarawa

“Women get VVF through men, but men desert women when they develop VVF, now our husbands no more run away from us.”

Fistula client Nassarawa

“My former husband wants me to come back.”

Fistula client Nassarawa

“I was on admission for treatment before I realize, they have reinstated my marriage. I am back with my husband..”

Fistula client Nassarawa

“Fistula is reducing, it will soon be eradicated in Kano and Nigeria.”

Fistula client Nassarawa

“After my treatment, I have 3 suitors seeking my hand in marriage.”

Fistula client Nassarawa

“I swear by God, cases are reducing. The work of the mobilizers is bringing about increase in awareness.”

Woman of reproductive age, Nassarawa

“I can live with a fistula patient as a co-wife as far as she will take good care of her personal hygiene. VVF is not like HIV.”

Woman of reproductive age, Nassarawa

“Due to the activities of the mobilizers in the last few months our people gradually understand fistula and the stigma is gradually reducing as well.”

Traditional ruler, Nassarawa

It is also pertinent to note that there are some pockets of resistance/rejection of the project. In Kankara LGA some fistula patients identified by the Community Educators have declined to come for treatment, apparently due to the prevailing stigma. Some of the communities include:

- Maraku community
- Sagaba community
- A Fulani (nomadic) settlement

3.2 Increasing Availability and Accessibility Emergency Obstetrics Care in Selected LGAs

3.2.1 Facilities for Emergency Obstetrics Care.

Overall 5 major facilities (Secondary health care and comprehensive primary health care centres) were identified for participation in this project. The facilities included 3 (three) in Katsina (Kankara) and 2 (two) in Kano (Nassarawa). The facilities in Katsina are;

Maternal and child health clinic, Kankara, General Hospital Kankara and Babbar Ruga Fistula Centre which serves as a referral centre for fistula surgical intervention. However, in Kano the facilities are Gwagwarwa clinic and maternity and Murtala Muhammed Specialist Hospital.

The survey identified clear linkages between the facilities especially the Babbar Ruga Fistula Centre and the project in Katsina. However such an effective arrangement was lacking in Kano according to the officials of Nassarawa LGAs officials. Therefore the linkages and interrelationship between the facilities and the project was not clearly articulated and understood in the Kano project site(s)/Nassarawa. The fact that UNFPA has a subsisting programme in Katsina state (guided by a MOU with the state government) which provided a structure for the project could be responsible for the foregoing.

The evaluation reveals that both the secondary and primary facilities meet the standard criteria for the provision of EOC services in terms of their capacities to provide the critical services. However not all the essential elements of EOC Services such as manual removal of retained products of conception and assisted vaginal delivery using vacuum/forceps were provided in the period under review. Furthermore, while good records were kept in the General hospital Kankara in particular, the primary health facilities of the 2 project LGAs were less efficient in their record keeping.

Table 3 below shows the summary of obstetrics admission in General Hospital Kankara. From the table, the number of obstetric admissions has increased from 91 between April to July just about the inception of the programme to 140 between December- March 2008. This increase can be attributed to the increase in awareness on the need to seek for care. In the same vein the number of normal deliveries has increased from 220 to 336 during the same period under consideration. Furthermore, there is decrease in number of caesarian operations from 33 to 19. Other EmOC services such Vacuum and forceps delivery have not been recorded through out the period.

Table 3 - Utilization of maternal health services in Kankara General Hospital

Admissions	First Quarter April-July 2007	Second Quarter August- November 2007	Third Quarter Dec 2007- March 2008	Total
Obstetric admissions	91	105	140	330
Normal deliveries	220	298	336	854
Vacuum deliver	-	-	-	-
Forceps delivery	-	-	-	-
Caesarean section	33	12	19	54
Total	344	415	495	3440

Table 4 below shows an increase in the number of normal deliveries conducted in the second quarter, this did not change much in the third quarter in the Maternal and child health clinic, Kankara. Information on other service are not available because they were not provided at the level of care.

Table 4 – Utilization of maternal health services in Maternal and child health clinic, Kankara

Admissions	First Quarter April-July 2007	Second Quarter August- November 2007	Third Quarter Dec 2007- March 2008	Total
Normal deliveries	639	751	643	2033

As to the number of obstetric complications seen in the hospital the table (5) below shows increase in the number of cases of obstetric hemorrhages (ante partum and post partum) from 9 in first quarter to 35 in the last quarter, pre-eclampsia/eclampsia from 8 to 28. However there is a decrease in the number of cases of postpartum sepsis from 12 to 10 and prolonged labour from 20 to 7. Other obstetrics complications such as ectopic pregnancy and ruptured uterus have not been recorded during the period under evaluation. The foregoing thus provides an insight into the utilization of services which has slightly increased accounting for the reduction in cases of prolonged labour and post partum sepsis due to the apparent increased skill attendance at birth which follows improvements in service utilization.

Table 5 - Major obstetric complications as seen at General Hospital Kankara April 2007 to March 2008

Obstetric complications	First Quarter April-July 2007	Second Quarter August- November 2007	Third Quarter Dec 2007-March 2008	Total
Hemorrhage (ante or post-partum)	9	14	35	58
Prolonged/obstructed labour	20	6	7	33
Post-partum Sepsis	12	8	10	30
Pre-ecclampsia/eclampsia	8	24	28	60
Total obstetric	45	52	80	177

complications due to major causes				
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The increase in cases of eclampsia and obstetric hemorrhages could be due to increase level of awareness of danger signs in pregnancy resulting in positive health seeking behaviour and service utilization.

3.3 ANC and Family Planning services utilization

From the qualitative information, there is a consensus which indicates that there is increase in the number of women utilizing maternal and health services especially ANC services. With regards to Family Planning and Post Natal Care services, the paucity of data in all the facilities has militated against arriving at conclusion on their true status. Below are some of the responses of the respondents.

“It helps (the project) in convincing men to allow their wives to attend ANC even for about 25 kilometers distance.”

Male group respondent Kankara

“Attendance at ANC is on the increase. How I wish you came on Tuesday, you will see how people from village and town came to this clinic”

Female Community Educator, Kankara

“The fact that we convince the fistula victims to go to hospital for treatment have made more of our people to embrace ANC.”

Female Community Educator, Kankara

“We now go for ANC regularly, we appreciate birth spacing.”

