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MIDTERM EVALUATION OF THE FISTULA CARE PROJECT

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ACRONYMS

AOTR	Agreement officer's technical representative
ANC	Antenatal care
DHS	Demographic Health Survey
DRC	Democratic Republic of the Congo
EH	EngenderHealth
EmONC	Emergency obstetric and neonatal care
ECSA	Southern African Health Community
ESD	Extending Service Delivery
FC	Fistula Care
FGC	Female genital cutting
FIGO	Federation of International Gynecologists and Obstetricians
FMOH	Federal Ministry of Health
FP	Family planning
GHI	Global Health Initiative
HIDN	Health, infectious diseases, and nutrition
IEC	Information, education, communication
IR	Intermediate result
ISOFS	International Society of Obstetric Fistula Surgeons
MCH	Maternal and child health
M&E	Monitoring and evaluation
MNH	Maternal and neonatal health
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Non-governmental organization
OAA	Office of Assistance and Acquisitions
OB-GYN	Obstetrics/gynecology
OFWG	Obstetric Fistula Working Group
PAUSA	Pan African Urological Surgeons Association
PMP	Program monitoring plan
QOC	Quality of care
RCT	Randomized controlled clinical trial
RH/FP	Reproductive health and family planning
RVF	Recto-vaginal fistula

UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VVF	Vesico-vaginal fistula
WHO	World Health Organization

EXECUTIVE SUMMARY

Fistula is a severe birth-related morbidity resulting from prolonged and obstructed labor (obstetric fistula), severe sexual violence (traumatic fistula), or surgical error (iatrogenic fistula). Fistula causes deterioration in tissue between the vagina and bladder or rectum (and sometimes both); and it subjects women to great discomfort, pain and embarrassing lack of control over urine and/or feces. While some women are supported by families and friends, many others suffer social isolation and are among the most impoverished members of society.

This report is an evaluation of the Fistula Care (FC) Project, a five-year global project implemented through September 2012 by EngenderHealth that represents the majority of USAID's Program for fistula treatment and prevention. The assessment was conducted by a team of four: the former and current USAID technical advisors to the project and two consultants. The evaluation methodology, which builds on a 2010 USAID Mission survey, included a review of project publications, research and evaluation reports, and technical tools and training materials, as well as interviews with key stakeholders and site visits in Ethiopia, Guinea, Nigeria and Uganda to assess implementation.

Fistula Care assists countries in strengthening the capacity of surgeons and hospitals to provide fistula repair. It also works to help countries increase access to and timely use of emergency obstetrical care; increase understanding about obstetric fistula and the steps to prevent it; provide support to women for social reintegration; and conduct research to strengthen the quality and efficiency of fistula services. The project operates in 10 countries, and previously supported an additional 3 countries through Mercy Ships. USAID also supports bilaterally and regionally funded projects in five countries. Fistula Care assists USAID/Washington in monitoring fistula activities Agency-wide and in reporting on this area of congressional interest.

This evaluation provides the United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Health, Infectious Disease and Nutrition Office (HIDN)/Maternal and Child Health Division (MCH) with an independent midterm assessment of the FC Project.

This evaluation report analyzes achievement of results through an analysis of strengths, weaknesses, lessons learned, best practices and responsiveness to the field. Findings are organized by intermediate result, highlight progress to date based on an analysis of indicators, and include a discussion of challenges and prospects for the future sustainability of project strategies. This report summarizes key findings in the conclusions, discusses lessons learned, and provides short- and longer-term recommendations about future fistula programming.

SUCCESSSES

Fistula Care provides strong global and national leadership, maintains strong working relationships with USAID Missions, and plays a critical role in collecting and analyzing data across all USAID-funded fistula activities that USAID reports to Congress. The project headquarters and country offices demonstrate strong technical, clinical, research, and managerial leadership and appear to be competently run and well respected by the USAID Missions, country governments, other donors and local partners.

The project does not set fistula repair targets, but sets yearly benchmarks, which have been regularly met or exceeded every year except for one. Between October 2005 and September 2011, USAID funds supported 22,364 repair surgeries. Fistula Care has been responsible for more than three-quarters (78%) of all fistula repairs during this period.

Fistula Care has improved the quality of fistula treatment and increased providers' capacity in fistula repair, family planning (FP), and emergency obstetric care. The project has done an excellent job of providing a consistent set of interventions through strategies and models adapted to national and local contexts. The project has adopted measurable criteria of surgical outcomes and quality, and almost all supported sites have met these criteria regularly. The project introduced a standard training curriculum for surgeons and nurses. Post-training follow through is supported by supervision and monitoring of surgical outcomes and complications.

The project's Levels-of-Care model appears to improve preventative care and promote better surgical outcomes. The model is designed to expand access to care and direct women to appropriate care based on the complexity of their fistulae. In several countries, camps or pooled surgical events facilitate the matching, access and skill-building opportunities for less experienced surgeons and nurses.

In collaboration with non-governmental organizations (NGOs) and community-based health volunteers and committees, the project has supported outreach and prevention activities to raise community awareness about fistula as (1) a treatable condition and where to find treatment; and (2) as a preventable condition with prevention messages that focus on promoting labor and delivery with a skilled provider at a health facility, delaying the age of marriage, and stopping the practice of female genital cutting (FGC).

Fistula Care has demonstrated the power of data to improve clinical practice and generate new knowledge about fistula. Through monitoring, evaluation and research, the FC Project has had a transformative impact on the fistula landscape—what is known and how to respond more effectively. Fistula Care has responded flexibly and adeptly to those changes. In addition to routine monitoring, FC has conducted or plans to conduct nine research studies, including a prospective study of fistula repair outcomes, which has significantly increased understanding about clinical outcomes and the social profiles of women living with fistula.

Fistula Care has an excellent reputation at local, national, and international levels and is seen as a positive force, both technically and as an advocate. Fistula Care has worked with national, state, and local governments to strengthen policies, guidelines, and protocols on fistula repair, as well as support reintegration and prevention; it has also supported six countries in initiating and establishing national fistula prevention and repair strategies. Fistula Care developed tools (guidelines, protocols, etc.) that have effectively standardized practices in supported centers, and have been adopted by many ministries of health as national standards of care.

CHALLENGES

Most supported countries face severe shortages of trained fistula repair surgeons and nurses, difficulty in retaining trained surgeons, and shortages of OB-GYN specialists for fistula prevention. Access to c-sections for prolonged, obstructed labor is difficult, and poor c-section practice also contributes to a significant but unsubstantiated number of iatrogenic cases.

The project has been unable to adequately address the needs of two groups of women. These include the significant number of women who exhibit fistula symptoms caused by other severe maternal morbidities (e.g., uterine prolapse or cystocele) outside the project's mandate, and those women who continue to suffer incontinence after fistula surgery. This evaluation echoes concerns raised by the project team about effectively addressing these equally devastating conditions. Upon USAID's request, the FC Project examined the literature and options to address uterine prolapse and convened experts to explore the feasibility of various responses to help women with post-repair incontinence.

While the project has greatly improved data collection and record keeping at prevention and repair centers, capacity to independently synthesize, analyze, report, and use the findings remains limited. The project has developed data for a Decision-making Training Module and applied it in some centers, which should strengthen the capacity of centers to analyze and use their data.

As USAID Missions develop their GHI (Global Health Initiative) strategies and BEST action plans, they are challenged to make strategic choices about what to support. Some Missions noted the difficulty of incorporating fistula repair into maternal mortality reduction strategies, stating that they would prefer to invest in their other projects and strategies. This has implications for the long-term sustainability of fistula programming.

RECOMMENDATIONS FOR CURRENT PROJECT

1. Develop a model for collaboration with other maternal and neonatal health (MNH) and FP programs, especially for case identification and treatment referrals.
2. Adapt community mobilization to operate in different locales depending on the preponderant provenance of fistula repair patients for each center, noting changes in patients' provenance over time.
3. Inventory all sites capable of repairs with minimal support and location of surgeons with fistula repair skills.
4. Clarify to supported centers their responsibility for adhering to women's stated reproductive intentions post repair. Women who decide to use a contraceptive method should be offered that method immediately after counseling at discharge, with clear guidance and recommendations on healing prior to resuming sexual intercourse. Discussion of and access to contraception methods should not be delayed until post-surgery follow-up visits (one to three months).
5. If the Nigeria community survey of fistula incidence aligns with recent Demographic Health Survey (DHS) estimations, inform other USAID Missions with DHS fistula data (e.g., Uganda), of the potential use for calculating estimates of incidence, and perform the analysis to set a clear baseline for country plans to significantly reduce fistula.
6. Introduce fistula screening during pre-discharge and postpartum visits for early diagnosis and treatment. This complements the planned development of a protocol for immediate catheterization for women having undergone prolonged or obstructed labor. It is a potent strategy to improve access to early treatment and thus radically diminish the rejection and discrimination suffered by women living with fistula, thereby negating the necessity for resource-intensive reintegration.
7. The community survey of the Guinea evaluation of the Levels-of-Care model is investigating the social impacts of the project's outreach and reintegration activities. Time and resources permitting, the project should use this information and some of the demographic information collected as part of the prospective study to more thoroughly analyze:
 - a. The value added of reintegration. Is it sufficient to justify continuation and is reintegration support necessary in all countries? Which women really need these services, and what services would be most helpful?
 - b. The economic and social factors that either facilitate or impede women's access to care.
 - c. The relative efficacy of mass media versus community-based outreach activities for generating demand and communicating prevention messages. Who is reached by these different approaches and helped most by them?

- d. What are the most persuasive types of prevention messages and who are the key decision makers in different contexts?
- e. What are the constraints to access women face once they become aware of the availability and location of services?

RECOMMENDATIONS FOR FUTURE PROGRAMMING

1. Expand fistula knowledge, outreach, and prevention by working more closely with other reproductive health and family planning (RH/FP) and MCH programs to better integrate fistula prevention and screening messages as well as interventions. A follow-on project could broaden adaptation and dissemination of FC tools and information, education, and communication (IEC) materials, and use postpartum maternal and neonatal visits to promote early fistula detection and intervention towards preventing new cases and limiting the backlog.
2. From a country-level health systems perspective, the next project should strengthen integration of fistula and other maternal and neonatal health (MNH) services. Several USAID Missions voiced their preference for this approach.¹ There are pros and cons to moving toward such an approach. The advantages of the current global project include (1) generating generalizable evidence on treatment practices and fistula client profiles through multi-country research; (2) producing standardized training curricula, screening protocols, supervision, medical monitoring, auditing of deaths, and program monitoring indicators; and (3) supporting international advocacy at the global level. These transnational efforts all benefit from a centrally funded global program. At the national level, however, a future program should move local actors through a process of greater institutionalization and ownership with more reliance on national skills and resources.
3. The Levels-of-Care evaluation in Guinea should elucidate the value of local governance as vital to fistula prevention and reintegration, and inform future prevention and reintegration impact evaluations. This methodology should be adapted in other countries and a broader analysis of prevention activities can compare key indicators such as uptake of FP methods and numbers of health center and hospital deliveries in FC and non-FC supported facilities.
4. Large numbers of women suffer birth-related morbidities other than fistula. Within USAID's GHI, which largely focuses on reduction of maternal and newborn mortality, HIDN should engage a panel of experts to assess how to best address maternal morbidities in its fistula or other maternal health programs, and how USAID can more actively engage other donors and national governments to address other severe birth-related morbidities.
5. In a few select countries, USAID should consider a global project design more narrowly focused on repairs and clinical prevention in order to develop and implement national fistula elimination plans. Technical assistance could focus on surgical repairs and tertiary prevention

¹ This was particularly true in Uganda and Ethiopia. In Nigeria, the evaluation team concluded that centers with more comprehensive services are likely to be more sustainable for several reasons. Fistula surgeons, for reasons related to professional growth opportunities, are unlikely to want to dedicate their career to fistula repair only. Integrated service delivery sites allow them greater opportunity for more varied practice. Secondly, integrated centers offer more opportunity for sustainability of higher quality of care (QOC), which will contribute to both fistula treatment and prevention. The improvements introduced for fistula treatment such as better record keeping, monitoring of complications, auditing of deaths, and infection control will also strengthen obstetric care, and other surgical practice if institutionalized through a whole-facility approach. Currently they are only applied to fistula care within repair and prevention sites. The fistula technical working groups are also good models for involving diverse stakeholders in strengthening the health system more broadly. Ultimately the sustainability of fistula repair and prevention services will depend on governments and the private sector working together. The public-private partnership in Uganda is an excellent example of how to make this work.

strategies, such as use of partograph to monitor labor and improve the availability and quality of c-sections.

