



# Qualitative Research on Communication Needs and Channels: Study Report

Assessment of Communications Needs for Obstetric Fistula Programming in Nigeria

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## **I. Overview:**

This report describes the objectives, methods, and findings of a study conducted by the Fistula Care *Plus* (FC+) Project in Nigeria. This document addresses the qualitative data collected by the study. The findings of a review of fistula patient records, inventory of communications partners, and feedback exercise on existing IEC materials are summarized in separate reports. State-specific findings are documented in individual briefs.

## **II. Objectives:**

The **Assessment of Communication Needs for Obstetric Fistula Programming in Nigeria** study was implemented by FC+ in early 2016. The study sought to identify key information gaps related to maternal health and childbirth injury prevention and treatment that need to be addressed through fistula prevention and treatment communications strategies; and the best communications channels to reach women of reproductive age and their partners, other influential household decision-makers, and women living with childbirth injuries.

The specific aims of this study were to:

- Explore knowledge about and attitudes towards:
  - Availability & use of routine and emergency obstetric care (EmOC);
  - Related health behaviors (e.g. birth preparedness, complications readiness);
  - Childbirth injuries (primarily fistula and prolapse) and treatment options for these;
- Identify barriers to and motivations for care-seeking for services that prevent and treat childbirth injuries;
- Identify existing and potential information channels for transmitting information and messages on the topics above;
- Identify partners at state, ward and community levels who can be involved in communications, health promotion and community mobilization efforts related to fistula prevention and treatment; and
- Identify geographic areas where past treated fistula cases have originated to guide the geographic focus of future communications efforts related to fistula prevention, treatment, and social reintegration.

## **III. Methods:**

The study targeted five of the 11 states where FC+ is active in Nigeria: Bauchi, Zamfara, Ebonyi, Cross River and Kwara. The study included four types of data collection: qualitative investigation at the community, health system, and policymaker level; an inventory of communications partners in each state; a quantitative review of fistula patient records; and a feedback exercise reviewing existing communications materials with community members in each state. Qualitative data were obtained through focus group discussions (FGDs) and in-depth interviews (IDIs). The Appendix provides the results of the communications material feedback exercise. A separate report provides the results of the quantitative review of patient records.

Table 1 describes the FGDs and IDIs conducted during the communications assessment. Wards/communities were selected purposively to include rural and urban/peri-urban communities in each state, focusing on wards where the project’s fistula activities are being implemented. Individuals were also purposively sampled to provide representative perspectives for their groups. Informed consent was obtained from all FGD and IDI participants.

Audio-recordings of FGDs and IDIs were transcribed by the study team in Nigeria and translated into English when necessary. A data analysis team in New York coded the transcripts using a structured codebook that was revised as new themes and topics emerged from the qualitative data. Narrative briefs were developed summarizing findings in each state and providing illustrative direct quotations from respondents. Textual data analysis was conducted using ATLAS.ti 7.

**Table 1: Summary of FGDs and IDIs**

Category	Type	Abuja	Bauchi	Cross River	Ebonyi	Kwara	Zamfara	Total
State/federal ministry	IDI	2	3	4	4	4	4	21
Community-based organizations (CBOs)	IDI		1	2	2	2	2	9
WDC members	FGD		1	2	2	2	1	8
Health facility staff	IDI		2	2	3	2	2	11
Women of reproductive age	FGD		2	2	2	2	2	10
Male partners of WRA	FGD		2	2	2	2	2	10
Community leaders	IDI		2	2	2	2	2	10
Fistula patients	FGD		1	1	1	1	1	5
Total		2	14	17	18	17	16	<b>84</b>

#### **IV. Findings:**

This report focuses on findings and recommendations that are relevant to a community-focused social and behavior change communication (SBCC) strategy.

##### A. Preventing fistula and other childbirth injuries

Community respondents displayed a great deal of ambivalence and heterogeneity in their attitudes about facility-based health services. Positive attitudes about the benefits of care

seeking often went hand in hand with preferences for traditional providers, skepticism about quality of care, and concern about a wide range of access barriers.

Women of reproductive age were often quite positive, in principle, about seeking antenatal care (ANC) and skilled care at delivery. Male community members also sometimes expressed support for facility-based delivery.

*F: Do you think a woman with normal labour should deliver in the hospital or only when a complication sets in?*

*All: Correct! Yes! The health facility.*

*R5: Yes because it prevents this uncontrollable leakage of urine (than to let her continue to labour and delivery mechanism get damage and it becomes a case to be repaired later on.*

*R2: If they go to the hospital on time, it will prevent them from getting fistula. [FGD, Zamfara, urban men of reproductive age]*

Fistula patients in particular emphasized the importance of spending money on hospital care in order to keep women from “dying unnecessarily” and discussed seeking skilled care in very positive terms. This was notable given that several fistula patients identified neglect and delays at the health facility as factors in causing their condition (see Section B below); this finding suggests that, despite the negative experiences they may have had, treated fistula patients may be effective champions in SBCC strategies.