Woman of reproductive age Nassarawa

“There is an increase in the number of women attending ANC. This is as a result of mobilization by the community educators.”

Male group respondent Nassarawa

“They are getting more information even on family planning. They are eager to come and learn. Even men group are coming to us. We use to refer them, I have taken 3 families for family planning, 2 for IUCD and 1 for oral contraceptives”.

Female Community Educator Nassarawa

3.4 Birth attended by skilled attendants

From this evaluation 2 pointers provide useful insight to appreciating any significant changes in this output. One, the number of health workers trained in Life Saving Skills in the 2 projects sites amounting to 40 and secondly, the apparent increase in the number of normal deliveries and as explained in the tables above. This fact can also be supported by the testimony of some of the respondents interviewed such as the one below;

“Hospital delivery is good because some pregnant women will require surgical operation. It is also important to prevent death of mother and child.”

Female group respondent Kankara

“Yes, more women attend ANC, more hospital delivery, staying at home as reduced.”

Female Community Educator, Nassarawa,

“More women are coming out to seek for care which otherwise they will not.”

Female Community Educator, Nassarawa

“We now appreciate importance of hospital delivery because it is good for the health of the mother and child.”

Woman of reproductive age, Kankara

3.5 Caesarian Section rate

As highlighted above only one of the facilities in the project offers caesarian section. And from that facility we have noted downward trends of the number of caesarian section from 33 to 19. Due to the ineffective linkages with secondary health facilities in Nassarawa and the metropolitan/urban nature of the LGA (Nassarawa) the proper documentation and attribution to the project remains a challenge.

3.6 Reduction of Fistula

The evaluation confirmed that prior to the intervention there has been suppression of the problem in all the 2 project sites because of stigma and discrimination. But following the intervention, increased numbers of fistula clients are gradually coming out to seek for care. Therefore, unless we are able to establish the rate of new cases (incidence of the condition) which would actually be impractical due to the short duration of the project, a conclusion on reduction of new cases remains impossible.

3.7 Personnel trained on Live Savings Skills

From the outset the project intended to train 20 health care providers at primary health care level in basic EmOC in each of the project LGAs. This target has successfully been achieved in both project sites with 40 health workers trained (20 per LGA). The primary

health workers interviewed have confirmed receiving the training and acknowledged that the training has definitely improved their skills in new issues like administration of antibiotics and oxytocin, manual removal of placenta and the importance of early referral especially to higher levels of care.

3.8 Improving availability of Vehicular Transportation for Pregnant Women During Emergency

The timely transportation of women with obstetric emergencies to the next referral facility has a vital role to play in preventing obstetric morbidity including VVF as well as maternal mortality. Looking at the 3D model of the different types of delays encountered, the 2nd D is very critical because it is the intermediary between the patient and the place of treatment. The issues under consideration in this objective are as follows;

3.8.1 Community with organized support for referral

The project intended to put in place mechanism to be managed by the communities for meeting the challenge of transportation through partnership with ministry of women affairs and social development under NURTW (National Union of Transport Workers) and the Motorcycle rider association, the local government, CBOs and Federal Road Safety Commission. UNFPA and their Rural Transport Partners will also develop plans to introduce reliable, safe and sustainable motorcycle ambulance services in some very remote communities. Transport owners within the communities would be sensitized and their members would be selected and trained on emergency transportation. The local commercial transport association would be contacted to implement the MoU, which would allow them to provide transport services to women in need according to defined guidelines. While the project would support the initial costs, its expected that the communities will be empowered to design and implement more sustainable transport solutions for accessing emergency medical care.

From the evaluation conducted all components of this arrangement has not been fully put in place and at the time of the evaluation the communities have not assumed ownership of an organized support for referral of women. It is however, pertinent to highlight that while in Kankara some arrangement has been done with the Chairman of NURTW supported with a Memorandum of Understanding (MOU), while in Nassarawa this is yet to be accomplished.

In Kankara the survey revealed that some community members assist women to go to the next referral facility at the time of emergency or to transport a fistula client from their community to Kankara and then to Babban ruga fistula treatment centre at Katsina. The NURTW through its Chairman and with the coordination of the local government officials provide transportation (from Kankara) to the treatment centre in Babbar Ruga. However due to challenges of poor road network amongst others, support to the women

from their communities (mostly hard to reach areas) to Kankara is the responsibility of the patient and her families.

However, in Nassarawa there is some elements of community participation which assist women to go to the next referral facility at the time of emergency or to transport a fistula client from his community to (the fistula treatment centre) Murtala Muhammed Specialist Hospital. Below are some of the responses of the respondents with respect to transportation;

“I don’t know if Union (NURTW) are involved. We organize for a vehicle to transport us.”

Fistula patient Nassarawa

“When we meet a woman with difficult labour, we arranged and accompany her to the hospital, stay with her until she delivers. A times we debate and discuss until we convince them to go. It has not been easy.”

Female Community Educator Kankara

“They are (fistula patients) transported from Kankara to Katsina. There is the need for similar programme from villages to Kankara for onward transportation to Katsina.”

Male per educator, Kankara

“There is an ambulance at the hospital which transport women to Katsina.”

Woman of reproductive age, Kankara

With the advent of this programme there is a referral arrangement. The programme use to sponsor trip of the patient to Babban ruga, but before we sponsor our self .

Fistula patient, Kankara

“Transportation is shouldered by the families of the patient. No organized system which is linked with NURTW. I have however worked with other associations e.g. SWODA and KAPA that try to assist us transport women with difficulty during delivery.”

Female Community Educator, Nassarawa

“We hear there is a plan, or they are assisting those going to Murtala hospital, or in other states, it is working. ”

Woman of reproductive age, Nassarawa

“The only thing I know, when there is a case in remote areas, the local government sends ambulance to convey the patient to the clinic.”

Male Community Educator, Nassarawa

“To the best of my knowledge, I am not aware, it may be operating, but in this my locality no such thing.”

Traditional ruler, Nassarawa

3.8.2 Women with complications reaching the health facilities

Since there is yet to be an effective transport system it is very difficult to ascertain the proportion of women with complications (referred by the project) reaching appropriate health facilities. And to obtain even a vague idea there must be a uniform format of reporting this process by the community educators. However the data provided in Table 5 provides some insight and suggests increase in number of women with complications reaching the health facilities.