6. Fistula Care has focused its capacity building on project-supported centers. USAID should consider an alternative or complementary approach of supporting surgeons where they practice. In doing so, some countries can add these skilled surgeons to the cadre of master trainers who train less skilled surgeons through pooled efforts or camps in their respective regions. A critical element is to also train nurses who can support surgeons during surgery and provide effective pre- and post-operative care. Exchange and collaboration across different sites can include those supported by USAID, the government, private hospitals, and other donors. USAID should assess the value of focusing on specific centers versus on specific surgeons with a demonstrated interest and opportunity to practice fistula surgery where they work.
7. Engage other HIDN office staff, particularly MNH program managers, to integrate key prevention messages and activities into other MNH technical assistance. The current USAID management team should liaise more with Mission health officers to build understanding of the FC Project's objectives at country and global levels—as well as its contributions to GHI goals and principles for reducing maternal and neonatal mortality and morbidity, health systems strengthening, and a women- and girls-centered approach.

I. INTRODUCTION

PURPOSE

This evaluation aims to provide the United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Health, Infectious Disease and Nutrition Office (HIDN)/Maternal and Child Health Division (MCH) with an independent midterm assessment of the Fistula Care (FC) Project. Fistula Care is a five-year global project—beginning on September 25, 2007, and ending on September 24, 2012. HIDN/MCH commissioned this midterm assessment to examine the project's progress toward achieving planned results and the lessons learned to date. The assessment draws from and builds on a USAID Field Mission survey conducted by HIDN/MCH to determine the need and anticipated future demand for a fistula treatment and prevention focused project. This report identifies FC activities that may warrant continued future investment, as well as other fistula prevention, treatment, and reintegration interventions not currently part of FC's current portfolio that would likely contribute to improvement of the program. The evaluation examines the degree to which planned results are being achieved: strengths, weaknesses, lessons learned, best practices, and responsiveness to the field. The questions addressed include:

- **What is the progress to date?** (From the performance monitoring plans, work plans and annual reports.)
- **What are the major challenges**—technical and managerial—to achieving results? (From key informant interviews, project documents, and field visits.)
- How has FC supported the **sustainability of strategies and interventions** to build capacity for fistula prevention, treatment and reintegration, emphasis on IRs (intermediate results) 1 and 2? (From key informant interviews, project documents, and field visits.)
- What contribution has FC made to **global leadership**, emphasis on IRs 3 and 4? (From key informant interviews, project documents, and field visits.)
- Has FC been **responsive to USAID** Missions, USAID Regional Bureaus, and other global stakeholders? (From key informant interviews, project documents, and field visits.)
- Is the project **on course to achieve its intended results** by the end of the project? (From key informant interviews, project documents, and field visits.)
- Are there **ongoing challenges**? (From key informant interviews, project documents, and field visits.)

BACKGROUND

Fistula is a severe birth-related morbidity resulting from prolonged and obstructed labor (obstetric fistula), severe sexual violence (traumatic fistula), or surgical error (iatrogenic fistula). Fistula causes deterioration in tissue between the vagina and bladder or rectum (and sometimes both). It subjects women to great discomfort, pain, and embarrassing lack of control over urine and/or feces. While some women with fistula find support from families and friends, many others suffer social isolation and are among the most impoverished members of society.

It wasn't until the UNFPA-sponsored Katherine Hamlin's² first visit to the U.S. to advocate before Congress for the allocation of funds to support fistula repairs for girls and women that the American public became more aware of the issue. UNFPA supported the Campaign to End Fistula as a means to raise worldwide awareness of the impact of fistula on women's lives throughout much of Africa and south Asia.

In 2005, Congressional language in the foreign appropriations bill prompted USAID to implement activities to support fistula prevention, repair, and reintegration in two countries, Uganda and Bangladesh, through the EngenderHealth-led ACQUIRE Project. EngenderHealth (EH) drew on its prior experience to assist in the identification of countries where fistula activities would be beneficial. EH's prior experience includes:

- **2001**—Research in Tanzania and Uganda to address the needs of women with fistula. With support from DFID, EH served as the managing partner in collaboration with the Women's Dignity Project.
- **2002**—Rapid assessments in seven countries to determine the availability and need for fistula repair services. Support was provided by UNFPA; AMDD supported assessments in two additional countries.
- **2002**—A five-year project to address fistula services. With support from Bill & Melinda Gates Foundation, EH served as managing partner in collaboration with UNFPA and Women's Dignity Project.
- **2003**—A presentation to USAID Africa Bureau.
- **2004**—A Congressional briefing on fistula in collaboration with UNFP.
- **2005**—At the request of USAID, identification of two initial countries (Uganda and Bangladesh) where fistula services would be beneficial. Work began in 2006.

In September 2007, GH/HIDN/MCH awarded the Fistula Care Project, a five-year worldwide Associate Award under the ACQUIRE Leader Award, to EH as the implementing partner.³ The Fistula Care Associate Award is designed to allow USAID Missions and Bureaus to easily access high quality and specialized technical assistance and support for their activities in fistula prevention, treatment, and reintegration as well as monitoring, evaluation, and research. USAID Missions may use traditional field support mechanisms to obtain services for the project. The agreement officer's technical representative (AOTR) resides within HIDN, and two technical advisors and a program assistant from PRH are members of the USAID management team.

The FC Project is designed to (1) assist countries in strengthening the capacity of surgeons and hospitals to provide fistula repair; (2) increase access to and timely use of emergency obstetrics care; (3) increase understanding about obstetric fistula and steps for prevention; (4) provide support to women for social reintegration; and (5) conduct research to strengthen the quality and efficiency of fistula services. The project also assists USAID/Washington in monitoring fistula activities Agency-wide and report on this area of Congressional interest.

² Dr. Hamlin is the founder, along with her husband, of the Addis Ababa Fistula Hospital in Ethiopia. During her visit, she also appeared on Oprah Winfrey's television show and is profiled in *Half the Sky* by Nicholas Kristof and Sheryl Wu Dunn.

³ The Leader ACQUIRE Cooperative Agreement was awarded to EngenderHealth as the lead implementing organization, in partnership with IntraHealth International, CARE, Meridian Group International, Adventist Development and Relief Agency (ADRA) and Society for Women and AIDS in Africa (SWAA). Under the Fistula Care Associate Award, EngenderHealth remains the lead implementing partner, with IntraHealth International providing technical assistance and leadership in two countries. All other partners are country-specific service provision partners (e.g., Mercy Ships, REF in Niger, Gloag Foundation in Sierra Leone, and private hospitals and ministries of health).

The service delivery design is based on an integrated model of prevention, repair, outreach, and reintegration components. The project's technical assistance focuses on repair and prevention activities, and provides limited support to in-country partners responsible for community-level and mass media outreach and prevention messages, and to state and local government and community groups who support women's reintegration into their communities post-repair.

FUNDING

The project has a ceiling of \$70 million. The total amount of funding obligated through June 30, 2011, was \$43,474,812, three-quarters of which supports work in the field. Fistula Care's core and field support are each funded fairly evenly from the MCH and POP accounts. The project has expended approximately \$8,000,000 per year.⁴ The project is on track to meet its cost share obligations of 10%. The allocation of core funding between 2008 and 2011 across the IRs is approximately:

IR1: Repair Services—39.75%

IR2: Prevention and Community Mobilization—15.99%

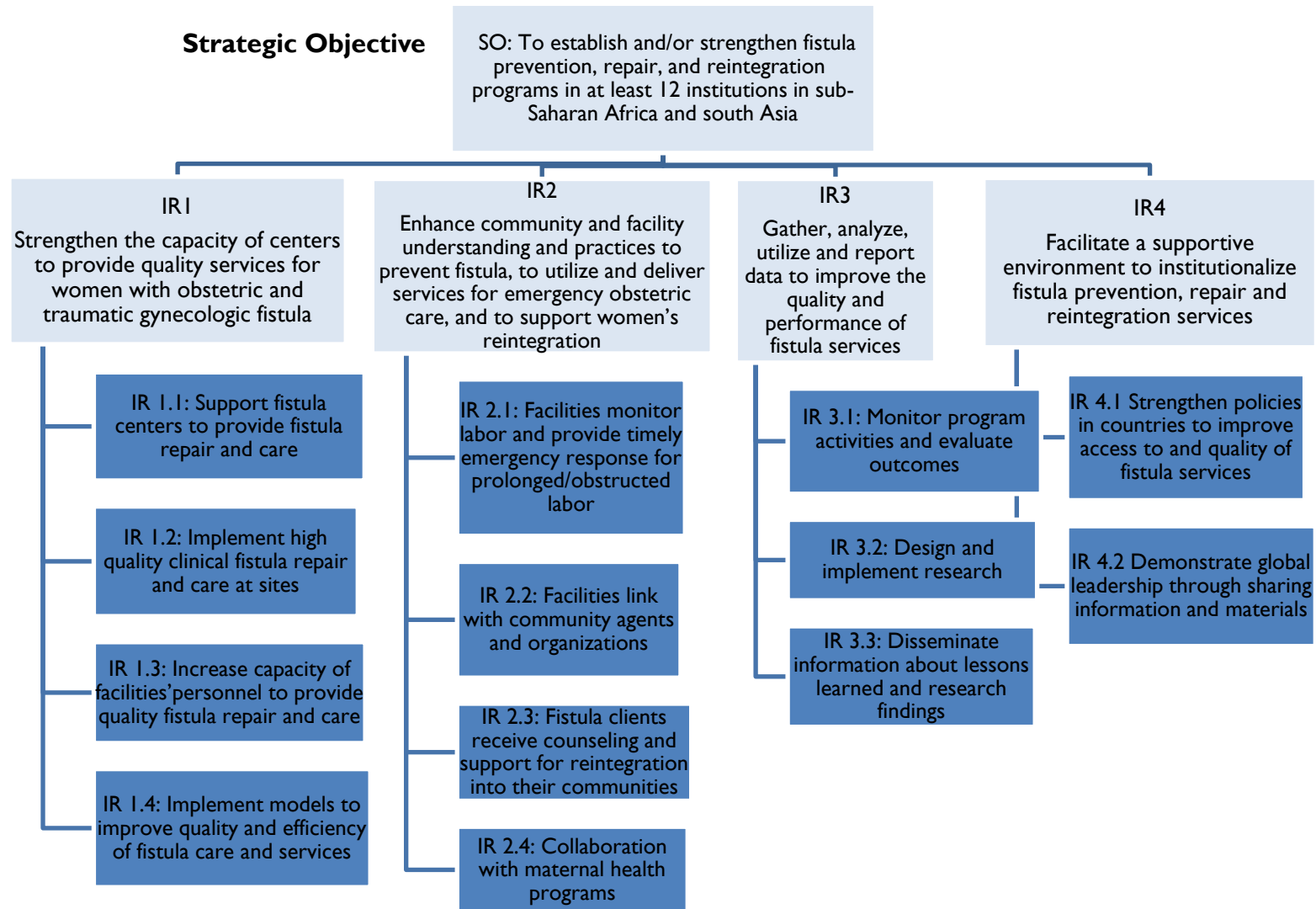
IR3: Research and M&E—30.57%

IR4: Enabling Environment—13.68%

The distribution for field support, while not easily calculable by the project, is likely to tip the balance more heavily towards IRs 1 and 2 because research, monitoring and evaluation (M&E), and advocacy functions are a greater focus of central office than national activities. USAID's total funding for fistula (including to other bilateral projects) from 2004 to June 30, 2011, was a cumulative \$59 million.

⁴ A USAID program to prevent and treat obstetric fistula has been a Congressional priority since 2004. Congress does not set a funding level, but it does keep a close watch on the funding level. Because of USAID's own concern for women with fistula and because of Congressional interest, USAID has kept overall Agency funding for obstetric fistula at approximately \$11 million per year over the past several years.

Figure 1. FISTULA CARE RESULTS FRAMEWORK



PROJECT ACTIVITIES

The project currently implements programs in 10 countries, and previously supported activities in an additional 3 countries through a sub-award to Mercy Ships. USAID also supports bilateral and regionally funded projects in five countries. The FC Project collects and reports on indicator data for all USAID bilateral and global fistula activities.