Both community members and health facility staff described several issues that act as barriers to seeking and receiving services that can prevent fistula and other childbirth injuries. Frequently-cited barriers that could be targeted by community-focused SBCC include:

- Poor birth preparation
- Low awareness about health services
- Requiring husbands’ permission to seek care/disapproval of care seeking from husbands and other family members
- Preference for traditional birth attendants (TBAs) and techniques
- Expectations attached to gender roles, such as:
  - Being “not a woman” if not participating in “natural” birthing processes
  - Greater pride among husbands when women deliver at home
- Belief that only God has control over birth processes and outcomes
- Lack of confidence that health facilities can provide an adequate standard of care

Notably, both community members and health system personnel emphasized ANC as essential in preventing fistula, often giving it greater priority in their comments than skilled care at birth or emergency obstetric care. Some respondents noted that “registering at the hospital” if pregnant was a preventive strategy. This may indicate that women who have sought ANC have a false sense of confidence that they are not at risk and/or that potential complications can be definitively identified

during ANC. This has important implications for SBCC, requiring messages that highlight skilled care at labor and delivery, rather than implying that ANC is adequate for the prevention of fistula and other childbirth injuries.

In multiple states, women of reproductive age described preparing for birth, for example through purchasing materials such as razors, baby clothing, food and blood. Fistula clients stated that there had been no taboos against preparing for birth. Despite the generally positive views about facility care-seeking and birth preparation expressed by community members, health system personnel and policymakers felt that families don't prepare well and only seek skilled care at health facilities if they experience danger signs before or during labor. For example, in Bauchi, women were described as "waiting until they are very weak" to see care in a hospital. In Cross River, state government respondents felt that women were impeded from facility delivery by cultural issues, religious beliefs, and other social barriers. For example, it was reported that church members often do not want to give birth at a health facility:

*They get to church that put prophecies, some of them, the church would tell them that if they give birth in the hospital, that the baby would die so those intimidation facts keeps them in church and at the end of the day, they lose either the baby or find themselves with fistula.*

*[IDI, Cross River, state government representative]*

Two other aspects of childbirth injury prevention were discussed by community and health system respondents: early marriage and family planning. Underage marriage was described by many respondents in Bauchi, Cross River, Kwara, and Zamfara as a known cause of birth injuries and spoken of negatively. In Ebonyi, some respondents suggested that early marriage was a response to (or preventive of) immoral behaviour by girls. Across states, community leaders suggested that lack of awareness contributed to the persistence of the practice and that the government should raise families' knowledge about the risks of early marriage.

Both positive and negative attitudes towards family planning were described by respondents. A number of community respondents, notably in Ebonyi, Kwara, and Zamfara, described benefits from family planning, such as improved health and reduced poverty. However, cultural and health concerns were identified by many respondents, all of which have implications for SBCC related to family planning. In Bauchi and Zamfara, concerns about family planning among Muslims were noted, specifically a fear that the goal of contraception is limiting the size of this community. Across states, numerous respondents described a fear of the effects of modern contraception, including that contraceptives may make a woman ill or infertile; interfere with the number of children a woman was fated or ordained to have; and/or cause specific side effects such as weight gain, prolonged menstrual bleeding, or lack of menstruation for many months.

Respondents also described gender dynamics that undermine family planning uptake – for example, men in Cross River noted that a woman using family planning is exerting control, whereas men should

be the household decision makers. Women in Cross River noted that men and community leaders do not support family planning and that it can cause a “problem in the house.” Similarly, in Zamfara respondents suggested that women generally accept family planning, but that men frequently do not – an urban respondent described a woman in his ward using family planning without her husband’s knowledge, leading to divorce. Even in Kwara, where the majority of respondents said that community leaders are supportive of family planning, a male respondent suggested that contraception might promote promiscuity. In Ebonyi, respondents identified a friction between the ideal number of children and preserving a woman’s health.

All types of respondents also identified numerous barriers to adopting behaviors that prevent fistula and other childbirth injuries that are outside the scope of SBCC strategies, such as geographical, financial, and transportation challenges and facility shortages (e.g., lack of doctors, drugs and supplies, blood, ambulance drivers, 24/7 opening, and reliable electricity). Poverty and distance in particular were cited repeatedly as preventing women from seeking or reaching timely care. Respondents noted that financial barriers persisted even when services were free, as supplies had to be purchased and the expenses required at health facilities were variable and unpredictable. Additionally, some respondents were skeptical that medicines provided at health facilities are effective.

*Women often skip the time they need to visit the health facility.... some women say that the drugs are ordinary chalk.*

*[FGD, Ebonyi, Rural men of reproductive age]*

Notably, policymakers, health system representatives, local government officials, and community members across states also identified health worker attitudes as barriers to use of ANC and skilled care. This was linked to preferences for TBAs, who are described, in Cross River for example, as kinder than nurses or other health providers. While this report focuses on findings and implications for community-focused SBCC, behavior change activities can also target health workers, who comprise a “community” as well.

*Even though LGA [local government area] helps in raising awareness, there is some heavy handedness in the way the nurses work in their facilities. Some show bad attitude and sometimes harass women with unpleasant words, and you know women do not tolerate such things.*

*[IDI, Bauchi, community leader]*

Together, health facility and system shortages and negative attitudes from caregivers combine to create a lack of confidence among some community members that facility-based preventive services are worth the effort and cost. While SBCC strategies can combat incorrect perceptions (e.g., about fake medications) and improve awareness of health services that can prevent fistula and other childbirth injuries, messages must be realistic – it is not appropriate to create false expectations about available care.