3.8.3 Communities with Partnerships for transportation

As highlighted above the community partnerships and ownership for the transportation support is yet to be fully functional along the lines described in the project document. This may be due to the various sectoral challenges that confront transportation and the short duration of the pilot.

3.9 Increasing Access to Livelihood and micro-credits to women in selected LGAs

Under the project design, the poorest women in the community would be identified to benefit from livelihood skills and training on job creation. To achieve this micro-credit system with funding from the state branches of NAPEP would be extended to the communities by NGOs already engaged in such scheme. The project also intended to adopt comprehensive economic empowerment strategy based on community needs and markets availability. Potential areas identified include, Bio-fuel production, to save time from fetching firewood, improving access to water within the communities, involving women in environmental protection as well as looking for technologies for scaleable businesses.

From the evaluation all the planned output are yet to be fully delivered in achieving the objective. To buttress this assertion lets look at the specific performance indicators;

3.9.1 Access to existing livelihood skills

All the fistula clients that accessed surgical repair under the project passed through the existing government rehabilitation services – Babbar Ruga (Dr Kees) rehabilitation centre (Katsina) and Kwali rehabilitation centre (Kano) which routinely offer skills acquisition as part of their services. These women were therefore able to access skill acquisition services in these facilities even though they were limited in the range of services available.

3.9.2 Women Accessing Micro credit

Twelve (12) women, some of whom had gone through the rehabilitation centres received seed grants and in some cases equipment support to facilitate the start up of livelihood activities. These women were trained in basic functional literacy and numeracy, and supported with equipment and input that properly matched their needs and circumstances such as bicycles and grinding machines.

3.10 Improving access to obstetrics fistula treatment and rehabilitation for women from selected LGAs

The last aspect of the project is to ensure meaningful job opportunities to enable fistula clients to reintegrate into their communities this will contribute to community level economic upliftment and fistula prevention. This project emphasized that all women who have been discharged from the treatment programme would have access to rehabilitation services. Below are some the performance indicators.

3.10.1 Women with obstetric fistula identified

Under this the project set out to identify and treat 100 women with fistula in each local government.. Based on the evaluation as shown in the table below close 94% success rate have been achieved in Kankara whereas only 32% was achieved in Nassarawa. Aggregate from the communities 63% success rate has been achieved in the 2 project sites.

Table 6: Summary of fistula repairs supported by the project.

Location	Number of repairs targeted	Number of Surgical Repairs
Kankara LGA (Babbar Ruga Fistula Centre, Katsina)	100	94

Nassarawa LGA (Murtala Muhammed Specialist Hospital)	100	32
Total surgical repairs	200	126

3.10.2. Fistula clients accessing rehabilitation services

The evaluation of this pilot phase of the project revealed that this is one of the strongest and most functional components of the programme. There is evidence that fistula clients in Kankara, Katsina state have received financial and monetary support from the project. Specifically some received grinding machines, while some were given small ruminant animals like sheep and goats others receive long ruminant animals like cows. However, in Nassarawa, Kano state, this aspect was yet to be implemented. The rehabilitative approach was found to be effective in;

- (a) Empowering the fistula clients economically.
- (b) Reduce VVF associated stigma.
- (c) Encourage and motivate other untreated fistula patients to seek treatment.
- (d) Provided additional assistance and succour to the families of the victims.
- (e) Promote awareness and acceptability of the project activities among members of the community.

There were a lot of encouraging responses from nearly all the respondents interacted with below are some:

“Three women were supplied with grinding machine and it is of benefit to both women and their husband.”

Male Community Educator , Kankara

“It provides economic empowerment and makes other fistula patients to come out for treatment.”

Male Community Educator , Kankara

“The programme has contributed to women economically and has increased intimacy between husbands and wives.”

Religious Leader Kankara

“I am a beneficiary, my wife was given grinding machine and the family is enjoying it”

Male group respondent , Kankara

“They gather treated patients through traditional leader and give them various kind of assistance such as money, grinding machine, cows for fattening and so on.”

Male group respondent , Kankara

“I was given grinding machine and bicycle which my child also rides to school.”

Female Community Educator , Kankara

“I was given animals. They are now pregnant and about to deliver. We thank God we thank UNFPA.”

Female Community Educator , Kankara

“The economic assistance has helped reunite marriages. It has encouraged others to come and seek for care. It is motivating.”

Woman of reproductive age , Kankara

“Because of this assistance, some can accept to be (fistula patients) in order to receive the assistance.”

Woman of reproductive age , Kankara

3.10.3 Fistula clients successfully reintegrated

Due to the short duration of the project, it would be challenging to report of successful reintegration of the fistula clients into their communities. However those clients that have benefited from the economic support enumerated above have commenced income generating activities in their communities which provides an indication to their level of reintegration.

It was also gathered some of the repaired firstula clients in Kankara LGA had returned to their communities and families/husbands outside the LGA. These were women who had been marginalized and had to leave their communities sometimes to their parent’s homes in Kankara only to return after successful surgery. This like the foregoing paragraph provides an indication of reintegration.

The evaluation did not however identify a consistent reintegration strategy by the project to support the reintegration of the women over the long term especially as reintegration can be seen as a long term process.

4 MONITORING AND EVALUATION

The monitoring and evaluation component of the project requires strengthening. The monitoring activities were implemented largely as part of the UNFPA assisted state programme by the programme advisory unit (PAU) in Katsina with support from a CBO

officer. The Programme Officer from the UNFPA Field Office also monitored programme activities and provided technical assistance.

The monitoring was however not adequately coordinated with the appropriate units of the respective governments partly as a result of governments ambiguous coordination structure for obstetric fistula interventions. This weakness can be responsible for some of the gaps identified in the project such as community level coordination activities for transport and poor record keeping.

5 COORDINATION AND COLLABORATION

The project clearly benefited from the existing UNFPA supported Population and Development programme especially in Katsina state. The project therefore did not duplicate any activity that, even though were related to the campaign to end fistula, was being implemented by the RH programme . The rehabilitation component benefited from the training of social workers implemented by the RH programme as well as the training and activities of the “fistula voices” – community advocates.

The RH programme further provided bicycles to the Community Educators in Katsina state to facilitate their capacity to reach difficult areas while serving income generating purposes for some recipients. Partnership with other development partners and NGOs remain weak and inconsistent..