TABLE I. USAID-funded Fistula Programming Countries		
Fistula Care		Other USAID-funded Programs
Bangladesh	<u>Mercy Ships</u>	
DR Congo	Benin (2009)	Benin
Ethiopia	Ghana (2005)	DR Congo*
Guinea	Liberia (2008)	Ethiopia*
Mali	Sierra Leone (2007)	
Niger	Togo (2010)	Pakistan
Nigeria		
Rwanda		
Sierra Leone		
Uganda		
* USAID provides support under bilateral projects to DR Congo and Ethiopia, in addition to funding other activities in both countries through the FC project.		

*AIDan integrated data reports on indicator data for all USAID funded fistula activities

Project activities include:

- Upgrading facilities and providing medical equipment and supplies
- Training of surgical teams and trainers for fistula repair
- Training for health care providers in counseling for fistula repair patients prior to, during and post repair, and on how to avoid repeat fistula
- Capacity building for health care workers on fistula surgery, FP counseling and contraceptive technology, use of the partograph during labor, and EmONC (including use of catheterization as primary treatment or as prevention)
- Support to health care facilities through training and technical assistance on quality of care (QOC) through improvements in record keeping, monitoring and application of standards of clinical practice and interpersonal care

- Defraying the costs for transportation between patients' homes and repair centers, as well as for care prior, during, and post-operative follow-up visits
- Social mobilization and mass media dissemination to raise awareness in communities and health care facilities on how to prevent fistula and where women with fistula can access repair and care services
- Improving facility-based delivery and emergency obstetric care to prevent fistula, with emphasis on training nurses and doctors in the use of the partograph and quality c-section procedures
- Strengthening of partners' social and economic reintegration activities for women after repair
- Rigorous monitoring and evaluation
- Research on fistula protocols and outcomes.

A detailed list of activities and funding levels by country is found in Annex F.

METHODOLOGY

A team of four—the former and current USAID technical advisors to the FC Project and two consultants—conducted this assessment. The team used a variety of methods for collecting information and data.

The team read through the technical, advocacy and research documents, as well as annual and semiannual report provided by HIDN/MCH and PRH/SDI and the FC Project. The team also reviewed FC's Web site. The team discussed the rationale for the selection of the four countries chosen for field visits. The USAID AOTR and technical advisors provided background on the models and programs in the different countries where the project operates. A 2010 survey of USAID country and regional Missions that have worked with the project provided additional information on countries not visited. The USAID AOTR and the technical advisors decided that it was sufficient to complement the earlier survey of Missions with interviews of Mission staff during the field visits. The two consultants conducted telephone or in-person interviews with key international partners at USAID, UNFPA, Fistula Foundation, and with internationally recognized fistula surgeons.

The assessment team divided into two and each visited two countries in which FC implements substantial activities. The first team visited Uganda and Ethiopia (East Africa) and the second team went to Guinea and Nigeria (West Africa). While in-country, the teams interviewed project staff; USAID Mission PHN staff; other implementing organizations and FC partners (including national, regional, and local governmental officials, local NGOs and public sector representatives); fistula patients and their families; and community members. They also reviewed some of the service delivery records in health facilities (see Annex B for a list of people interviewed).

Following the country visits, the whole team met for two days to analyze the information collected. This analysis continued in preparation for two presentations on key evaluation findings, one to USAID staff and the other to the FC Project leadership team.

II. FINDINGS

FISTULA CARE AND USAID MANAGEMENT

The project is well managed at all levels. As the flagship project on fistula prevention and treatment, USAID looks to FC to provide strong global and national leadership. Given the high level of Congressional interest, it is also critical that the project maintain a good relationship with USAID Missions, especially as the project is responsible for collecting and analyzing data across all USAID-funded fistula activities so that USAID can report to Congress. The project has done an excellent job of collecting, analyzing, and reporting the information so as to make USAID's reporting to Congress on fistula seamless and opportune.

USAID conducts annual management reviews of the project, which offer an opportunity for sharing information and joint problem-solving. The primary challenges have been securing procurement approvals in a timely fashion and the resulting large funding pipelines. Overall, these obstacles have been overcome in the past year as a result of USAID's appointment of a project assistant, who is extremely adept at working with the Office of Assistance and Acquisitions (OAA) and has streamlined review and approval processes, expedited the flow of funds, and facilitated implementation without interruption. Both the 2009 and 2010 Project Management Reviews primarily discuss programmatic themes and not management and administrative problems, which speaks to the strength of project leadership and staff. The review also always includes a financial review, and depending on where the project is in its five-year cycle, USAID and project leadership also address other management issues like start-up, staffing, and updates related to OAA approvals.

The project benefits from strong technical, clinical, research, and managerial leadership at headquarters and in country offices. The country program offices, based on observations from the assessment team's field visits, appear to be competently run and well respected by the USAID Missions, country governments, other donors, and local partners. The country directors are highly regarded professionals with a depth of experience working on fistula in their countries. The country office staff is also highly skilled and well connected to government, professional organizations, university faculties, and non-governmental organizations (NGOs) working on fistula. As a result, the project enjoys a great deal of technical credibility and political influence. There also appears to be a collaborative working relationship between technical staff based in New York and their counterparts in the country offices.

Also noted, a key subcontractor stated that EngenderHealth provided timely, high-quality advice and technical support when needed, but did not try to micromanage the country programs for which they are responsible.

USAID's management team consists of an AOTR (who is in HIDN) and two technical advisors (who are in PRH). The project staff reports that there is strong collaboration and communication between USAID and project leadership. They affirm that the USAID AOTR is supportive of and engaged with the project, but does not micromanage. The AOTR is respectful of project staff expertise and knowledge, but offers constructive, direct input when needed. Similarly, project management staff described the technical advisor as someone who offers strong support and easily facilitates communication and requests between EngenderHealth and USAID, as she knows both organizations well. They describe the former technical advisor as an excellent partner in helping Missions understand fistula, as most have little prior experience with the issue, unlike FP and emergency obstetric care. The entire USAID management team has provided constructive advice and help in dealing with the USAID Missions.

From USAID's perspective, there has been little disagreement on how MCH funds and the POP funds are used in the project. MCH funds are used for repairs, training and facility-based clinical prevention measures, such as training on the use of partograph to monitor labor and promote quality c-section surgical technique. The project has followed USAID's guidance on the appropriate use of MCH and POP funds for fistula treatment and prevention activities. POP funds are used by the project for FP, community and mass media prevention activities, and reintegration. Key actors in both offices describe collaboration across HIDN and PRH as smooth and collaborative.

GLOBAL LEADERSHIP FOR RESEARCH, INNOVATION AND TECHNOLOGY TRANSFER

The FC Project plays a dynamic role in promoting international and national attention to women affected by fistula. Through FC, EngenderHealth is a partner organization in the UNFPA-led Campaign to End Fistula that supports 42 countries in Africa, Asia, and the Middle East with funding and technical assistance. Because both agencies are based in New York, they routinely coordinate and collaborate. The FC Project participates in the International Obstetric Fistula Working Group (IOFWG), which is a consultative group of advisors from different organizations to the campaign. Fistula Care's deputy director co-chairs the sub-working group on Data, Indicators and Research (DIRG) and the clinical director co-chairs the sub-working group on Prevention, together with a representative from CDC and UNFPA. One of the UNFPA Campaign officers interviewed for the evaluation said "If there is a major issue of concern, [the FC project director], would be the first person I would speak to." She also praised the project's AOTR as highly creative about programming, and voiced her desire to collaborate with USAID more closely. Another UNFPA staff member in charge of advocacy for the campaign stated that EngenderHealth has been a terrific partner.⁵ They have coordinated on many Washington, D.C., based activities, including:

1. The project director and a program officer reviewed draft legislation by Representative Carolyn Maloney to ensure technical accuracy and that USAID and EngenderHealth support for this work was recognized. They emphasized the critical importance of prevention in addressing fistula, which was then included in the bill. They have provided technical input to other proposals put forward as requested. Fistula Care provided technical input for the Congressional briefing during the Women Deliver Conference. Project partners attending the conference, including the First Lady of the state of Ebonyi in Nigeria and a fistula surgeon, who spoke during the briefing. The briefing was praised for its use of simple language to describe a complex issue, and included the importance of prevention and variation in the impact on women across different contexts.
2. Earlier this year, FC and UNFPA collaborated on another Congressional briefing on how fistula fits within the GHI Strategy. The outcome was a broader recognition of multiple prevention strategies for addressing fistula, including the need for access to emergency obstetric care services, skilled birth attendance and access to FP.

Fistula Care has successfully brought together different professional disciplines to work towards consensus, share learning and advance new ideas on treatment and prevention approaches. Fistula Care has collaborated closely with the international surgical community through its work with professional organizations such as the Federation of International Gynecologists and Obstetricians (FIGO), Southern African (ECSA) Health Community, the International Society of Obstetric Fistula Surgeons (ISOFS), and the Pan African Urological Surgeons Association (PAUSA), in addition to the World Health Organization (WHO). The project worked closely

⁵ Based on phone conversations with UNFPA Fistula Campaign representatives, Gillian Slinger and Sara Craven on June 23, 2011.

with FIGO, ISOFS and PAUSA in the development of a standardized training manual for fistula surgery, recently published by FIGO. The project is currently supporting the rollout of this manual to fistula training centers in Africa. The project and UNFPA also coordinated work with these groups, other professional associations and leading fistula surgeons to consider the feasibility of a standardized classification system (there are at least 25 classification systems in use); and this work continues.

Members of these groups and project partners contributed to the selection and development of research topics and protocols, including the recently completed prospective, observational study of determinants of fistula outcomes, the survey of clinical practices and a randomized controlled trial on duration of post-operative catheterization (see section on IR3 for more details on both studies). Further, FC joined with the Harvard Humanitarian Initiative to host a consultative meeting in September 2011. Participants aimed to facilitate development of standardized approaches and guidelines for diagnosis and management of clinical, ethical, psychosocial, and programmatic issues for women who are living with fistula that is deemed to be incurable. Participants included representatives of professional associations—gynecologists, urologists, urogynecologists, nurses, counselors and general surgeons. Participants also included—professionals involved in national task forces that support regional model fistula policy development and work with the East, Central and institutions providing care.

RESPONSIVENESS TO USAID, ITS MISSIONS, AND GLOBAL STAKEHOLDERS

The project has been responsive to the requests of USAID Missions. In a 2010 survey, 8 out of 10 missions reported that expectations of the project had either been somewhat or wholly fulfilled. Two Missions (including one regional Mission) were less positive—with one being unsure that expectations were met and one reporting that expectations had not been met. Most responded that project activities were effective and that the project has successfully organized meetings, facilitated new networks and fistula task forces, and built successful partnerships with ministries of health and other donors. They also stated that FC has provided effective leadership on training, research, and strategy development. Similarly, the project has made significant impact on increasing the availability and quality of services, identifying women in need of repair, and helping to reintegrate women into their communities after undergoing surgery. In general, the Missions viewed the project as responsive to local country settings and needs, competent at managing project resources, responsive to Mission requests, and highly knowledgeable about fistula throughout the world.

The survey shows that many problems were related to issues beyond the control of the project. These include delays in funding and OAA approvals from USAID/Washington; the retention of trained personnel at repair sites (especially surgeons); and inadequate emphasis on community awareness and prevention. Two Missions also identified problems in establishing strong networks with partners in country or difficult working relationships with partners.

Two Examples of Fistula Care’s Response to Mission Concerns:

- In Nigeria, the USAID Mission requested FC to estimate incidence of new fistula cases every year and to develop a plan for eradication. The FC Project immediately conducted an analysis of NDHS data and, based on the analysis, developed a methodology to collect community-level data to validate the NDHS-based estimate. The project team also developed a three-year, scale-up plan to support working towards eradication and sustainability.
- In Guinea, the USAID Mission required that all programs in country support democracy and governance (e.g., orientation of project activities to support development of good governance in the country). The project worked with district governments to develop the market town approach to financing fistula prevention, outreach and reintegration activities. The approach has been very effective in building local ownership of the project and provides a model for how to develop local health financing mechanisms (see Annex F for a full description of the approach).