## B. Awareness and local description of fistula and other childbirth injuries

Across respondent groups, many individuals expressed awareness of fistula. However, sometimes the depth of knowledge was very limited, with individuals having heard the term fistula or VVF at a community outreach event but not knowing much about its meaning or context.

*F: Have you ever heard of the problem of obstetric fistula?*

*R4: Is it VVF? There was a time somebody came to our church and announced that those suffering from it should go to Calabar for treatment. We only heard like that but we don't know what it is.*

*[FGD, Kwara, rural WDC members]*

Knowledge of prolapse was far more limited, including among federal and state government representatives. However, when the symptoms were described, some respondents (e.g., male partners in Bauchi) agreed that they had heard of this problem. Some respondents who were aware of prolapse cited traditional beliefs about its cause (e.g., witchcraft in Ebonyi).

Community respondents provided a variety of local terms for fistula and prolapse, summarized in Table 2. In several states, multiple terms were suggested for fistula. Some respondents knew of fistula as “VVF” but felt that there were no specific local terms. It is important to note that many of the terms given for fistula are literally phrases denoting incontinence, rather than descriptions of the specific, physical/anatomical nature of fistula. This has important implications for SBCC messages and community-based case finding.

**Table 2: Local terms for fistula and prolapse**

State	Fistula terms	Prolapse terms
Bauchi	<ul style="list-style-type: none"><li>yoyon fitsari (most common)</li><li>yahade</li></ul>	<ul style="list-style-type: none"><li>albasa (“onion”)</li><li>kabarmahaifa</li><li>jaka</li><li>gwaiwar mata</li></ul>
Cross River	<ul style="list-style-type: none"><li>ati nyebetia (literally, “broken urinary passage”)</li><li>ikem/unong ikem</li></ul>	<ul style="list-style-type: none"><li>akposong ubia uma (“strong labor”)</li></ul>
Ebonyi	<ul style="list-style-type: none"><li>oya mgbapu akpa mamiri (“perforated bladder”)</li><li>afunwanyi (more general term for obstetric problem)</li><li>onye ike na ana ana (“leakage of urine”)</li></ul>	<ul style="list-style-type: none"><li>ochenwa</li></ul>
Kwara	<ul style="list-style-type: none"><li>ito jijo ati igbe jijo lati oju ara obinrin (literally, “leaking of feces and urine from the private parts”)</li><li>atoole (bedwetting)</li></ul>	<ul style="list-style-type: none"><li>oyorobo/orobo (rectal prolapse)</li><li>oyodi</li></ul>

	<ul style="list-style-type: none"> <li>• ile ito ati ile igbe japo/mo ara won (bladder and rectum link together/linked with uterus)</li> </ul>	
Zamfara	<ul style="list-style-type: none"> <li>• yoyan fistari</li> <li>• gwaiwa mata</li> <li>• several participants appeared to refer to yakan gishiri, the ‘salt cut,’ as a term for the condition of fistula as well</li> </ul>	<ul style="list-style-type: none"> <li>• dakalin mata</li> <li>• nama zai fito a gaban ta (literally, “meat will protrude from her vagina”)</li> <li>• naginza</li> <li>• fitar gaba</li> </ul>

In describing the cause of their fistula, a number of fistula patients described prolonged labor, ranging in duration from 1.5 to 5 days. Notably, several fistula clients across states described laboring in the hospital without adequate care and developing fistula subsequent to delivery. They described not being informed about the risks to themselves and their babies, being left alone for many hours, and delays in receiving surgery or other care. Several patients noted that “the doctor was not around” during their prolonged labor.

In Bauchi, Cross River, and Kwara some attributed their fistulas to mistakes during surgery (including prolapse treatment), episiotomy, and other interventions by providers. At least one woman in Kwara described her leakage as following catheter removal, but it is unclear if she believed that the catheter caused the fistula, or was merely describing that leakage became evident after the catheter was removed.

*R3- when my baby was 2 years, I had prolapse & operation was done then after that urine began so they said that part of my ileito (bladder) was cut.  
[FGD, Kwara, fistula client]*

*R2: Like for me, when I got pregnant, I went to the hospital, I laboured for 5 days, so the baby head press my bladder, from there I had fistula.*

*R2: Some doctor because of mistake can cut you and you get fistula.*

*R10: Me I laboured for 5 days, my baby was in a corner, when the facility staff inserted his/her hands, I then had fistula  
[FGD, Cross River, fistula client]*

Some women attributed their fistula to injuries sustained during traditional cutting (*yankan gishiri*), including in labor (*zar-zar*). In Kwara, government representatives also blamed some fistula cases on aggressive cutting by TBAs to facilitate delivery during prolonged labor, especially among younger mothers.