6 LESSONS LEARNED

The community level interventions especially on the platform of the Community Educators delivered significant output. It facilitated access to key gate keepers, groups, families and individuals within the community. It also allowed the local community members to address culturally sensitive issues related to obstetric fistula and maternal health.

Strengthening the capacity of the health system to deliver quality maternal health services alone would not achieve the intended results with respect to utilization and maternal health outcomes without facilitating linkages with the community level activities especially the community educators.

The centralization of fistula treatment services present a formidable challenge of access to treatment services for the fistula clients as they would have to take their turn on the waiting list of the treatment centres. The development of treatment capacities in other facilities will be beneficial to the eventual attainment of the project outputs.

Rehabilitation services usually follow a predefined pattern in the government facilities dedicated to fistula rehabilitation. This may not equip the women with skills that are useful for economic activities in their own environment. Innovative, needs-specific methods should be adopted for future interventions.

7. CONCLUSION

The content, design and activities of the project were to a large extent adequate, appropriate and relevant. The key issues that underpinned the obstetric fistula challenge in the communities were articulated and addressed. Despite the challenges that confronted the project in the eventual translation of the project as conceived into actual activities, there was clearly identifiable impact of the project within the short period of implementation. It has addressed to various degrees critical RH/Maternal health issues such as low utilization of services, shortage of equipment and supplies as well as poor skills of health workers in the provision of the required services.

Stakeholders involvement was to varying levels of participation which could be partly due to the short period of intervention and would therefore have to be strengthened. The project was more effective in achieving individual capacity building against institutional capacity, which requires a more systematic approach than thus far demonstrated.

9. RECOMMENDATIONS

1. There is the need to define the delivery structure for the project with clear roles and responsibilities.
2. The roles and responsibility of the LGA should be clearly articulated by a Memorandum of understanding (MOU) signed by all the concerned parties.
3. The project has to been mainstreamed into to the existing managerial structures and functions at the LGA level.
4. In view of the successes recorded in the area of awareness creation, the strategy needs to purposefully sustained and consolidated.
5. To increase the effectiveness and efficiency of awareness creation, the projects needs to develop and produce appropriate and adequate quantities of BCC/IEC materials.
6. In the project communities, the use of radio jingles, home videos, drama and posters is suggested in view of their popularity, acceptability and feasibility.
7. There is the need to evolve a more encompassing youth involvement strategy which would strengthen the community level activities prevent the occurrence of VVF.
8. The project should adopt innovative approaches to strengthen its partnership with the fistula treatment centres especially the Murtala Mohammed Specialist Hospital to support the expansion of access to fistula repair services.

9. The project should explore strategies to promote the availability of essential items at the labour wards/maternal health service delivery centres, such as maternity registers, patographs and essential drugs.
10. The project needs to support institutionalized mechanisms to improve the data management systems at the project locations and facilities. This should include the collection and collation data about the project activities at all levels.
11. The arrangement of transport system needs to be revisited and implemented taking due consideration of the physical and social realities at the community level while actively involving all stakeholders.
12. The facilitation of the entrepreneurial activities through various strategies including a micro-credit scheme need to be revisited and appropriately implemented in accordance to the economic realities of the communities.

APPENDIX

Appendix 1

Focus Group Discussion Guide for Women Groups

I. Preliminaries

A. Introduction: Welcome participants. Describe what FGD is – a group discussion that allows you to discuss among yourselves the topic rather than talking to us.

B. Purpose/Modus Operandi: We will be discussing your participation on health as it affects women in your communities especially as it relates to VVF. We are interested in all your ideas, comments and suggestions. All comments both positive and negative are welcome. Please feel free to disagree with one another. We would like to have many points of view. (WE WOULD WANT YOU TO DISCUSS ALL THE ISSUES AMONG YOURSELVES).(Explain use of audio tape) All comments are confidential and for research purposes only. We would also want you to speak one at a time so that the tape recorder can pick your voice appropriately and clearly.

1. How do describe the magnitude of VVF in this community?
2. What do you think are the causes of this problem?
3. What are the various encountered by the VVF in this community?
4. What arrangements were in place to take care of VVF clients prior to project ?
5. Are you aware of this programme?
6. What do you know about the programme?
 - Inception
 - Promoters
 - Goals and objectives
 - Benefits
 - Target beneficiaries
7. What are the various activities conducted under this programme?
8. Are you aware of a group of people who go around educating people on VVF(Probe for peer health educators and any other community mobilization activity)
9. Have their activities influence your understanding of VVF and safe motherhood ?
10. One of the components of the programme is Behavior Change Communication. Has the programme helped you in understanding more about safe motherhood, knowledge and perception of VVF?
11. In your own opinion, to what extent has the BCC helped in;
 - a. Improving knowledge of women in pregnancies
 - b. Complications of pregnancy
 - c. Stigma reduction
 - d. Reduction of VVF in the community

Ask specific questions below:

- 1What is the importance of ANC
- Where should women deliver and why?
- What are the signs you will c in a pregnant woman that will show she is in danger?
- What actions should be taken?

- What causes a woman to develop a VVF?
 - Has any of your relatives suffered or is suffering from VVF?
1. Who is to blame for the occurrence of VVF?
 - Probe:
 - The sufferer
 - Her parents
 - The husband
 - The community
 - Government
 - Others
 2. Are you willing to live in the same house with VVF sufferer?
 3. Are you to share common utensils with a VVF client?
 4. Would you consent to your son, brother or relative to marry a VVF victim
 5. Are you willing to offer assistance to a VVF clients?
 6. Are you willing to live with her as a co-wife?
 7. Should VVF victims be regarded and accepted as noermal members of the society?
 8. Is VVF curable?
 9. Is VVF preventable?
-
12. What kind of information were you provided with during BCC?
 13. What kind of media and method used during the BCC?
 - Drama
 - Jingles
 - Video
 - Pamphlets
 - Posters
 - Radio
 - Newspapers
 - Town crier
 - Campaign
 14. What type of IEC materials have you received during the BCC
 - Pamphlets
 - Posters
 - Souvenirs
 15. Another component of the programme is the training of Volunteer Community Educators, What kind of activities do these volunteers conducted?
 16. How do you assess the performance of the volunteers trained in terms of reaching out to women and what is your judgment of the contribution in reducing the incidence of VVF in this community.
 17. What is the level of participation and support by your male counterpart in this project.