A potential challenge for fistula programming as an integrated part of a Mission programs is whether or not fistula is incorporated into Mission GHI strategies and BEST action plans, particularly in GHI focus and GHI plus countries. It was the impression of USAID health officers in both the Asia and Africa Bureaus that fistula is unlikely to be mentioned in these country level documents because most GHI country strategies are likely to be focused on two or three GHI priority activities, such as reducing maternal and newborn mortality or unintended pregnancy. The only real opportunity to address fistula is within the context of improving access and quality of EmONC and FP, with the goal of reducing morbidities, as well as mortality. However, this prevention approach does not necessarily address the surgical repairs of fistula or other severe maternal morbidities, although it could be written to do so. The FC Project and USAID/Washington could work with Missions, using the strategy discussed with Congress for aligning fistula services within the GHI, to help them incorporate language to promote both prevention and repair within the maternal health strategy.

EMOC training will have an impact on reducing fistula if women have access to c-sections. Similarly, most maternal health programs emphasize skilled attendance at birth, as well as improved active management of third stage of labor. Timely access to these services can reduce obstetric fistula—and these aspects are addressed in FC’s prevention strategies. In discussions related to the evaluation, FC committed to integrate fistula prevention messages into these activities more effectively and to better collaborate and coordinate with others to do so.

STRATEGIC OBJECTIVES

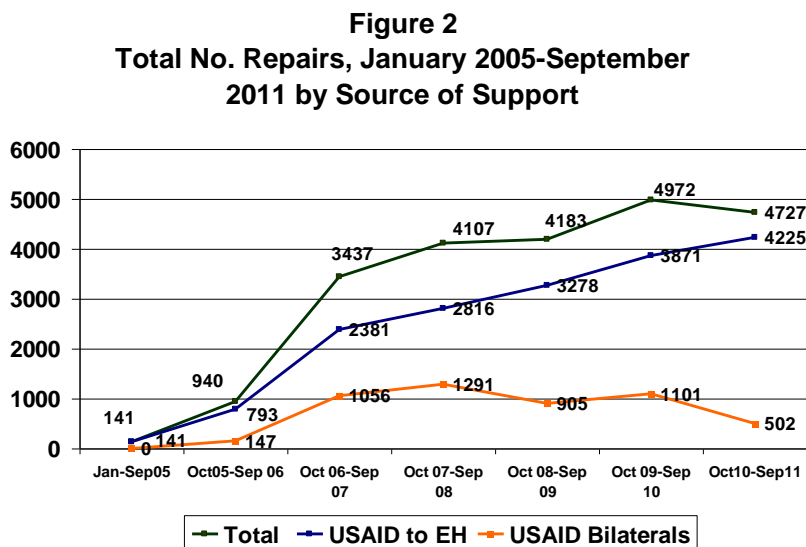
Progress to Date

In lieu of end-of-project benchmarks, the project set yearly benchmarks for its strategic objective (SO) indicators.⁶ Therefore, the evaluation team measured progress according to (1) the degree to which the project met or exceeded planned benchmarks; and (2) a demonstrated upward trend in planned and achieved benchmarks as compared to previous years. Based on these criteria, FC has made significant progress over the life of the project. It has met or

⁶ These benchmarks are not targets for repairs, as the FC Project is careful not to set targets that would pressure sites to perform surgery without having the appropriate set of skills and conditions to do so—such as adequate surgical expertise for complex repairs or adequate nursing staff to care for postoperative patients.

exceeded benchmarks for its SO indicators every year, except in fiscal year 2008–09 when delays in the obligation of funds and approvals by the USAID Contracts Office interrupted activities in some countries.⁷ Between October 2005 and the end of September 2011, USAID funds supported 22,364 repair surgeries. FC is responsible for more than three quarters (78%) of all fistula repairs supported by USAID funding during this period. Fistula Care has demonstrated an approximate increase of 15% in the number of repairs each year since the 2007 baseline. Between October 1, 2010, and September 30, 2011, the number of repairs produced by bilateral programs decreased by more than half and the total number of USAID-supported repairs decreased by 5% from the previous year’s number. These decreases resulted from the end of the AXxess Program in the DR Congo. The number of repairs supported by FC in fiscal year 2011 increased by 9% over fiscal year 2010 and represent 89% of all USAID supported repairs.⁸

Figure 2. Total Number Repairs from January 2005–September 2011 by Source of Support



The second SO indicator—number of repair sites supported—shows strong progress as well. By October 2010 the project supported 70 sites, of which 32 are repair and prevention sites and 45 are prevention-only sites. Combined, the total number of repair and prevention sites has more than doubled, from 37 to 77, since the beginning of the project.

⁷ Information on the delays comes from the Management Review Memorandum dated February 24, 2009.

⁸ Information comes from the Fistula Care Annual Report October 2010 to September 2011.

Figure 3. Number of USAID Supported Sites and Countries, January 2005 to September 2011

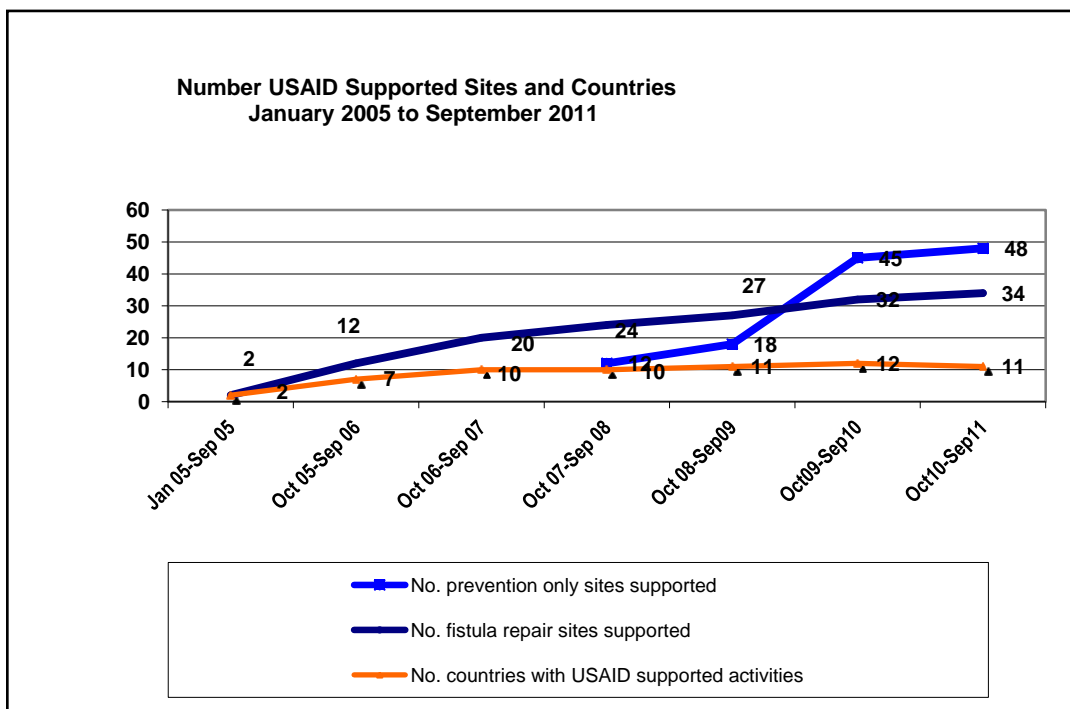


TABLE 2. Strategic Objective Indicators

Year	FY 2007-08	FY 2007-08	FY 2008-09	FY 2008-09	FY 2009-10	FY 2009-10	FY 2011
Indicator	Planned	Actual	Planned	Actual	Planned	Actual	Planned
Total Number of Sites Supported	37	37	68	45	70	77	85
Number of Repair Sites	25	24	33	27	32	32	35
Number of Prevention Only Sites	12	12	35	18	38	45	50

RESULT I: STRENGTHEN THE CAPACITY OF CENTERS TO PROVIDE QUALITY SERVICES TO REPAIR AND CARE FOR WOMEN WITH OBSTETRIC AND TRAUMATIC GYNECOLOGIC FISTULA.

- I.1 Fistula centers supported to provide fistula repair and care.
- I.2 High quality clinical fistula repair and care implemented at the sites.
- I.3 Increased capacity of facilities' personnel to provide quality fistula repair and care.
- I.4 Models implemented to improve quality and efficiency of fistula care and services.

Progress to Date

Fistula Care has made major contributions in the 10 countries where it works to increase the quality of fistula treatment and build capacity in fistula repair, FP and emergency obstetric care. The project has done an excellent job of providing a consistent set of interventions while delivering them through strategies and models adapted to different national and local contexts across the 10 countries. The evaluation team was able to observe these different approaches in Ethiopia, Uganda, Nigeria, and Guinea (see Annex F for a description of the different models and their strengths and challenges). Each model developed in response to the history of fistula repair services and particular constraints and opportunities in each country.

Project Models

In Ethiopia, the pre-repair units (PRUs) addressed the need to identify cases of fistula and provide initial screening and pre-repair health services closer to women's homes in order to prepare them for surgery at the repair hospital located in Bahir Dar, in the Amhara region of Ethiopia.⁹ The PRUs also provided post-operative support for women with fistula. In Uganda, the partnership model built alliances between the public and private sectors to provide repairs in rural areas where church mission hospitals provided the necessary infrastructure and training, and both the mission hospitals and government provided medical personnel. In Guinea, the USAID Mission requested that the project organize their activities around strengthening local governance, resulting in transparent collection of market vendor taxes that are used to support social houses for women before and after repair sessions. In Nigeria, a country with pre-existing surgical capacity, the project developed a pooled-effort for training and repair that allows more skilled surgeons to train doctors and to practice side by side at one another's sites for a week or two at a time to care for the backlog of women awaiting treatment. These innovations contributed to developing a sense of ownership, camaraderie, and pride in their work among local partners.

The evaluation team observed a good level of QOC at the fistula repair centers visited. The centers take pride in successful surgeries, in a welcoming and clean environment for patients and in providing empathetic and supportive care. As a result of the project, centers also keep better records on repair outcomes, monitor complications, and investigate deaths from fistula surgery.

There are three measures that the project uses to assess whether the results of fistula surgery are within reasonable expectations. The first is a measure of post-operative outcomes as determined by whether the surgery resulted in closing the fistula to the point of eliminating any incontinence. The FC Project has achieved its benchmark of a 75% average rate for surgeries

⁹ USAID supports two satellite hospitals of Hamlin Fistula Ethiopia (formerly the Addis Ababa Fistula Hospital), which are located in Bahir Dar and Mekele. Five pre-repair units serve to identify clients, ensure they are healthy enough to withstand surgery, and refer them for treatment.

resulting in “closed and dry” fistula performed at all project-supported repair centers. This is a good measure of outcomes, given the complexity of many fistulae that cannot be totally closed or dry without interventions that are impractical or unacceptable to most women in the countries where the project operates. Success is defined by the percent of women upon discharge who have a closed fistula and no incontinence.¹⁰ A second measure refers to complexity. Between 25–30% of repairs in the Determinants study were assessed by surgeons to be complex, while 25–30% of repairs were viewed as simple. The remaining 60–65% were viewed by participating surgeons to be of average difficulty to repair.¹¹ Complexity is not directly correlated with outcome, but is important in determining the skill level of surgeon required to perform the repair. The number of repairs that can be performed at a site is limited in large degree by the surgeons’ skills and by the availability of beds for pre-and post-operative care. The third measure, rate of complications, is a measure of QOC. The supported repair centers have also managed to keep the average rate of complications at 3% (2010), which is significantly below the benchmark of less than 20% and just a third of the 9% average at baseline.¹²

The FC Project’s Levels-of-Care model appears to be an important strategy for improving quality of prevention care and promoting better surgical outcomes. The model is designed to expand access to care and direct women to the appropriate level of care based on a determination of the relative complexity of their fistula at screening. Level I centers provide FP, community outreach, initial screening to determine if a woman with incontinence has a fistula, antenatal care, skilled birthing care and referral. Level II facilities provide all Level I services, plus they offer secondary screening to determine whether the fistula is simple or complex, repair surgery for simple fistulae, post-operative care and one to three month check-ups. Level III facilities provide all Level I and II services, plus they repair simple and complex cases, train surgeons and nurses, and provide mentorship to surgeons and nurses at Level II facilities. This model has been implemented in varying degrees in different countries. Most Level II and III facilities also provide comprehensive emergency obstetric and neonatal care services that include the capacity to prevent fistula by offering c-sections when women experience prolonged and/or obstructed labor. The Levels-of-Care model focuses on four priority interventions:

1. Prevention through building awareness about the importance of skilled delivery care and integration of FP into fistula services.
2. Improvement in the quality of services through a standardized training curriculum; application of the fundamentals of care; training by different master surgeons in different environments; use of tools for supervision and medical monitoring; establishment protocols and mechanisms for reporting complications and deaths; and use of standardized indicators for monitoring progress.
3. Prioritization of research to provide evidence for building consensus for quality clinical practice and program design, and provision of quality information to different stakeholders.
4. Establishment of a supportive environment for prevention and repair through collaboration with national task forces, professional organizations, partner donors and implementing agencies, and improved reporting and briefings to the U.S. Congress.