*Yes you know I mentioned to you that during delivery that if the child is so small and the reproductive organs are not yet fully developed, you know it will be very difficult for the child to pass and eh if the delivery is taking place at home, you know like the TBAs that are*



*not trained, they will just... cut the vagina the way they think they should cut it and this... during the process of cutting, they can mistakenly cut the bladder or perforate the rectum.*  
[IDI, Kwara, state government]

Health systems personnel in Cross River noted that some women believe their fistula has been caused by “powers” such as witchcraft; this was affirmed in WDC interviews. Community respondents in Bauchi and Zamfara also attributed fistula and prolapse to evil spirits (“jinns”). In Kwara, a respondent attributed fistula to insufficient urination during pregnancy, described as “keeping urine.”

While barriers that can be addressed by SBCC strategies are not the sole causes to which patients ascribe their fistula, such issues often play a role. For instance, one patient in Kwara emotionally described the combination of poor medical advice, cultural barriers, and access challenges that led to her developing fistula:

*When I start labor I was taken to hospital in my town, when examine the doctor said yet there is till time, that I should come back all this happen in the night and I was taken back home. I wanted to follow my parent but my husband did not allow me to do that, around 12:00 am mid-night labor start seriously and there is heavy rainfall at time he cannot take me to hospital that moment. Due to the prolonged labor I had, I find myself in this condition (crying).*  
[FGD, Zamfara fistula client]

### C. Treatment seeking and access for fistula and other childbirth injuries

Across states, many community respondents knew generally that fistula can be treated at a hospital; some referenced surgical repair. Some community respondents were able to name specific facilities providing fistula repair. While federal policymakers referenced non-surgical treatment of fistula, this option was not described by other types of respondents.

Fistula clients themselves said that they learned about the treatment site where they were interviewed from a variety of sources, including family members, friends, radio, posters at clinics, medical providers, and prior facilities where they had sought care. Some respondents described being referred through multiple health facilities before arriving at a fistula treatment center.

Some respondents seemed unaware that treatment is available for fistula and prolapse, or lacked knowledge of what treatment entails. Some described treatment approaches that would be ineffective or potentially harmful. This confusion or lack of knowledge seemed particularly pronounced for prolapse, including among state government representatives.

*Yes we use to hear it [prolapse], is coming out of the uterus from the vagina, to some extent... A women need to call her fellow women to come so that they will wash it and push it back.*  
[FGD, Zamfara, rural men of reproductive age]

*F: To your knowledge, where can this type of problem be treated?*

*R4: Most of the time you will see that they heat it up with the intent that it will retract back into the womb this is done at home. But in the hospital, what is done is different. [FGD, Zamfara, urban men of reproductive age]*

*F: To your knowledge, where can this type of problem be treated?*

*R: It can be treated with drugs, I don't know the name of the drugs.  
[IDI, Cross River, state government representative]*

In Ebonyi, one respondent also noted that inadequate health services and misinformation from health providers acted as a barrier to treatment.

*... but most times, the doctors are also the problem. The doctors in a bid to make their own money. Let's assume a woman has fistula and when she came down with it, the doctors will tell her not to worry, "I can handle it" and you will find out that this doctor will mess up this woman up, not even messing up you know because at the point of conducting that surgery, a lot of muscle are being damaged and she will go in for the first surgery, second and third and you know it third doctor kept assuring her, don't worry, we are on it, noting will happen and all that. She will relax and before you get to the right place, you know a lot of things might have damaged. So the doctor or health practitioners should also be sensitized or should be educated either because there is need for timely referral. They should just refer immediately. It's not about making money because they have destroy a lot of women because most times, by the time the women come her, they will stay irreparable and all that.*

*[IDI, Ebonyi, health facility staff]*

#### D. Stigma and social experiences of women with childbirth injuries

Women with fistula were widely reported as being shunned and marginalized by communities and families. After developing fistula, women frequently suffered a cascade of difficulties, including being abandoned by their husbands, rejected by communities, and experiencing widespread social avoidance and isolation. In some settings, women with fistula were not allowed to participate in religious ceremonies or community activities, denied everyday social interactions, and treated as 'contaminated.'

*Such person is highly avoided because we are afraid of being infected or contaminating from such person. In fact, we don't collect anything from them as they are always covered with urine.*

*[FGD, Ebonyi, urban men of reproductive age]*

*F: In your community, how would family members treat a woman living with the problem of continual leaking of urine/feces? How would other community members treat such a woman?*

*R6: She will be separated away from others and they will try to avoid her because she will be smelling.*

*R3: What I believe is that they will say because she has done something bad.*

*R7: Some will even say it's an attack or arrows.*

*R10: May God not allow that in this community people will not even want to patronize her if she sells food.*

*[FGD, Kwara, rural men of reproductive age]*

*... they use to... tell me not come closer to them and when I sit on the chair nobody will seat close to me (crying)... and also in my house my step mother doesn't allow me to go closer to her it is only my mother that sleeps with me in the same room. [FGD, Zamfara, fistula client]*

However, some women with fistula reported that they were still treated well by spouses or family members. One FGD respondent recounted that he had taken his daughter multiple times to different hospitals for fistula repair. Interestingly, a health facility representative in Ebonyi, where community reports of stigma against women with fistula were quite strong, contested the belief that women with fistula would be stigmatized. He reasoned that fistula is a non-communicable, curable physical condition and argued that there should not be “any difficulty in getting them reintegrated into the community because such fistula is not stigmatized disease.”

Some community members also expressed compassion and support for women with fistula.