18. How do you describe the influence of this programme on your male counterparts in participation of maternal health issues? Explain your experiences?
19. What is your opinion on the activities of the trained providers in the health care providers under this programme?
20. Referral/Transportation services are other components of this programme; how has it operated so far.
21. Another component of this programme is skill empowerment of women; how is this activity being operated?
22. What are the various and activities and success recorded in this empowerment activity.
23. How do you rate acceptability of the entire programme;
 - a. By the traditional leaders
 - b. By religious leaders
 - c. By the women
 - d. By the men
 - e. By the VVF clients
 - f. By the community at large
24. What are the various successes recorded by the programme?
25. Do you think that the programme has contributed to increase utilization of services by the pregnant women in the community? Why?
26. What are the opinions of the women with respect to quality of EmOC services provided by the selected health facilities?
27. Do you think that the incidence of VVF in this community is on the increase or decrease? Explain
28. Do you think that the programme has improved the participation of males in the maternal health issues? how
29. If on the decrease do you think that programme has contributed to this decline? How?
30. What the various challenges/ problems associated with the programme
31. What recommendations do you have on how to improve and scale –up this programme

Appendix 2

Focus Group Discussion Guide for Community educators (To be administered to both male and female groups)

I. Preliminaries

A. Introduction: Welcome participants. Describe what FGD is – a group discussion that allows you to discuss among yourselves the topic rather than talking to us.

B. Purpose/Modus Operandi: We will be discussing your participation on health as it affects women in your communities especially as it relates to VVF. We are interested in all your ideas, comments and suggestions. All comments both positive and negative are welcome. Please feel free to disagree with one another. We would like to have many points of view. (WE WOULD WANT YOU TO DISCUSS ALL THE ISSUES AMONG YOURSELVES).(Explain use of audio tape) All comments are confidential and for research purposes only. We would also want you to speak one at a time so that the tape recorder can pick your voice appropriately and clearly.

1. How do describe the magnitude of VVF in this community?
2. What do you think are the causes of this problem?
3. What are the various problems encountered by the VVF patients in this community?
4. Are you aware of this programme?
5. What do you know about the programme?
 - Inception
 - Promoters
 - Goals and objectives
 - Benefits
 - Target beneficiaries
6. What are the various activities conducted under this programme?
7. You are among the people selected by your communities to serve as volunteer peer health educators and community mobilisers under the project.
 - a. When and how were you identified?
 - b. When and where were you trained?
 - c. What was the duration of the training?
 - d. How many times were you trained?
 - e. Were you given some materials to work with?
 - f. Do you receive any incentive for the work?
 - g. How many communities did you cover?
8. Since your training, what activities have you carried out?
9. How many communities have you covered ?
10. How many groups/ individuals have you reached?
11. What kind of information were you provided with during BCC?
12. What kind of media and method used during the BCC?
13. Drama
14. Jingles
15. Video
16. Pamphlets
17. Posters
18. Radio
19. Newspapers
20. Town crier
21. Campaign

22. What type of IEC materials have you received for your activities
 - Pamphlets
 - Posters
 - Souvenirs
23. In your own opinion, to what extent has your activities as Community Educators under the project helped in;
 - a. Improving knowledge about maternal health
 - b. Understanding of complications of pregnancy, delivery, perpeurium,
 - c. Understanding of family planning
 - d. Improving knowledge and perception of people on VVF
 - e. Stigma reduction as related to VVF
 - f. Reduction of VVF in the community
 - g. Increase in utilization of maternal health services
 - h. Increase in uptake for VVF services (preventive, curative and rehabilitative)
24. What is the level of participation and support by men in this project?
25. How do you describe the influence of this programme on male participation in maternal health issues? Explain your experiences?
26. What is your opinion on the activities of the trained providers in the health care providers under this programme?
27. Referral/Transportation services are other components of this programme; how has it operated so far. Is there any link with you Community Educators?
28. Another component of this programme is skill empowerment of women; how is this activity being operated?
29. What are the various and activities and success recorded in this empowerment activity.
30. What are the various successes recorded by your activities and the programme in general?
31. What are the opinions of the women with respect to quality of EmOC services provided by the selected health facilities?
32. What the various challenges/ problems associated with the programme
33. What recommendations do you have on how to improve and scale –up this programme

Appendix 3

Focus Group Discussion Guide for Male Groups

I. Preliminaries

A. Introduction: Welcome participants. Describe what FGD is – a group discussion that allows you to discuss among yourselves the topic rather than talking to us.

B. Purpose/Modus Operandi: We will be discussing your participation on health as it affects women in your communities especially as it relates to VVF. We are interested in all your ideas, comments and suggestions. All comments both positive and negative are welcome. Please feel free to disagree with one another. We would like to have many points of view. (WE WOULD WANT YOU TO DISCUSS ALL THE ISSUES AMONG YOURSELVES).(Explain use of audio tape) All comments are confidential and for

research purposes only. We would also want you to speak one at a time so that the tape recorder can pick your voice appropriately and clearly.

1. How do describe the magnitude of VVF in this community?
2. What do you think are the causes of this problem?
3. What are the various problems encountered by the VVF in this community?
4. Are you aware of this programme?
5. What do you know about the programme?
 - Inception
 - Promoters
 - Goals and objectives
 - Benefits
 - Target beneficiaries
6. What are the various activities conducted under this programme?
7. One of the components of the programme is Behavior Change Communication. What are the various activities conducted with respect to the BCC?
8. Has this project helped in your understanding and participation in maternal health services?. Probe for importance of ANC, knowledge of danger signs of pregnancy, knowledge and perception of VVF.
9. In your own opinion, to what extent has the project helped in;
 - a. Improving knowledge of women about pregnancies
 - b. Complications of pregnancy
 - c. Stigma reduction
 - d. Reduction of VVF in the community
10. What kind of information were you provided with during BCC?
11. What kind of media and method used during the BCC?
 - Drama
 - Jingles
 - Video
 - Pamphlets
 - Posters
 - Radio
 - Newspapers
 - Town crier
 - Campaign
12. What type of IEC materials have you received during the BCC
 - Pamphlets
 - Posters
 - Souvenirs
13. Another component of the programme is the training of Volunteer Community Educators, What kind of activities do these volunteers conducted?