¹⁰ The FP Project’s “Determinants of Post-Operative Outcomes in Fistula Repair Surgery: A Prospective Facility-based Study,” shows that the percent of repairs that were closed and dry at three months post-operative was 79.1%, which is better than the 75% benchmark.

¹¹ The information on the results of the study is preliminary and comes from presentations made at a meeting in May 2011 that brought together the investigators from the participating centers. Currently, there is no one classification system. The rating of the complexity cited is based on participating surgeons’ subjective assessment.

¹² Data comes from the project’s 2009–2010 Annual Report.

Training

Fistula Care has effectively supported training of surgeons, midwives and nurses. The training spans various topics, including different levels of surgical technique for fistula repairs, training on FP counseling and procedures, fistula counseling, use of the partograph, and community-based training of volunteers in prevention, outreach and reintegration. The project has trained an average of 5,770 participants annually in all types of training.

By Selected Subjects	FY 2007–08	FY 2008–09	FY 2009–10	TOTAL
Fistula Care Management	255	358	304	917
Quality Assurance	211	140	320	671
Family Planning	82	45	286	413
Obstetric Care	0	197	525	722
Total of all Providers Trained	548	740	1,435	2,723
Total of all Participants Trained ¹³	4,858	5,531	6,922	17,311

Potential New Repair Technique

The project supports routine catheterization during c-sections for women with obstructed or prolonged labor. They are also exploring application of a protocol for early catheterization to treat small, simple fresh fistulae (without surgery) for women who come into repair facilities within two weeks of delivery. The protocols have not been developed or tested yet, but the prospects for early catheterization hold promise for preventing women from having to live with fistula and to undergo surgery.

Challenges and Constraints

1. A significant number of women who present for fistula repair don't actually have fistula. During the assessment, surgeons reported that an estimated 20–50% of women who suffer from severe incontinence have other severe maternal morbidities, such as uterine prolapse or cystocele. There is no standard procedure at the prevention and repair centers for treatment of these women. Although these women are provided referrals for treatment, the surgery costs money in contrast to fistula repair, which is free at all project-supported clinics. Women with these conditions also suffer greatly and many live in conditions similar to those with fistula. This issue has been a continuing source of discussion in FC Project management reviews with USAID. USAID requested the project to develop a concept for exploratory work on uterine prolapse and other stress incontinence in one or two

¹³ This includes non-clinical personnel, including community volunteers. The data comes from Fistula Care Project 2009–2010 Annual Report.

countries.¹⁴ The project is limited in its response by the terms of agreement, which designates resources for addressing fistula. In 2010, the project considered opportunities for integrating uterine prolapse and fistula services and prepared and discussed a paper with USAID/Washington during the 2011 management review.¹⁵ The following actions are recommended:

- FC will conduct community screening in Nigeria to gather information on the relative number of women with fistula, uterine prolapse and general incontinence. They will all be referred to local facilities for care.
- Review information on uterine prolapse in Nepal, which is one of the few countries for which published research exists on incidence and a programmatic response exists, to see if the approach can be adapted elsewhere.
- Review costing studies on uterine prolapse to estimate the cost to treat women who are identified in the process of fistula screening.
- Survey surgeons at fistula repair sites to gauge their skills and capacity to treat women with uterine prolapse.
- Collaborate with other partners to develop advocacy tools to address uterine prolapse.

USAID has given permission to the project to begin implementing these recommendations in order to generate additional information upon which to base decisions about future programming.

Of the women diagnosed with fistula, some are deemed incurable due to complexity of the fistula or because of previous repair attempts. At the time of writing, the FC staff had a meeting planned on the topic for September 2011 in collaboration with the Harvard Humanitarian Institute (HHI). HHI, which trains the medical staff of Panzi Hospital in the DR Congo in advanced urogynecological surgery, will assist in facilitating the meeting. It would also provide information on the advisability and feasibility of offering more advanced surgical and mechanical solutions in the contexts in which the project works. The meeting was expected to produce recommendations that would lead professional associations, ministries of health and institutions to establish standards and guidelines to facilitate the diagnosis and management of women whose fistula is deemed incurable.

Another challenge is the difficulty of retaining surgeons as a consequence of transfer and mobility within and outside of country. This problem is also attributable, in part, to selecting of the wrong people for training. While FC has clear selection criteria for surgeons, some stakeholders—such as federal and state ministries of health (MOH) and other donors—do not adhere to the same criteria. FC shares these criteria, but ultimately these decisions belong to MOHs and other donors who are also influenced by their own institutional and political exigencies. The project has trained surgeons to work at supported centers, but some leave for professional advancement elsewhere or changes in political leadership.

¹⁴ During the Accra partners meeting in 2008, participants discussed what ancillary surgeries were to be provided in support of fistula services. This guidance was discussed with USAID/Washington and incorporated into the indicators identified and data collected. They agreed the program would cover uterine prolapse or cystocele in the presence of fistula, but not if they occur without fistula. Foot drop related to fistula should be covered in all programs by physiotherapy and further treatment if feasible. The central project office in New York provides instructions to country program staff to refer other morbidities to the nearest service for treatment, with the recognition that these other services may not be free or readily available.

¹⁵ Wegner, Mary Nell, and Rachel Schecter, April 2011 “Programming Considerations for Integrating Uterine Prolapse and Fistula Services.” Discussion draft. New York: EngenderHealth.

Another challenge is how to ensure that the fistula surgeons, once trained, continue to have the opportunity to use these skills if they leave or practice at an unsupported site. Best practice suggests that any surgeon identified for training should be selected on the basis of interest, capacity, and willingness to practice at a current workplace or another center during pooled-effort sessions or camps. In Nigeria, surgeon trainers who have been promoted continue to participate in pooled-effort repair sessions with other colleagues every so often. The project focus has been to establish or strengthen service sites where one trained surgeon is necessary, but it's not sufficient to ensure continuity of services at a site.

RESULT 2: ENHANCE COMMUNITY AND FACILITY UNDERSTANDING AND PRACTICES TO PREVENT FISTULA AND UTILIZE AND DELIVER SERVICES

- 2.1 Facilities monitoring labor and providing timely emergency response for prolonged/obstructed labor.
- 2.2 Facilities linked with community agents and organizations.
- 2.3 Fistula clients received counseling and support for reintegration into their communities.
- 2.4 Collaboration with maternal health programs.

Progress to Date

Project-supported outreach and prevention activities have focused on raising community-level awareness of fistula. Messages highlight that fistula is preventable and how to prevent it, and that fistula is treatable and where to get treatment. Prevention messages promote giving birth with a skilled provider at a health facility, delaying the age of marriage, and stopping the practice of female genital cutting (FGC). Fistula Care has worked through a combination of NGOs and community-based health volunteers and committees to conduct social mobilization and outreach activities. It has also sponsored radio programs to broadcast similar messages. Both are designed to be interactive. At the community level, peer educators use educational materials to engage people in discussions about fistula, its consequences and the need to treat women affected with compassion and respect. The project has also worked with religious leaders to reiterate similar messages in their services.

Radio programs also communicate messages about fistula and its causes, encourage women to seek care at treatment sites, and work to eliminate stigma. They encourage listener interaction through text messaging and phone calls. Radio producers pass medical and other challenging questions to the FC Project for accurate information.¹⁶ The Prospective Study of Fistula Repair Outcomes (see IR3) collected information on women's provenance and how they heard about fistula repair services. This information offers the opportunity to analyze which form of outreach is most effective at stimulating demand for repairs.

The project collects monitoring data on the number of events (community and mass media) held, and number of people reached. Between October 2009 and September 2010, FC held 5,728 community events and reached 1,026,674 people. The latter information is an estimate and the radio programs do not collect information on the number of listeners.

NGO and community workers also engage in outreach activities to identify and assist women with fistula in accessing services. Community mobilization activities also support social and

¹⁶ Information based on interviews with Radio Nigeria.

economic reintegration for women post-repair, as many of them have been socially marginalized as a consequence of their disability.

The project also supports clinic-based prevention services. The FC project promotes facility-based births by supporting ANC services, training health care providers at supported centers in labor monitoring using a partograph and BEmONC and CEmONC, and providing information on evidence-based c-section practice. Since the beginning of the project, **869 providers have been** trained in the full EmONC package. Births at supported sites doubled between 2009 and 2010, from **30,000** to **58,930**. The c-section rate has increased from 34% to 40% of all births at FC-supported facilities.¹⁷

All prevention and repair sites offer FP counseling to all patients post-repair. At the one or three month check-up, patients can choose a contraceptive method during a second FP counseling session. In Catholic hospitals and some evangelical Christian mission hospitals, counselors provide women with FP information; some provide natural family planning or refer patients elsewhere for other FP services. At both prevention and prevention and repair sites, the project strives to reach the general population with FP counseling and methods. Community outreach volunteers and safe motherhood committees, who are supported by the project, could provide community-based distribution of contraceptives through part of the project or in conjunction with other reproductive health/ family planning (RH/FP) programs operating in FC project areas.¹⁸

The data shows that FP has increased over the course of the project—especially among postpartum women. Fistula Care reports being responsible for counseling **79,493** people, with **55,676** accepting FP at 64 centers between fiscal years 2007 and 2010. The number of people counseled has more than quadrupled between October 2007 and the end of September 2010. The number of people accepting FP has increased by more than 900% and nearly 70% of all counseled opted for a contraceptive method.

TABLE 4: Number of People Counseled and Accepting FP Methods by Year in Project-Supported Sites

	FY 2007-08	FY 2008-09	FY 2009-10	Totals
Number of Sites Reporting FP Services	22	33	64	
Number of People Receiving FP Counseling	17,349	20,966	41,178	79,493
Number of FP Acceptors	6,114	10,024	39,538	55,676

¹⁷ While this appears high by the internationally established standard of <15%, most of facilities performing c-sections are tertiary facilities that generally see more obstetric complications. The other contextual factor is that in most of the countries supported by the project, the c-section rates are considerably below 10%, which is inadequate. The project has also attempted to measure the percentage of c-sections that are due to obstructed labor, but they have not been able to get accurate numbers as a consequence of poor record keeping.

¹⁸ In Nigeria, there was a lot of discussion about how to best ensure access to FP in the project areas. As the Mission has a large RH/FP project in the northern part of the country, USAID encouraged the two projects to collaborate by agreeing on one FP service provider. This was not the case in all FC project areas; and it makes sense for the project to continue to provide FP in areas where there is no other source of FP services. In those areas, expansion to provide CBD in conjunction with outreach and reintegration activities might also make sense in a future project.