*F: In your community, how would family members treat a woman living with the problem of continual leaking of urine/faeces? How would other community members treat such a woman?*

*R8: We pity them.*

*R1: We do not discriminate against them, in fact we advise to go to hospital, explain their problems and seek treatment.*

*R2: It is really pitiful situation. She (VVF patient) will have to keep changing dresses frequently because they get wet very easily.*

*R10: I can only sympathize with her.*

*Multiple respondents: We pity them. If we see any, we will advise them to come to this clinic, register their names and surnames so that we could link them up.*

*[FGD, Bauchi, urban women of reproductive age]*

#### E. Messages, channels, and targets for SBCC activities

Previous SBCC campaigns appear to have had an impact on care seeking behaviors. Respondents in FGDs spoke about “before and after,” where previously women would resist seeking skilled care, but after being educated or made aware of the benefits of services, would actively seek them out. Past community outreach and health education by community health workers was frequently mentioned in relation to awareness of facilities and services available. Respondents described several current means of providing information relevant to the prevention and treatment of fistula and other childbirth injuries, including jingles and “pep talks” to disseminate information at health centers. However, it was noted that health centers are difficult to get to, particularly just to receive information.

Respondent suggestions for **SBCC content** focused on preventive messages, including the reduction of child marriage. In terms of treatment, reducing the stigma and shame associated with fistula was cited as key to encouraging care seeking, accompanied by information on the appropriate health care providers available to refer women with fistula.

Respondents offered thoughts for **SBCC target groups** for messages and materials. Across states, many respondents suggested that it was important to target men, given their essential role in care-seeking decisions. From a practical perspective, some respondents also noted that women in traditional communities might have limited contact with those outside the household, heightening the importance of information transmission through males. The potential ancillary impact of targeting men on reducing stigma was also discussed.

*Another thing involvement of the male factor in this most cases you find out that when you target this women you're only targeting those women on treatment you really to organise men and tell men to go whenever you see somebody who divorces his wife as a result of the wife having VVF why not you call that man and you sit him down and campaign against that, 'stay with your wife take care of her when you marry her from her parent you take her good and healthy why is it now that she is having so so and so so you're rejecting her.' If you can involve male factor in this and then we have their participation aggressively you know you find out even the stigma itself will reduce.  
[IDI, Zamara, state government representative]*

Some respondents suggested maintaining a wide scope for SBCC messages, aiming them at all concerned parties: government officials, community leaders, health care providers, community members and those especially vulnerable to childbirth injuries. A health provider from Abakaliki suggested targeting girls starting at the secondary school level to dissuade them from using TBAs when they became pregnant.

Respondents in each state suggested **SBCC channels, influencers, and partners** to disseminate messages, including the individuals in each community who were perceived as the most influential. Most respondents focused on channels for prevention messages – family planning, early marriage, and care seeking during pregnancy and at delivery.

- *Bauchi*: Most respondents suggested radio and town criers as the best channels to transit SBCC messages. Women of reproductive age also suggested that ward heads, village heads, and preachers (in both churches and mosques) would be useful channels for SBCC messages related to the risks of early marriage and childbearing, along with Meyetti Allah, a group of Fulani nomads and herdsmen. Particular radio programs recommended by women of reproductive age included *Da bazarku* (With your mandate), *Duniyarmu a yau* (Our world today), *Lafiya Uwar jiki* (Health is Wealth). The Federation of Muslim Women’s Associations of Nigeria was also recommended as an SBCC channel and/or partner. Respondents noted that imams are already encouraging the use of family planning in Bauchi.
- *Cross River*: Respondents emphasized radio, although also suggesting churches, town criers, schools, and other community groups, as well as markets where people from many communities congregate. A weekly radio program on pregnancy was suggested as a good channel for SBCC messages. Fistula clients also offered themselves as “ambassadors” to raise awareness about fistula treatment. Local leaders suggested enlisting TBAs as SBCC agents for health services, rather than antagonists to the health system. Because of a lack of collaboration between fistula treatment centers and other health facilities, it was noted that outreach and messaging should go “straight to the clients” rather than through intermediary facilities. Respondents identified religious leaders and chiefs as the most influential individuals in the community.
- *Ebonyi*: CBOs were cited as reliable and effective channels of conveying information, whereas mass media channels, such as radio or television, were less commonly proposed. Churches religious leaders were mentioned as being influential sources of information, perceived as carrying more weight than other channels. Community-based sensitization, using meetings or a ‘town crier’ were seen as current and effective means of disseminating information about health and social issues.
- *Kwara*: Many respondents indicated a desire for the government to be involved in raising awareness about fistula, birth injuries, and prolonged labor. Suggestions for other actors to transmit SBCC messages included health centers, community leaders, town criers, government members, parents, television programs, and radio programs. Chiefs and religious leaders were cited as the most influential community members.
- *Zamfara*: Community-based health workers and radio were frequently mentioned as avenues for SBCC messages. Community health workers were described as bringing the advantage of personal contact, in addition to being embedded in the communities they serve, providing a steady presence to motivate women to care-seeking behaviors. Traditional community and religious leaders were identified as among the most influential individuals.