14. How do you assess the performance of the volunteers trained in terms of reaching out to women and what is your judgment of the contribution in reducing the incidence of VVF in this community.
15. What is the level of participation and support by males in this project.
16. How do you describe the influence of this programme on male participation of maternal health issues? Explain your experiences?
17. If a woman wants to go to a health facility for services, does she have to take permission from her husband?
18. If a woman is who is pregnant or in labour is very sick and needs to be taken to the hospital, must her husband's permission be obtained before taking her to the hospital?
19. Have you ever accompanied your wife to the hospital for ANC, delivery, VVF services and etc?
20. Since the inception of this project, have you ever discussed with you wife the number of children to have?
21. Since the inception of this project, have you ever discussed child spacing with your wife?
22. Since the inception of this project, what assistance do men give women during pregnancy and childbirth?
23. Probe:
 - i. Financial
 - ii. Help with chores
 - iii. Accompany them for treatment
24. What is your opinion on the activities of the trained providers in the health care providers under this programme?
25. Referral/Transportation services are other components of this programme; how has it operated so far?
26. Another component of this programme is skill empowerment of women; how is this activity being operated?
27. What are the various and activities and success recorded in this empowerment activity?
28. How do you rate acceptability of the entire programme;
 - a. By the traditional leaders
 - b. By religious leaders
 - c. By the women
 - d. By the men
 - e. By the VVF clients
 - f. By the community at large
29. What are the various successes recorded by the programme?
30. Do you think that the programme has contributed to increase utilization of services by the pregnant women in the community? Why?

31. What are the opinions of the women with respect to quality of EmOC services provided by the selected health facilities?
32. What are some of the reasons that make it difficult for women in this community to go to a health facility for care during pregnancy?
33. What are the reasons that make it difficult for women to go to the health facility for delivery?
34. Do you think that the incidence of VVF in this community is on the increase or decrease? Explain.
35. Do you think that the programme has improved the participation of males in the maternal health issues? How?
36. If on the decrease do you think that programme has contributed to this decline? How?
37. What the various challenges/ problems associated with the programme
38. What recommendations do you have on how to improve and scale –up this programme?

Appendix 4

Focus Group Discussion Guide for VVF clients

I. Preliminaries

A. Introduction: Welcome participants. Describe what FGD is – a group discussion that allows you to discuss among yourselves the topic rather than talking to us.

B. Purpose/Modus Operandi: We will be discussing your participation on health as it affects women in your communities especially as it relates to VVF. We are interested in all your ideas, comments and suggestions. All comments both positive and negative are welcome. Please feel free to disagree with one another. We would like to have many points of view. (WE WOULD WANT YOU TO DISCUSS ALL THE ISSUES AMONG YOURSELVES).(Explain use of audio tape) All comments are confidential and for research purposes only. We would also want you to speak one at a time so that the tape recorder can pick your voice appropriately and clearly.

32. How do describe the magnitude of VVF in this community?
33. What do you think are the causes of this problem?
34. What are the various problems encountered by the VVF in this community?
 1. For how long have you developed this problem of VVF?
 2. What do you think are factors that contributed to your developments of the VVF?
 2. What are the various encountered y the VVF in this community?
 3. What arrangements were in place to take care of VVF clients prior to programme?
 4. Are you aware of this programme?
 5. What do you know about the programme?
 - Inception
 - Promoters
 - Goals and objectives
 - Benefits
 - Target beneficiaries
 6. What are the various activities conducted under this programme?
 7. One of the components of the programme is Behavior Change Communication. Are you aware of a group of people who go around educating people on VVF(Probe for peer health educators and any other community mobilization activity)
 8. Has the project and the activities of the Community Educators improve your understanding of safe motherhood **Probe:** importance of ANC, timing, danger signs in pregnancy, right place for delivery,
 9. Have their activities influence your understanding of VVF ? How?
 10. Is VVF curable?
 11. Is VVF preventable?
 12. Hs the project brought abut better Maternal\health services in your community? **Probe** for availability of drugs supplies, attitude of workers etc
 13. Hs the project brought abut better VVF services in your community? **Probe** for promptness of repairs, rehabilitation and preventive services.
 14. What kind of information were you provided with during BCC?
 15. What kind of media and method used during the BCC?
 - Drama
 - Jingles
 - Video
 - Pamphlets
 - Posters
 - Radio
 - Newspapers
 - Town crier
 - Campaign

16. What type of IEC materials have you received during the BCC
- Pamphlets
 - Posters
 - Souvenirs
17. Have you received treatment for VVF? Probe for place number of times, cost and difficulties encountered
18. What is the level of participation and support by your male counterpart in this project.
19. How do you describe the influence of this programme on your male counterparts in participation of maternal health issues? Explain your experiences?
20. What is your opinion on the activities of the trained providers in the health care providers under this programme?
21. Referral/Transportation services are other components of this programme; how has it operated so far.
22. Another component of this programme is skill empowerment of women; how is this activity being operated?
23. Since the time you were treated, did you receive any financial or material support from the project or any organization/group?
24. Were you given any loan/financial assistance?
25. Were you trained on any vocation? Probe for types, location, duration
26. Are you currently earning any income as a result of the above mentioned vocational training? If Yes, what is your average monthly earning
27. How has this project improved your livelihood?
28. What are the various activities and success recorded in this empowerment activity.
29. How do you rate acceptability of the entire programme;
- a. By the traditional leaders
 - b. By religious leaders
 - c. By the women
 - d. By the men
 - e. By the VVF clients
 - f. By the community at large
30. What are the various successes recorded by the programme?
31. Do you think that the programme has contributed to increase utilization of services by the pregnant women in the community? Why?
32. What are the opinions of the women with respect to quality of EmOC services provided by the selected health facilities?
33. Do you think that the incidence of VVF in this community is on the increase or decrease? Explain

34. Do you think that the programme has improved the participation of males in the maternal health issues? how
35. If on the decrease do you think that programme has contributed to this decline? How?
36. What are the various challenges/ problems associated with the programme
37. What recommendations do you have on how to improve and scale –up this programme