Challenges and Constraints

1. Little is known about the most effective approaches for promoting prevention through facility-based births or for reaching women for repairs. With the exception of radio outreach, social mobilization models are mostly confined to areas near fistula repair centers. In more established centers, evidence shows that women are coming from further and further away (evidence from Ethiopia, Nigeria, and Guinea). In Nigeria, one approach would be a type of “mapping” to send outreach teams to areas where more women are coming from for repairs. There are questions about the efficacy of approaches that confine activities to areas near the center, as women can come from points outside of the centers’ immediate radius of action. As the backlog of fistula cases near the center site are addressed and the fistulae repaired, women are coming from further and further away. Little research or evaluation-based evidence exists on what kind of outreach and communication activities are most effective. There are many outstanding questions about community interventions—including those focused on prevention, outreach, and reintegration—that would benefit from social science research. The evaluation under way in Guinea is the first attempt to evaluate the impact of community-based outreach and prevention activities.
2. Poor c-section practice appears to be contributing to a significant but unsubstantiated number of iatrogenic fistula cases. The anecdotal accounts of incidence of iatrogenic fistula raise concerns about the quality of c-section surgical practice. Surgeons anecdotally report that 10–25% of fistula cases are due to iatrogenic causes, principally from c-section.¹⁹ In one hospital in Nigeria, the OB-GYN specialist is offering refresher training for physicians doing c-sections.
3. As facility-based births increase, so does the opportunity to screen and educate women about fistula. Screening women for incontinence during postpartum visits can identify fistula early in order to spare women the pain and suffering of living with it. There is also an opportunity to promote the value of postpartum visits for detecting fistula so that women who give birth at home also seek postpartum care within one week after delivery. Many other organizations and projects support facility-based births and community- and facility-based postpartum care. The challenge is to incorporate fistula screening questions and referral for women with postpartum incontinence into a standard postpartum care package.
4. Although the FC Project offers FP counseling to all women post-repair, women are not routinely given a contraceptive method at discharge. Most facilities delay a woman’s access to contraceptives until her one- to three-month follow-up visit. The fear is that offering contraceptives sooner may promote intercourse before the recommended three-month abstinence period.²⁰
5. There are no defined criteria to determine which women are in need of reintegration support and what would be beneficial. Increasing evidence shows that most fistula patients are not as young or isolated as once thought. The project has generated much of this evidence and it would be useful to analyze its programmatic implications. (see the section on IR3 for a discussion on how this evidence has called into question some of the long held beliefs about fistula.)
6. One of the challenges for doctors and nurses trained in facility-based prevention (c-sections and partograph, respectively) is that facilities often lack basic infrastructure and supplies necessary for such care. The project provides supplies and equipment for fistula repairs, but

¹⁹ The needs assessment conducted by the project found that 10–15% of fistula was iatrogenic. It is possible that the higher number reported in interviews is a result of surgeons becoming increasingly aware of the problem.

²⁰ Fistula Care indicates that this is not a practice promoted by the project, however, the project has also not stated a clear policy about providing women with a method prior to discharge if she so desires.

not for selected preventive procedures. The project has provided c-section and vaginal delivery kits to most FC-supported sites—and FC supports c-sections in some countries. Some countries have requested and received vacuum extraction kits as well. Catheters that can be used for immediate catheterization are included in consumables. In Guinea, the FC project provided partographs and job aides to all prevention and repair sites following BEmONC training.

RESULT 3: GATHER, ANALYZE, AND REPORT DATA TO IMPROVE THE QUALITY OF PERFORMANCE OF FISTULA SERVICES

- 3.1 Program activities monitored and outcomes evaluated.
- 3.2 Research designed and implemented.
- 3.3 Information disseminated about lessons learned and research findings.

Progress to Date

Fistula Care has demonstrated that data is a powerful tool in improving clinical practice and generating new knowledge about fistula. The knowledge garnered through monitoring, evaluation, and research has had a transformative impact on the fistula landscape—what is known and how to respond more effectively. Fistula Care has been flexible and adept at responding to those changes. For instance, there has been considerable pressure to standardize classification of fistula type and complexity into one system—choosing from the many that currently exist. The study found that none of the current 25 to 40 systems was superior in predicting surgical outcomes, but all were helpful in identifying the level of surgical skills needed to competently perform repairs. The study also identified a number of conditions that correlate with failure to completely close a fistula and to eliminate all residual incontinence.²¹ These findings have shifted the focus from developing a single classification system for the purpose of prognosticating surgical outcomes, although such systems may have value for training or communication purposes. The research did not exam other uses of the systems.

The Determinant Study Fistula Care has improved the routine collection, analysis, and use of data in fistula prevention and repair centers—strengthening and complementing the collection and use of data collected for the performance monitoring plan (PMP). It has expanded the knowledge of fistula repair outcomes and generated new findings about women affected by fistula. Globally, the project has also engaged with international organizations (UNFPA, CDC, and ORC/Macro) to analyze findings from Demographic and Health Surveys and to propose a set of standardized questions for future surveys. It has also elaborated on a set of international indicators for prevention, repair, and reintegration based on use and analysis of the project’s reporting indicators. In addition, the project has developed a data for decision-making tool that it is rolling out in all supported sites to achieve a standardized approach to reviewing, analyzing, and using monitoring data.

The availability of comprehensive data is critical to decision-making in health care. The collection of clinical information in transparent and well-maintained registers, and the analysis of this information to inform practice and decision-making, is essential to improving the QOC. It also can inform the generation of new ideas and transform practice. Fistula Care has made a major contribution to institutionalizing the collection and use of data for monitoring and evaluation of

²¹ According to preliminary findings, these include a small bladder, prior repairs, severe scarring, and impairment of the urethra.

fistula treatment and prevention activities in the facilities they support. The information generated through monitoring and research has also greatly increased worldwide knowledge on fistula clinical practice, repair outcomes, and women affected by fistula.

The project has developed a set of standard procedures and registers for record keeping on fistula repair and care. Supported facilities' staff collects data and reports it to the project on a quarterly basis. In most cases, project staff assists the facilities in synthesizing data into a summary form that is aggregated at the country office. The FC Project is phasing in routine quarterly review of facility-level data, with quarterly reviews taking place in 20% of supported centers and annually in 83% of centers. To a lesser extent, facilities have begun analyzing and using the data to track trends in the number of repairs, complication rates, and deaths to assess their own performance.²² The project plans to put more emphasis on facility-level data analysis and use through the dissemination of the Data for Decision-Making module. The module goes beyond the routine quarterly reviews to focus on how to more sustainably integrate the analysis and application of data to improve the QOC and effective use of resources.

In addition to routine monitoring, FC has conducted or plans to conduct a number of operations and formative research studies. They have involved a selected sample of supported centers in the research. These centers appear to have gained a greater appreciation for data collection and use through participation in the research. Fistula Care trained doctors and nurses in the use of the research protocol and instruments; they were also trained on informed consent procedures and the ethics of conducting research on human subjects.

The project has conducted or is in the process of conducting nine studies. They are:

Study	Status	Purpose/Importance	Contribution to Evidence Base
Prospective determinants of post-operative outcomes in fistula repair surgery: A prospective facility-based study (facility-level predictors of urinary fistula repair outcome)	Study completed; publications are being prepared and submitted.	To determine factors that predict outcomes (closure and residual incontinence) of fistula repair surgery. To examine socio-structural factors associated with fistula.	Largest collection of data assessing fistula repair outcomes across multiple sites and countries. Followed 1,300 women after discharge to determine predictors of longer-term outcomes. Prospective focus provided assessment of a great variety of fistula and patient characteristics and facility-level factors.
Qualitative clinical practices: Identification of current practices in fistula treatment—a qualitative review	Completed	The overall objective is to collect information about current practices in the care and treatment of fistula. The primary goal of the study is to provide information to USAID and FC to help in the decision-making as to	The results provided a window into current fistula treatment. The review found consensus on some practices (e.g., routine use of prophylactic antibiotics, limited bed rest until the catheter is removed,

²² Deaths have been rare. They are audited and confidentially reported according to a process the project disseminated through medical monitoring training and supervision.

Study	Status	Purpose/Importance	Contribution to Evidence Base
		whether to pursue the development of one or more RCCTs.	nonsurgical treatment for postsurgical incontinence), and wide variations in other practice areas (e.g., duration of catheter use, surgical treatments for postsurgical incontinence). ²³ The results have been used to recommend eight topics for RCT research. ²⁴
Retrospective record review of indications for cesarean deliveries (multi-country with 10 individual site reports, plus 1 summary analysis)	Ongoing	To assess the availability and quality of data on indicators for cesarean delivery (3,289 cesarean records reviewed in 2008 for 10 facilities in Uganda, Bangladesh, Mali, Guinea, and Niger).	Develop fistula prevention indicators and assess the feasibility of using them as a proxy measure for fistulae averted. Identify current practices and gaps for how data on c-sections is collected, reported, and maintained. Contribute to knowledge on trends for clinical indications for c-sections in selected facilities.
Cost study (multi-country)	One study in Nigeria completed in FY 2010–11.	To test a cost-analysis tool developed by UNFPA.	To enable managers at fistula facilities to gather data for decision-making about resource allocation and to periodically assess costs for fistula repair services.
Partograph literature review	Completed	Literature review of more than 80 publications (articles, technical manuals and book chapters) to examine:	Provides guidance for the effective training on and use of the partograph to monitor labor. In summary: Must take into account

²³ From Arrowsmith, Steven D., Joseph Ruminjo and Evelyn Landry. 2010 “Current Practices in Treatment of Female Genital Fistula: A Cross Sectional Study” *BMC Pregnancy and Childbirth*. Vol. 10.

²⁴ The research topics identified include (1) Efficacy/safety of short-term catheterization; (2) efficacy of surgical and nonsurgical therapies for urinary incontinence; (3) technical measures during fistula repair to reduce the incidence of post-surgery incontinence; (4) identification of predictive factors for “incurable fistula;” (5) usefulness of urodynamic studies in the management of urinary incontinence; (6) incidence and significance of multi-drug resistant bacteria in the fistula population; (7) primary management of small, new fistulas by catheter drainage; and (8) antibiotic prophylaxis in fistula repair (Arrowsmith et al., 2010).

Study	Status	Purpose/Importance	Contribution to Evidence Base
		<p>Use and efficacy of the partograph.</p> <p>Training strategies for introducing and effectively implementing use of the partograph.</p> <p>Barriers to partograph use.</p>	<p>variations in use and knowledge of staff using the partograph for training.</p> <p>Effective supervision and monitoring are critical to success.</p> <p>Improvement in knowledge and skills for labor monitoring is needed to reduce adverse outcomes from obstructed labor.</p>
Levels-of-Care (LOC) evaluation	Ongoing in Guinea	Evaluation of how the LOC framework has been introduced in Guinea.	Will address some of the outstanding questions about the effectiveness of outreach and reintegration approaches.
RCT: The non-inferiority of short-term urethral catheterization following fistula repair surgery	Ongoing	To examine whether 7-day urethral catheterization is not inferior to 14-day urethral catheterization in terms of incidence of fistula repair breakdown.	<p>Shortening the duration of urethral catheterization following fistula repair surgery can potentially increase treatment capacity by freeing up available bed space and nursing staff.</p> <p>Potentially lowers both the costs of services and the risk of health care associated infections.</p> <p>Will generate empirical evidence, of which there is little, to support length of time for urethral catheterization following fistula repair.</p>
Evaluation of FP integration framework	Planned for FY 2011–12	Evaluate of the effectiveness of integrating FP into fistula prevention and repair sites.	Will examine some of the pros and cons of including FP as part of an integrated model of fistula care.
Evaluation of fistula counseling (multi-country)	Completed in Mali, ongoing in Rwanda, and to be completed in DRC in FY 2011–12	Evaluation of provider counseling skills pre- and post-training.	Measure the effectiveness of training in two countries, Mali and DRC.

Participating in the research and data collection has motivated many centers to continue collecting data that was part of a completed research study protocol—even though it is not part of the routine record keeping or monitoring system.

It is estimated that fistula affects 2 million women globally. Through research, the FC Project has provided initial evidence that challenges some long-held beliefs about these women and will, if confirmed by additional analysis of the data, prompt changes in programming. The general belief is that fistula affects young women who give birth before their bodies have matured sufficiently to deliver a baby without serious complications. Obstructed labor causes the uterus to place pressure on the bladder and results in a fistula. Ultimately, the baby dies and the mother is condemned to a life of disability, social marginalization, isolation, and economic destitution.

The research—Fistula Care’s prospective study on determinants of surgical outcomes and two studies conducted in Tanzania and Uganda during prior EngenderHealth activities, funded by DFID—challenge the abovementioned assumptions. In summary, the majority of the women who develop fistula are not young girls; women do not necessarily live with fistula for many years before getting help; not all women affected by fistula lose their babies (although the majority do); and not all women experience fistula in their first birth. The prospective study shows that of women seeking a first repair, their median age is 28 and they have lived with fistula for an average of 1 year. The data also show that only about 30% of women who present with their first fistula are younger than 19 and have had other children.

Baseline Characteristics of Women in the Prospective Determinants Study²⁵		
Median Age (years) at First Marriage (n=1239)		15
Median Age at Occurrence of Fistula (n=963)		20.3
Median Age at Repair (n=1347)		25
Parity at Repair (n=1306)		2.0
Duration in Months of Urinary Fistula (n=963)		12.0
Duration in Months of RVF (n=25)		5.0
Marital Status (n=1334)	Married	66.5%
	Divorced	26.6%
	Widowed	5.2%
	Single	1.7%
Residence (n=1339)	Rural	85.8%
	Town	8.4%
	City	5.8%
Who Participant Lived With at Time of Enrollment in the Study (n=1332)	Husband	48.3%
	Mother and/or Father	37.1%
	Young Children	26.4%
	Adult Children	12.1%
	Other Relatives	16.4%
	In-laws	6.0%
	Others	6.9%
	Alone	4.0%

²⁵ Fistula Care Presentation of descriptive results of Prospective Study (May 2011).