Across states, respondents suggested that traditional and religious leaders in the community be mobilized to disseminate SBCC messages, particularly those related to preventing childbirth injuries and those targeted to men. Additionally, while people may be receptive to messaging they hear from other channels, many respondents felt that messages from traditional community leaders carry more weight. Women in Bauchi reflected this attitude.

*F: Who do you think is well positioned to raise awareness about the risks of early marriage and early childbearing for women’s health?*

*R1: Ward heads and village heads are best positioned to talk about this. In addition you can involve the radio house. You know, such things need to start from the leaders, my sister.*

*R10: Preachers. I believe if well enlightened the preachers can also enlighten their followers. That way, we can make progress on early marriage.*

*[FGD, Bauchi, rural women of reproductive age]*

Perhaps due to most community members' focus on prevention, women with fistula were not suggested as SBCC channels by most other types of respondents. However, fistula clients themselves expressed interest in and specialized capacity for this role.

*F: Given that these childbirth injuries are often hidden by women and their family members, who, in the community is best positioned to identify women living with these problems and advising them about where to seek help?*

*R2: Its people like us that have had these problems that they should meet because it is those chiefs that will expose you. I am from Boki and if affected people from that area talk to me, I can keep the secret and direct them to where to get treatment.*

*R8: I have brought somebody to this facility. Client ambassadors are best.*

*[FGD, Cross River, fistula clients]*

"Negative influencers" or barriers to adopting behaviors to prevent or treat childbirth injuries were also identified. Men most frequently cited as such barriers, although always described as having the potential for positive or negative influence (similar to religious and traditional leaders).

*... as for me, I think even men are the source of their [women's] problems. They don't allow their wives to attend antenatal care clinics and the problems starts from there. They have the means but won't allow the pregnant woman to go for antenatal care. But they will follow tradition and culture instead of the going to the health facility. This is how they make the women not to think of use of the health facility. But we have to intensify awareness so that they can allow their wives to keep coming for ante natal care clinic. So the problem is from the men and not from the women.*

*[FGD, Zamfara, urban men of reproductive age]*

In Kwara and Zamfara, several respondents also described traditional providers as having a negative impact on care-seeking behaviors.

*In Kwara, we have this type of problem of "ALAGBO" (Herbs seller) especially when they are pregnant... the alagbo deceives them.*

*[FGD, Kwara, urban men or reproductive age]*

*...the traditional skilled birth attendant will try her best to see that the pregnant woman did not go to hospital, because most of the Hausa people none of them want to marry the woman that don't want to deliver at their homes.*

*[IDI, Zamfara, rural community leader]*

The inventory of communications partners in each state (summarized separately) also provides information on potential SBCC channels and partners. Notably, across states, respondents demonstrated limited awareness of the FC+ project. At the federal level, respondents did not know of state or national interventions regarding birth injuries. In some states, government representatives were not aware of initiatives to address birth injuries. In Ebonyi, there was discussion of initiatives under the prior administration, but these were described as ended.

#### F. Initiatives to complement SBCC approaches

Across states, respondents discussed actions that would improve use of services to prevent or treat childbirth injuries. Many were outside the scope of SBCC strategies, such as free services, drugs, and commodities; increased staffing at health facilities; improved roads and infrastructure, and more health facilities in rural areas. However, in several states, respondents discussed community-based initiatives that could complement or be built into SBCC approaches. These could increase the effectiveness of SBCC by addressing some barriers discussed in Section A.

Three key types of relevant community-based initiatives were discussed: systems for pregnancy monitoring, provision of small commodities or incentives to women, and transportation support. In most states it does not appear that such initiatives are currently occurring at any notable scale.

In several states, respondents discussed the potential impact of WDC-led pregnancy monitoring and care-seeking support in preventing childbirth injuries. In Ebonyi, pregnancy monitoring efforts were in place under the prior government, but appear to have been curtailed after changes in administration. In Bauchi respondents mentioned various systems for pregnancy monitoring, from informal volunteer-led efforts to more organized efforts through the LGA.

*We have voluntary health workers that are going to house-house to identified women that are pregnant through health talk. The community may not be aware.*

*[IDI, Bauchi, state government representative]*

Several respondents suggested that addressing the costs faced by women by providing delivery kits, clothing for babies, and/or other small incentives/gifts could promote care-seeking.

*F: What would be the most effective way to promote and increase women's use of ANC and skilled birth attendants during childbirth?*

*R: State house of assembly, he donated delivery kits free that makes them to come to the hospital because you will not ask them to bring pad so I think if everything is free it will encourage them to come to the hospital and also by giving them [bed] nets.*

*[IDI, Bauchi, Health facility staff]*

Transportation barriers were mentioned across all states as hindering uptake of preventive or treatment-

seeking behaviors. In Zamfara, women mentioned an initiative to address this, but its reach and scale are not clear.