Appendix 5

IDI GUIDE WITH RELIGIOUS LEADERS

1. How do you describe the magnitude of VVF in this LGA?
2. How do women with VVF take care of their problems before the Programme?
3. What are the various problems encountered by the VVF clients and her family?
4. Has there been any form community effort to address the VVF problem before the programme.
5. Has there been any external support available for the addressing VVF problem before the program?.
 - a. LGA
 - b. Federal Government
 - c. State Government
 - d. International Agencies
 - e. NGOs
 - f. Philanthropists
 - g. ETC
6. Are you and other religious leaders aware of this programme in this community?
7. What level of involvement do you have in the conceptualization and implementation of the programme?
8. What do you think is this programme set out to achieve programme.
9. What are the roles and responsibilities of the traditional rulers in the implementation of the programme?
10. What are the various activities conducted under this programme?
11. What kind of supports have the religious rulers provided so far in the implementation of this programme?
12. One of the components of the programme is Behavior Change Communication. What are the various activities conducted with respect to the BCC.
 - a. Number community reached
 - b. Number of religious leaders reached
 - c. Number women reached
 - d. Number of men reached
13. In your own opinion, to what extent has the BCC helped in;

- a. Improving knowledge of women in pregnancies
 - b. Complication of pregnancy
 - c. Stigma reduction
 - d. Reduction of VVF in the community
14. Another component of the programme is the training of Volunteer Community Educators, What training activities conducted under the component of activities.
 15. How do you assess the performance of the volunteers trained in terms of reaching out people and what is your judgment of the contribution in reducing the incidence of VVF in this community?
 16. What is your opinion on the activities of the trained providers under this programme?
 17. Referral/Transportation services are other components of this programme; how has it operated so far.
 18. Please explain the participation, contribution and support of NURTW in the operation of this programme?
 19. What are the various problems associated with this referral and transport and services.
 20. Another component of this programme is skill empowerment of women; how is this activity being operated?
 21. What are the various and activities and success recorded in this empowerment activity?
 22. How do you rate acceptability of the entire programme;
 - a. By the traditional leaders
 - b. By religious leaders
 - c. By the women
 - d. By the men
 - e. By the VVF clients
 - f. By the community at large
 23. What are the various successes recorded by the programme?
 24. Do you think that the incidence of VVF in this community is on the increase or decrease? Explain.
 25. Do you think that the programme has improved the participation of males in the maternal health issues? How?
 26. If on the decrease do you think that programme has contributed to this decline? How?
 27. What the various challenges/ problems associated with the programme?
 28. What recommendations do you have on how to improve and scale –up this programme?

Appendix 6

IDI GUIDE WITH TRADITIONAL LEADERS

17. How do you describe the magnitude of VVF in this LGA?
18. How do women with VVF take care of their problems before the Programme?
19. What are the various problems encounter by the VVF clients and her family?
20. Has there been any form community effort to address the VVF problem before the programme?
21. Has there been any external support available for the addressing VVF problem before the programme?
 - a. LGA
 - b. Federal Government
 - c. State Government
 - d. International Agencies
 - e. NGOs
 - f. Philanthropists
 - g. ETC
22. Are you and other traditional leaders aware of this programme in this community?
23. What level of involvement do you have in the conceptualization and implementation of the programme?
24. What do you think is this programme set out to achieve programme?
25. What are the roles and responsibilities of the traditional rulers in the implementation of the programme?
26. What are the various activities conducted under this programme?
27. What kind of supports have the traditional rulers provided so far in the implementation of this programme?
28. One of the components of the programme is Behavior Change Communication. What are the various activities conducted with respect to the BCC:
 - a. Number community reached
 - b. Number of traditional leaders reached
 - c. Number women reached
 - d. Number of men reached
29. In your own opinion, to what extent has the BCC helped in;
 - a. Improving knowledge of women in pregnancies
 - b. Complication of pregnancy
 - c. Stigma reduction
 - d. Reduction of VVF in the community
30. Another component of the programme is the training of Volunteer Community Educators, What training activities conducted under the component of activities?
31. How do you assess the performance of the volunteers trained in terms of reaching out people and what is your judgment of the contribution in reducing the incidence of VVF in this community?
32. What is your opinion on the activities of the trained providers under this programme?

33. Referral/Transportation services are other components of this programme; how has it operated so far?
34. Please explain the participation, contribution and support of NURTW in the operation of this programme?
35. What are the various problems associated with this referral and transport and services?
36. Another component of this programme is skill empowerment of women; how is this activity being operated?
37. What are the various and activities and success recorded in this empowerment activity?
38. How do you rate acceptability of the entire programme;
 - a. By the traditional leaders
 - b. By religious leaders
 - c. By the women
 - d. By the men
 - e. By the VVF clients
 - f. By the community at large
39. What are the various successes recorded by the programme?
40. Do you think that the incidence of VVF in this community is on the increase or decrease? Explain.
41. Do you think that the programme has improved the participation of males in the maternal health issues? How?
42. If on the decrease do you think that programme has contributed to this decline? How?
43. What the various challenges/ problems associated with the programme
44. What recommendations do you have on how to improve and scale –up this programme

Appendix 7

IDI GUIDE WITH NUTRW

1. How do you describe the magnitude of VVF in this LGA?
2. How do women with VVF take care of their problems before the Programme?
3. What are the various problems encountered by the VVF clients and her family
4. Has there been any form community effort to address the VVF problem before the programme.
5. Are you and other member of your union aware of this programme in this community?

6. Is your union involved do you have in the conceptualization and implementation of the programme?
7. What do you think is this programme set out to achieve programme.
8. One of the components of the programme is Behavior Change Communication. Has your union been fully sensitized and educated on this programme? How?
9. In your own opinion, to what extent has the BCC helped in;
 - a. Improving knowledge of women in pregnancies
 - b. Complication of pregnancy
 - c. Stigma reduction
 - d. Reduction of VVF in the community
10. Another component of the programme is the training of Volunteer Community Educators, What training activities conducted under the component of activities.
11. How do you assess the performance of the volunteers trained in terms of reaching out to people in the community?
12. What difficulty do women with labour complications and VVF clients encountered before the advent of this programme?
13. Referral/Transportation services are components of the programme that you have pivotal role to play. How these activities operate?
 - MOU
 - Reimbursement
14. How many such of transport services has your union provided since the inception of this programme?
 - Daily
 - Monthly
 - Etc
15. How do you explain the level of reception of the clients at the referral facilities?
16. What are the various problems associated with this referral and transport and services.
17. What suggestions do you have on how this transportation services could be improved.
18. How do you rate acceptability of the entire programme;
 - a. By the traditional leaders
 - b. By your members
 - c. By religious leaders
 - d. By the women
 - e. By the men
 - f. By the VVF clients
 - g. By the community at large
19. What are the various successes recorded by the programme?
20. Do you think that the incidence of VVF and obstetrics complications in this community is on the increase or decrease? Explain
21. If on the decrease do you think that programme has contributed to this decline? How?