Primary Source of Support Pre-and Post-fistula (n= 1353)	Pre n=1352	Post n=1352
	Husband	
Relatives	69.9%	51.4%
Self	14.9%	34.0%
Other	14.6%	12.6%
	0.6%	1.9%

Discussions during this assessment with health care providers and women at the fistula repair centers in the four countries visited, along with the two DFID-funded studies, demonstrate that while women experience considerable social marginalization, most are not totally isolated or abandoned by their families. The degree of social isolation seems to vary considerably and depends on local cultural and social contexts. Women's economic circumstances as a result of fistula also vary a great deal and depend on the precariousness of their circumstances prior to developing fistula, their relative social isolation, and the extent to which their disability restricts their ability to work.²⁶ In summary, the extent of socioeconomic isolation of women living with fistula differs in different countries and may vary by context of geography, education, culture, and social class in same country.

The estimates of prevalence have also undergone recent scrutiny as the result of analyses conducted by USAID and FC of the Nigeria NDHS module on fistula. UNFPA estimated prevalence in sub-Saharan Africa at 2 million, with about 40% said to occur in Nigeria.²⁷ FC analysis of the NDHS (2008/2010) in Nigeria indicates an incidence of around 12,000 new cases annually.²⁸ This finding, if corroborated by community-level surveys, changes the landscape considerably. It opens the possibility that Nigeria could perform a sufficient number of repairs annually to keep up with new cases as they occur and eliminate the need for women to live with fistula for years, as well as continuing to repair women with older cases of fistula. FC also predicts a significant reduction could be achieved in countries smaller than Nigeria in an even shorter timeframe, especially if effectively linked to enhanced prevention efforts.

At the request of the USAID Mission in Abuja, FC has developed a three-year strategy to conduct the research, including an inventory of existing sites and surgeon capacity, to expand service delivery and develop plans for sustainability beyond the three years.

Information Disseminated About Lessons Learned and Research Findings

The project has ambitious plans for disseminating research and evaluation findings, mostly in the form of published articles. The intention is to build the evidence base on fistula treatment and care. The project has been very consistent and opportune in sharing its research through published articles, research reports, and presentations at international professional meetings. USAID has also been a supportive partner by reviewing, commenting, and approving publications and reports in a timely fashion.

²⁶ Women's Dignity Project, 2006 and 2007.

²⁷ United Nations Population Fund (UNFPA). 2008. "Obstetric Fistula: A Tragic Failure to Deliver Maternal Care." New York: United Nations Population Fund. Accessed at: <http://www.unfpa.org/mothers/fistula.htm>.

²⁸ The incidence estimate of 11,208 was based on dividing the NDHS estimate of lifetime prevalence (150,000) by an estimate of average duration of fistula (10.7 years). FC has recommended using an approximate number of 12,000 new cases per year.

Challenges and Constraints

1. Most supported centers are not accustomed to synthesizing, analyzing, and using data. Center staff feels overwhelmed by the large quantity of M&E data. While they have been effective in data collection, especially data related to fistula care monitoring and the research, they have not been as capable in synthesizing and aggregating monitoring data, which is a first step toward analyzing and using it for decision-making. Most centers, particularly those that did not participate in the research, have limited capacity to independently synthesize, analyze, report and use the findings without input from the country project offices. Another issue is the resources to effectively collect and report data. The project faces many local challenges in overcoming these constraints. In some centers, there simply are no staff to gather data as part of routine tasks—and the project has asked them to gather a lot of data for reporting and quality improvement purposes. In places where the project has sub-awards, it is better able to support monitoring activities. In Nigeria, the project holds routine meetings with its established provider networks to provide surgeons with an opportunity to review the data and make determinations about its use in programs. The Data for Decision-Making training module is intended to improve data collection, analysis and use. They project recently began to train fistula centers with the module following a pilot in Guinea.
2. Implementation of the global research to date has raised awareness about the value of science and research for clinical practice, but has not sufficiently built local capacity for sustainable data analysis and independent research. Although this was not an objective of the project, the involvement of several centers in multi-country studies has raised interest and desire for more locally led research. Solid research capacity in country would provide a way of using research, particularly operations research to improve quality and efficiency of practice.

RESULT 4: STRENGTHEN A SUPPORTIVE ENVIRONMENT TO INSTITUTIONALIZE FISTULA PREVENTION, REPAIR AND REINTEGRATION OF SERVICES

- 4.1 Strengthen policies in countries to improve access to and quality of fistula services.
- 4.2 Global leadership demonstrated through sharing information and materials.

Progress to Date

Fistula Care has worked with national, state, and local governments to improve the environment for fistula by influencing policies, guidelines, and protocols on fistula repair, reintegration, and prevention. FC Project has supported six of the project countries (Nigeria, Sierra Leone, Uganda, Rwanda, Mali, and Bangladesh) in initiating and establishing national fistula prevention and repair strategies. In the last year, FC worked with Mali and Uganda to revise norms and protocols, policies, and standards of care. In both countries, the MOH has adopted FC tools as their own. FC also has given support to the regional ECSA Health Community to develop a model fistula policy—which is the basis for the one that is now being adapted in Uganda.

Fistula Care has an excellent reputation at the local, national, and international levels and is seen as a positive force in its technical expertise and advocacy role. The FC Project in Uganda galvanized partners to respond to the MOH's request to establish a National Fistula Technical Working Group. The diverse stakeholder group meets regularly and works collaboratively through a coordinated set of complementary roles and responsibilities according to their strengths and expertise. The project also supports national task forces in Bangladesh, Guinea,

and Rwanda. Fistula Care has been instrumental in resuscitating the Nigerian Technical Working Group to assume an active role after years of inactivity. In this revived capacity, the group is developing a national strategic framework and plan; mobilizing non-project funds and resources for fistula programming; overseeing national interventions; and using NDHS data to conduct analysis to recalculate incidence of fistula. This approach of creating an inclusive group has provided a more viable and collaborative networking model to work with other partners. These landmark contributions of FC to national programming hold promise for influencing and shaping the future direction for fistula treatment and prevention in these and other countries. Further, Fistula Care has developed tools (guidelines, protocols) that have been effective in standardizing practices in project-supported centers (see Annex D).

Challenges and Constraints

Maternal health, family planning, and other women's and girls' health interventions are supportive of fistula prevention and offer opportunities for early identification and referral of women with fistula. However, they have not effectively integrated messages on fistula prevention or treatment into their activities. One reason is that the project has not systematically developed modalities for collaborating with other USAID-funded MNH and FP projects on prevention, identification, and referral activities. Overall, the FC Project has connected more with other global organizations focused on fistula than with USAID-supported MNH and FP projects. But there have been some exceptions, particularly where either EngenderHealth or Intrahealth are partners or primary implementers of other projects.²⁹ The Missions expressed interest in strong linkages between FC and their other bilateral and global RH/FP and MNH programs especially in regions where multiple projects provide FP, BEmONC, and CEmONC services.

1. As Missions develop their Global Health Initiative strategies and BEST action plans, they are challenged to focus on strategic choices about what interventions to support. Some Missions have noted that it is difficult to incorporate fistula repair into maternal mortality reduction strategies, stating that they would drop the program except for the fact that they have control levels in their budgets.
2. Sustainability of fistula services by the country is constrained by a number of factors, including limited availability of qualified surgeons and limited financial resources to offer these services free of charge to women. Many countries have not integrated treatment of fistula and other severe obstetric morbidities into their Safe Motherhood or MDG 5 strategies, nor developed a separate strategy for addressing fistula or other morbidities. While the project is beginning to work with Nigeria on a strategy to increase capacity to keep up with the number of new fistula occurring annually, considerations should also be given to a strategy that transitions full responsibility to the federal and state governments to prevent and treat fistula.

²⁹ In Guinea, the project had a MOU with the ESD project for FP activities. In Sierra Leone, the project supported site received support from Marie Stopes for family planning. At the Gao site in Mali, FC collaborates with Kineya Ciwara and ATN, the two USAID bilateral projects on which IntraHealth is a partner. In Ethiopia, the outreach has been done throughout in coordination with the Pathfinder bilateral. In Bangladesh, the work is closely coordinated with the RESPOND Associate Award, Mayer Hashi, which is also managed by EngenderHealth.

III. CONCLUSIONS AND LESSONS LEARNED

Achievement of Objectives: Review of the monitoring data demonstrates that the project has achieved or surpassed its objectives under all four results. Its leadership on research and global and national advocacy has been particularly important for building and disseminating the evidence base on fistula. There has been a supportive interrelationship between service delivery and research. The project has also done a good job in integrating prevention and outreach efforts. The challenge is to broaden the prevention and outreach work beyond the confines of the project actions and integrate them more fully into RH/FP and MCH programs more broadly—even if in the future, the repair services, research and advocacy continue to be the focus of fistula-specific program.

Comprehensive Care: Fistula Care has made enormous contributions in strengthening fistula programming, service delivery, and different levels and types of care, as well as in supporting an enabling environment in countries supported by the project. Assessment observations show that the synergy between fistula repair and prevention was strongest and most effective when sites used a holistic approach to repair and prevent fistula, including FP, and maternal health with BEmONC and CEmONC services. To verify these observations, the project could do a simple comparative analysis of uptake of FP and the number of deliveries in health facilities at stand-alone and integrated services.

Participatory Approaches: The involvement of governments, facility managers, and providers at all levels of care, as well as community participation, have been critical to the achievements of the project and its partners in identifying women who need services, decreasing stigma and discrimination, supporting reintegration of isolated women, and institutionalizing fistula repair services within the health system for better sustainability. In Guinea, Uganda, and Nigeria, governments are taking ownership and supporting the project with various levels of policy pronouncements, human resources contribution, and M&E with use of data collected by FC-supported facilities. In Guinea, community taxes have generated support for reintegration services and support of women before, during, and after surgery. The Nigerian government has committed funds to expand training of health care personnel in fistula treatment to work in facilities beyond the FC Project's mandate. Bangladesh, Uganda, Mali, and Nigeria have developed national strategic plans. Strong community participation has been an effective and successful strategy for locating women living with fistula and helping them access facilities as well as reintegrating into their communities post-repair.

The Power of Data: Data collection and analysis have been powerful tools for clarifying, verifying, and dispelling long-held assumption about fistula, the women who get it, their situation and needs, and surgical outcomes. Data from the FC Project's research has provided new insight into the profile of women living with fistula, offering a somewhat different view from the existing literature. Improvements in monitoring data have helped facilities to understand where women come from and to assess the surgical capacity required in each country to cope with the number of cases. It is also helpful in improving the quality of repairs and overall QOC. The project is also examining the very high and sometimes intimidating prevalence and incidence data on fistula, with an eye toward adjusting its programming approaches.

IV. RECOMMENDATIONS FOR FISTULA CARE

Based on the key findings of this assessment, the following are recommendations for the remainder of the FC Project.³⁰

1. In the remaining time frame, FC should develop a model for collaboration with other USAID- and donor-funded MNH and FP programs, especially for identifying cases within communities and referring such cases to facilities where services are available. These other projects can take more responsibility for prevention (e.g., routine screening for fistula during postpartum visits and at FP service centers).
2. Current community mobilization models should be adapted to a more mobile model that can operate in different locales depending on the preponderant provenance of fistula repair patients for each center, especially if monitoring data demonstrates shifts in where patients are coming from over time. There are indications that longer-established centers are drawing women from farther and farther away.
3. The project should conduct, or support a partner's efforts to conduct, an inventory of (1) all sites capable of repairs with minimal support and (2) the location of surgeons with fistula repair skills. This will assist with FC program planning beyond the current project and could inform the development of models for other USAID initiatives, and those supported by governments, NGOs, and other donors.³¹
4. The project should be clear with supported centers that they are responsible for adhering to a woman's stated reproductive intentions post-repair. When a patient decides to use a contraceptive method, it should be offered immediately after counseling at discharge, with direct guidance for healing prior to resuming sexual intercourse. Patients should not have to wait until their post-surgery one- to three-month follow-up visits.
5. If the Nigeria community survey of fistula incidence coincides closely with recent DHS estimates, FC should let other Missions with recently collected DHS fistula data, or with plans to do so in the next year (Uganda), know of the potential use for calculating estimates of incidence and perform the analysis. This will build evidence behind current estimates and hopefully set a baseline for the development of plans for significant reduction of fistula in several countries.
6. Introduce a mechanism for fistula screening during postpartum visits. Early diagnosis and treatment can greatly reduce the number of women living with fistula. This strategy is complementary to the planned development of a protocol for immediate catheterization for women who have experience prolonged or obstructed labor. This is a powerful strategy to improve access to early treatment and thus decrease rejection and discrimination suffered by women living with fistula, thereby reducing the need for resource-intense reintegration. To encourage women to visit health facilities within two weeks after a home birth, social mobilization and outreach activities should include messages about the value of postpartum visits for prevention and early detection of fistula. To avoid overwhelming fistula services by such routine postpartum screening, the project could pilot the new protocol (once

³⁰ These recommendations are based on a two-year time horizon. The evaluation team recognizes that if the remaining time is restricted to one more year, the majority of these would not be possible. With a one-year time horizon, the project would only have time to finish out ongoing service delivery, policy, and research activities and document lessons learned and disseminate research findings.