*There is ETS drivers (Emergency Transport System) I attended their meeting were the members have either motor, canter, motor-cycle etc they do services free of charge. When a woman have such complication they took her to the hospital immediately but only when they are call in time.  
[FGD, Zamfara, urban women of reproductive age]*

## **V. Implications for SBCC Strategy, Activities, and Messages**

Before considering the implications of study findings for FC+ SBCC strategies, it is important to note one caveat: FC+ community-focused work addresses prevention of fistula and other childbirth injuries as well as treatment. Therefore, the IDIs and FGDs covered a wide range of topics, from family planning to ANC and skilled care delivery to fistula and prolapse treatment options. As a result of this broad range and the sequencing of questions, more data were obtained on the prevention topics than on fistula and prolapse treatment. The findings of this study, therefore, may be somewhat more useful in guiding FC+ SBCC strategy on prevention topics. Formative research conducted through a concurrent FC+/Pop Council study on barriers to fistula treatment provides complementary information to inform SBCC related to treatment.<sup>1</sup>

State-specific recommendations for SBCC strategies are described individual briefs. However, several findings have emerged from the assessment with implications that cut across states:

- Respondents described ambivalence about preventive health services such as skilled care at delivery, acknowledging benefits but noting significant barriers to access and concerns about poor quality of care. There is a gap between expressed positive attitudes about health services and actual care-seeking practices. This gap may reflect social desirability bias among respondents, but is also likely a pragmatic response to gaps and shortages in the health system. *SBCC messages must be realistic about health system gaps and link to or integrate practical solutions to extant barriers. This is particularly important when seeking health services may be seen by community members as incurring unpredictable costs.*
- Across states and groups, respondents described the dominance of men in making decisions about family planning and health care seeking. *SBCC strategies must directly target men to improve the acceptance and uptake of preventive care and treatment for birth injuries. However, messages should also seek to promote more equitable gender norms and not inadvertently reinforce existing gaps.*
  - *Note:* Possibly due to social desirability bias, men participating in focus groups often displayed positive attitudes, ascribing barriers faced by women to others in their community. For example in Bauchi, where many respondents described men as obstacles to

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<sup>1</sup> Warren C, Agbonkhese R, Ishaku S. 2015. Formative Research on Barriers to Obstetric Fistula Treatment in Nigeria. New York: Population Council. [http://www.popcouncil.org/uploads/pdfs/2016RH\\_FistulaCare\\_Nigeria.pdf](http://www.popcouncil.org/uploads/pdfs/2016RH_FistulaCare_Nigeria.pdf)



care seeking, there was little bias, misinformation, or aversion to their wives and/or other women seeking services in the comments of the male FGD. Men appeared to be supportive, knowledgeable, and have positive attitudes towards ANC, family planning, and receiving care for birth injuries. This suggests that male-targeted SBCC strategies have to go beyond 'surface' encouragement of positive behaviors to a more nuanced, honest, and in-depth discussion of the values and processes that shape care-seeking.

- Community members frequently described their profound respect for traditional and religious leaders. However, these leaders did not always demonstrate a complete or accurate knowledge of fistula, prolapse, and other childbirth injuries. *SBCC strategies must engage and educate these highly influential community leaders, so that they can become helpful allies for behavior change and care seeking.*
- Numerous respondents expressed beliefs that family planning brings health risks and other undesirable effects, from prolonged menses to amenorrhea. Such fears may affect family planning uptake as much as cultural and gender-related barriers. *SBCC strategies should include simple and clear information about the safety and efficacy of modern contraceptives and the full range of methods available to men and women.*
- Many respondents emphasized ANC far more than skilled care at birth in their discussion of how to prevent fistula and other childbirth injuries. This is consonant with much evidence on the “fall-off” between proportion of women receiving ANC visits and those having facility-based delivery. *SBCC strategies should emphasize birth preparation for all pregnancies, the impossibility of predicting obstetric complications, and the importance of skilled care and timely response to emergencies.*
- Community respondents described significant stigma towards women with fistula, discussing fear of contamination or infection, as well as visceral aversion. Fistula clients noted concerns about disclosure by community leaders through case identification. Such stigma impedes women’s ability to participate in community outreach and case finding events, and reduces their willingness to come forward as fistula patients. *SBCC messages must promote stigma reduction across all target groups and channels of dissemination.*
- Women with fistula expressed an interest in helping link other women to care and respondents spoke of the idea of “client ambassadors.” *When possible, SBCC activities should engage treated fistula patients in community awareness campaigns, as well as case identification referral, and support activities.*
- Respondent comments indicate that, while many community members have heard of fistula or know that it is treated “in hospital,” the depth of knowledge is limited. Fistula, incontinence, and other gynecological issues are intermingled in local terminology and causal understanding. Numerous local terms were identified, even in the same state, to describe fistula, prolapse, and incontinence. *It is important that SBCC messages incorporate a range of locally-used terms to ensure community understanding and emphasize the treatability of specific conditions.*
- Women with fistula described a wide range of mechanisms through which they heard about fistula treatment, including community members, radio, and information provided at lower-level health facilities. *SBCC messages must be “multi-channel,” to ensure coverage across the different segments of community populations.*

- Prolapse is less well understood than fistula. Community members described a variety of potentially harmful ways to treat prolapse. *SBCC messages about childbirth injuries should incorporate information about prolapse and its treatability.*

## Appendix: Feedback on Information, Education, and Communications (IEC) materials

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This appendix describes the feedback exercise on existing IEC materials in order to help address the research questions. Feedback was obtained on the materials used under the former Fistula Care project, to promote behavior related to preventing and addressing obstetric fistula.