22. What the various challenges/ problems associated with the programme
23. What recommendations do you have on how to improve and scale –up this programme?

Appendix 8

IDI GUIDE FOR LGA OFFICIALS

1. How do you describe the magnitude of VVF in this LGA?
2. What arrangements are there in the LGA to take care of VVF before the Programme in terms of;
 - Prevention
 - Curative
 - Rehabilitative
 - Economic empowerment.
3. Are these programmes well conceived to address the VVF problem in the community?
4. Has there been any form community participation to address the VVF problem before the programme?
5. What other external support available for the addressing VVF problem before the programme.?
 - Federal Government
 - State Government
 - International Agencies
 - NGOs
 - Philanthropists
6. When and how does programme Commenced in this LGA?
7. What are the goals and objectives of the programme?
8. How is the programme being operated?
 - Organizational structure
 - Funding
 - Administration and management
 - Finances and expenditure
 - Reporting
9. What are the commitments, obligations and responsibilities of the LGA with the respect to implantation of the programme?
10. What are the various activities conducted under this programme?
11. What kind of supports and contributions has the LGA provided so far in the implementation of this programme?
12. One of the components of the programme is Behavior Change Communication. What are the various activities conducted with respect to the BCC?
 - Number community reached
 - Number of traditional leaders reached
 - Number religious leaders
 - Number women reached

- Number of men reached
13. In your own opinion, to what extent has the BCC helped in;
 - Improving knowledge of women in pregnancies
 - Complication of pregnancy
 - Stigma reduction
 - Reduction of VVF in the community

 14. Another components of the programme is training of Volunteer Community Educators, What are the various training activities conducted under the component of activities?
 - Number of volunteers trained
 - Duration of the training
 - Facilitators of the training
 - Adequacy of the training
 - Satisfaction of the trainee
 15. How do you assess the performance of the volunteers trained in terms of reaching out people and what is your judgment of the contribution in reducing the incidence of VVF in this community
 16. Another components of the programme is training of providers on EmOC, What are the various training activities conducted under the component of activities
 - Number of providers trained
 - Duration of the training
 - Facilitators of the training
 - Adequacy of the training
 - Satisfaction of the trainee
 17. What activities are these trained providers supposed to carry out under this programme?
 18. Has this programme improved the skills of the providers in terms of;
 - Ability to administer antibiotics, oxytocin and anticonvulsant
 - Removal of retained products
 - Assisted vaginal delivery with forceps or vacuum
 19. To what extent has this project contributed in improving access to;
 - Treatment (provide figures)
 - Rehabilitative services for women with fistula
 20. Referral/Transportation services are another component of this programme; how has it operated so far.
 21. Please explain the participation, contribution and support of NURTW in the operation of this programme?
 22. What are the various problems associated with this referral and transport and services?
 23. Another component of this programme is skill empowerment of women; how is this activity being operated?

24. What are the various and activities and success recorded in this empowerment activity?
25. How is this programme being monitored?
26. How do you rate acceptability of the entire programme;
 - By the LGA
 - By the traditional leaders
 - By religious leaders
 - By the women
 - By the men
 - By the VVF clients
 - By the community at large
27. What are the various successes recorded by the programme?
28. What the various challenges/ problems associated with the programme?
29. What recommendations do you have on how to improve and scale –up this programme ?

Appendix 9

	April 2007	May 2007	June 2007	July 2007	Aug 2007	Sept 2007	Oct 2007	Nov 2007	Dec 2007	Jan 2008	Feb 2008	Mar 2008	Year's total
Obstetric admissions													
Normal deliveries													
Vacuum deliver													
Forceps delivery													
Caesarean section													
Total													
OBSTETRIC COMPLICATIONS													
Hemorrhage (ante or post-partum)													
Prolonged/obstructed labour													
Post-partum Sepsis													
Complications of abortion													
Pre-eclampsia/eclampsia													
Ectopic pregnancy													
Ruptured uterus													
Total obstetric complications due to major causes													
Other obstetric complications													

MATERNAL DETAILS													
Hemorrhage (ante or post-partum)													
Prolonged/obstructed labour													
Postpartum Sepsis													
Complications of abortion													
Pre-eclampsia/eclampsia													
Ectopic pregnancy													
Ruptured uterus													
Total maternal deaths due to major obstetric causes													
Other maternal deaths due to obstetric													

Appendix 10

	Available in the maternity ward (Yes/No)	Available in Pharmacy (Yes/No)	Reasons for unavailability Not applicable to level of care = 1 In pharmacy/Doctor's room/office = 2 Out of stock/not available presently = 3 Other reason(s) --- (write verbatim) = 4
Key drugs (iv/i.m)			
Oxytocics (e.g. pitocin, ergometrine, syntometrine)			
Anticonvulsants (e.g. valium, paraldehyde)			
Procaine Crystal Penicillin			
Gentamycin			
Metronidazole (Flagyl)			
Ampicillin			
			Reasons for unavailability Not applicable to level of care = 1 Available in other locations in facility = 2 Out of stock/not available presently = 3 Other reason(s) ... (write verbatim) = 4
LABOUR ROOM			
Vacuum extractor			
Obstetric forceps			
Manual vacuum aspiration (MVA) set			
IV Infusion sets			
IV fluids			
Ovum forceps			

Vaginal speculum			
Artery forceps			
Suture			
Sutures with needles			
Suturing needles			
Syringes and needles			
Fetal stethoscopes			
Gloves			
Partograph			
Sterilizer			
Gauze scissors			
Curette			
Sphygmomanometer			
LABORATORY EQUIPMENT			
Microscope			
Glucostix			
Multsx			
Test tubes			
Test tubes			
Slides			