### Methodology

The feedback exercise examines: content, comprehensibility/terminology, acceptability, effectiveness in delivering intended messages to the target audience, and appeal to community members. It targeted community members in Sokoto, Zamfara, Ebonyi, Cross River and Kwara. Respondents include CBOs, WDCs, health provider, media representatives, community members, religious and traditional leaders and also participants of the IEC materials review workshop. Table 1 below describes the number of discussions conducted during the review. Individuals were also purposively sampled to provide representative perspectives for their groups.

**Table 1: Summary of feedback exercise respondents**

Category	Total
CBO members	5 persons individually and 3 groups (of 5 persons each)
WDC member	2
Health provider	2
Media representative	3
Community leaders	2
Religious leader	5

### Findings from the feedback exercise.

#### 1. Comprehensibility

Respondents found the overall content of the materials to be clear, simple, appropriate and self-explanatory. Most of the respondents emphasized that the materials encourage women to go for antenatal care (ANC) and promote family planning to reduce maternal health risk.

An exception was the FGM/C posters: When asked, *“What are the main messages in these IEC materials – what behaviors do you think these materials are trying to promote?”* some respondents thought the graphics do not convey the messages clearly, although the text attempts to discourage the practice.

When asked, “Do the photos/drawings used in the IEC materials clearly illustrate and support the messages? If not, what would you change about these pictures?” most of the participants thought the pictures were clearly illustrated across IEC materials, with some minor suggestions for revision:

- ANC materials:
  - *“The Nurses in one of the posters are dressed like religious white garment worshippers or sect that should be corrected.”*
- FGM:
  - *“No, it does not. The woman should be holding a female child and using her hand to say no to a barber surgeon standing with the woman.”*
  - *Show both males and females doing the cutting.*
  - *Don’t overcrowd the background.*
- Family planning:
  - *Consider illustrating the benefits by showing a family that used FP and a family that didn’t.*
  - *Use pictures of local people.*
  - *Add a fistula patient and photos including husbands assisting their wives to encourage male involvement*

## 2. Terminology & Acceptability

Community members and leaders found the terminology to be appropriate and accepted.

Many respondents wanted the materials to be further translated into local languages as several of the study states speak multiple languages. In Cross River several participants wanted the materials to be translated to native languages of Efik, Ibibio, Ejagham and Bekwarra instead of Efik. Both community members and leaders described several local terms for project intervention areas and made recommendations for terminology. For example, the term “*ciki*” should be replaced with “*juna biyi*.” Frequently-cited local terms include:

<b>Terms</b>	<b>Hausa</b>	<b>Igbo</b>	<b>Yoruba</b>	<b>Bekwara</b>	<b>Efik/Ibibio</b>
Fistula	Yoyon Fitsari	Ikwado ezi n’ulo	Aani Ijapo Ile	Ebibere	Ndudu Idiok Itie
FP	Tazarar haiwuwa /Iyali	Nshi	Ifi etosone	Euban Agunnni	Eti Ini Uman
Urine	Fitsari	Mamiri	bini	Ebetia	Ikim

Faces	Bayan Gida/Kashi/bahaya	Nsi	ito	Abung	Ifuor
Bladder	Mafitsara	Akpa Mamiri	igbe	Iyebetia	Ekpad Ikim
Obstructed Labour	Dogumar Naguda /Toshewar mahaifa	Ndochi	Ijeetoide no ibimo	Ujuan akanni	Idiok Uman
Uterine prolapse	Gwaiwar mata/Fashewar or hudewar mahaifa	Omumu	Yiyi jade ile tumo		Iduo Idip Uman
Perineal (genital) terms	Kachiyar mata/yagewar fargi /yankan gishiri	Ngbawa Ike nwanyi	Yiya gu ara	Eba ki Iyanfo eyinye	Nwagha Itie Uman

Most of the respondents in the north wanted “*family planning*” to be substituted with “*child spacing*.”

Respondents recommended depicting local attires native to the community, e.g. of local working people. Most respondents found the clothing used in current materials culturally sensitive and acceptable

### 3. Appeal

Notably, both community members and leaders find the documents to be appealing to sight and self-explanatory, although a number of the participants suggested the use of brighter colors, such as white, as some of the tools are not visible like those in the FGM posters. Across states some respondents described the colors as not been attractive and appealing to the eyes.

Some suggested that the fistula poster might inadvertently reinforce stigma as it shows people closing their nose as the patient passes by to the fistula treatment center.

### 4. Effectiveness

Most respondents found the materials to be effective and to improve their knowledge. Some mentioned that the materials have enabled them make a behavior change, particularly in adopting modern FP methods, skilled birth delivery and stopping FGM. To some respondents the fistula materials depict hope for the fistula clients and availability of treatment. However, a few respondents explained that although the IEC materials have improved their knowledge of fistula, maternal health and FP, it has not actually led to a change in behavior

### **Implications for IEC materials revision and development**

Community member feedback provides the following crosscutting recommendations:

- General acceptable local terms should be used for more clarity and understanding. Respondents emphasized the use of cultural appropriate and acceptable terms in posters.
- Use brighter and more visually appealing colors.
- Use simple, uncrowded messages to provide clear information.

As materials are updated to reflect the findings of the main qualitative portion of the study, these community recommendations will also be incorporated.