³¹ The project is already collaborating with Project Relief International to map sites and train surgeons. In addition, it plans to reach out to previously trained surgeons to determine their current practice and needs.

developed) in several areas with stronger capacity for implementation and sufficient bed space to accommodate the demand.

7. The Guinea evaluation's community survey of the Levels-of-Care model is intended to investigate some of the social impacts of the project's outreach and reintegration activities. Time and resource permitting, the project should use this information and some of the demographic information collected as part of the prospective study to more thoroughly analyze:
 - a. The value-added of reintegration. Is it sufficient to justify continuation in the future? Is reintegration support necessary in all countries? Which women really need these services and what kind of services would be most helpful to them?
 - b. Which economic and social factors either facilitate or impede women's access to care?
 - c. The relative efficacy of mass media versus community-based outreach activities for generating demand and communicating prevention messages? Who is reached by these different approaches and helped most by them?
 - d. What types of prevention messages are most persuasive? Who are the key decision makers about acting on messages in different contexts?
 - e. What constraints do women face in accessing care and at what point do they become aware of the availability and location of services?

V. ISSUES AND QUESTIONS FOR FUTURE DIRECTIONS

Prior to the end of the project, USAID should consider some emerging conceptual issues for future program design.³²

1. A future project should increase the reach of fistula knowledge, outreach, and prevention through collaboration with other RH/FP and MCH programs to better integrate fistula prevention and screening messages and interventions. For instance, social mobilization on birth preparedness and ANC counseling undertaken by MCH programs should incorporate messages on fistula prevention. A follow-on project could support this process through broader adaptation and dissemination of FC tools and IEC materials. Similarly, postpartum and neonatal visits are an opportunity to identify women who have symptoms of fistula and then refer them for further screening to promote early detection and intervention. This could quickly address new cases and limit the backlog of patients. A new project could develop a protocol for routine screening, similar to the protocols have been developed to screen for gender-based violence during reproductive health and FP visits and HIV voluntary testing and counseling. FP programs, especially those with community-based distribution, could provide services for post-repair women while also training community-based distributors to (1) distribute information on fistula prevention and available repair services, and (2) conduct first-level screening to identify women with fistula-related symptoms.
2. From a health systems perspective, at a country level, it is recommended that the next project work toward greater integration of fistula and other MNH services. Several USAID Missions have voiced their preference for this type of approach.³³ There are pros and cons to moving toward such an approach. The current global project has a number of advantages. It has been able to conduct research across several countries to produce much-needed generalizable evidence on surgical practice, post-surgical care, and the socio-demographic profile of women with fistula. It has also produced standardized training curricula; protocols for screening, supervision and medical monitoring; auditing of deaths; and standard program monitoring indicators. The project has also been an important actor at the global level in international advocacy. All of these worldwide efforts benefit from a centrally funded global program. At the national level, however, it is incumbent that a future program move local actors through a process of greater institutionalization and ownership, with greater reliance on national skills and resources. A future program should more deliberately work toward building sustainable institutional capacity to offer fistula prevention and repair services as part of national reproductive health services. USAID/Nigeria's request for the project to develop a roadmap for fistula elimination (i.e., prevention, capacity to eliminate all backlog

³²These recommendations also reflect the recommendations offered by USAID Missions surveyed by USAID/Washington on future directions (see Annex E).

³³ This was particularly true in Uganda and Ethiopia. In Nigeria, the evaluation team concluded that centers with more comprehensive services are more likely to be sustainable for several reasons. Fistula surgeons, for reasons related to professional growth opportunities, are unlikely to want to dedicate their career to fistula repair only. Integrated service delivery sites allow them greater opportunity for more varied practice. Second, integrated centers offer more opportunity for sustainability of higher QOC, which will contribute to both fistula treatment and prevention. The improvements introduced for fistula treatment—such as better record keeping, monitoring of complications, auditing of deaths, and infection control—will also strengthen obstetric care and other surgical practice if institutionalized through a whole facility approach. Currently, they are only applied to fistula care within repair and prevention sites. The fistula technical working groups are also good models for involving diverse stakeholders in strengthening the health system more broadly. Ultimately, the sustainability of fistula repair and prevention services depends on governments and the private sector working together. The public-private partnership in Uganda is an excellent example of how to make this work

and to repair all new fistula cases every year) is worth evaluating as a model for future directions in fistula programming.

3. LOC evaluation of prevention activities in Guinea should provide some concrete evidence on the value of local governance as a vital component of fistula prevention and reintegration. This information should be used as the basis for evaluating the impact of similar methodologies, and should be applied in other countries prior to committing to replicating the community prevention and reintegration activities in a follow-on program. A broader analysis of prevention activities can be accomplished by comparing key indicators, such as uptake of FP methods and numbers of health center and hospital deliveries in FC and non-FC supported facilities.
4. This assessment found that many women who seek care at project facilities do not have a fistula, but suffer other serious birth-related morbidities such as cystocele, uterine prolapsed, and stress incontinence. Within USAID's GHI, which largely focuses on reduction of maternal and newborn mortality, HIDN should engage a panel of experts to assess (1) how to best address maternal morbidities in its fistula or other MHPs, and (2) how USAID can play a more active role in engaging other donors and national governments in seeking ways to address other severe birth-related morbidities.
5. The USAID management team should consider designing a global project with a more narrow technical focus on fistula repairs and clinical prevention; this could be implemented in select countries to develop and implement national fistula elimination plans. In such a model, technical assistance may focus on surgical repairs and tertiary prevention strategies, such as using partograph to monitor labor and improving the availability and quality of c-sections. Country selection could be based on a number of key criteria including capacity to estimate prevalence and incidence, in-country capacity to quickly scale up to conduct sufficient surgeries to meet annual incidence, and political commitment. The project might also emphasize expansion and institutionalization of partograph use to monitor labor, CEmONC, and comprehensive FP services, including long-acting and permanent methods in conjunction with other RH/FP and MNH programs.
6. Fistula Care has focused its surgical capacity building on surgeons who practice at supported centers. USAID should consider an alternative or complementary approach of supporting surgeons where they practice. There is also potential in some countries to go beyond the cadre of master trainers from supported centers and to bring in other surgeons who are skilled, but not practicing in project supported centers, to train less skilled surgeons through pooled efforts or camps in hospitals in their respective regions. It is critical to success to also train nurses who can support and assist during surgeries and effectively provide pre- and post-operative care. Exchange and collaboration across different sites can include both USAID-assisted sites and those supported by others, such as the government, private hospitals, and public services receiving support from other donors. USAID should assess if there is a greater value to focusing on specific centers or on specific surgeons with a demonstrated interest in fistula surgery and opportunities to practice at the facilities where they work.
7. A future project would benefit from greater engagement of other members of the HIDN, particularly those who manage other MNH programs, particularly to begin to integrate some of the key prevention messages and activities into other MNH technical assistance. The current USAID management team should also liaise to a greater extent with Mission health officers to provide a more comprehensive understanding of the program's objectives at both the country and global level and how it contributes to GHI objectives on reducing maternal and neonatal mortality and morbidity, to health system strengthening, and to a women- and girls-centered approach.

APPENDIX A. ASSESSMENT SCOPE OF WORK

Scope of Work

GH/HIDN & PRH: MID-TERM ASSESSMENT OF THE FISTULA CARE PROJECT

(revised: 05_26_11)

I. PURPOSE

The purpose of this activity is to provide the United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Health, Infectious Disease and Nutrition Office (HIDN)/Maternal and Child Health Division (MCH) with an independent mid-term assessment of the Fistula Care Project. Fistula Care is a five-year global project that began on September 25, 2007 and will end on September 24, 2012. As the project is over half way through implementation, HIDN/MCH is commissioning this mid-term assessment to examine the project's progress towards achieving planned results and lessons learned to date. The assessment will draw from and build on a USAID field mission survey conducted by HIDN/MCH to determine the need and anticipated future demand for a fistula treatment and prevention focused project. The assessment team will identify Fistula Care activities that may warrant continued future investment, as well as other fistula prevention, treatment and reintegration interventions not a part of Fistula Care's current portfolio that would likely contribute to improvement of the program.

II. BACKGROUND

In September 2007, GH/HIDN/MCH awarded the Fistula Care Project, a 5-year worldwide Associate Award under ACQUIRE Cooperative Agreement to EngenderHealth as the implementing partner.³⁴ The Fistula Care Associate Award is designed to allow USAID Missions and Bureaus to easily access high quality, specialized technical assistance and support for their activities involving fistula prevention, treatment and reintegration; and monitoring, evaluation and research. USAID missions may use traditional field support mechanisms to obtain the services of the project. The project has a ceiling of \$70 million. Fistula Care's core funding and field support are each split between the MCH account and POP funds. The AOTR resides within HIDN, and two Technical Advisors and a Program Assistant from PRH are members of the USAID management team.

Fistula Care is designed to assist countries to strengthen the capacity of surgeons and hospitals to provide fistula repair, increase access to and timely use of emergency obstetrical care, increase understanding about obstetric fistula and steps to prevent it, and conduct research to strengthen the quality of fistula services. The project also assists USAID/Washington to monitor fistula activities Agency-wide and report on this area of Congressional interest.

Fistula Care operates under the following four Intermediate Results:

³⁴ The Leader ACQUIRE Cooperative Agreement was awarded to EngenderHealth as the lead implementing organization, in partnership with IntraHealth International, CARE, Meridian Group International, Adventist Development and Relief Agency (ADRA) and Society for Women and AIDS in Africa (SWAA). Under the Fistula Care Associate Award, EngenderHealth remains the lead implementing partner, with IntraHealth International providing technical assistance and leadership in two countries. All other partners are country-specific service provision partners, e.g., Mercy Ships, REF in Niger, Gloag Foundation in Sierra Leone, private hospitals, and Ministries of Health.

- Intermediate Result #1: Strengthen the capacity of centers to provide quality services to repair and care for women with obstetric and traumatic gynecologic fistula
- Intermediate Result #2: Enhance community and facility understanding and practices to prevent fistula, utilize and deliver services for emergency obstetric care, and support women’s reintegration
- Intermediate Result #3: Gather, analyze, utilize and report data to improve the quality and performance of fistula services
- Intermediate Result #4: Strengthen a supportive environment to institutionalize fistula prevention, repair and reintegration of services

For more information on Fistula Care’s work, see Annex I.

III. STATEMENT OF WORK

The external assessment team will have two main tasks

- Task 1: Assess whether Fistula Care is achieving its planned results as stated in the project’s Performance Management Plan and approved annual workplans. By reviewing both the technical and managerial aspects of the project, the team will assess the project’s results, strengths, weaknesses, lessons learned and best practices, and responsiveness to the field.
- Task 2: Make recommendations to improve implementation for the remainder of the current project and to inform follow-on project(s). The team will identify current initiatives, activities or approaches that warrant continued investment, any that warrant modification (or discontinuation), as well as any other promising fistula program models and approaches that are not currently addressed but should be considered for future investment.

Illustrative questions to assist in the assessment are provided below. The assessment team is expected to refine, prioritize and finalize these questions in discussion with the HIDN/MCH and PRH/SDI team at the start of the assessment.

TASK 1: Assess Technical and Managerial Progress to Date towards Achieving Planned Results

(Estimated level of effort – 70%)

1. What has been Fistula Care’s progress to date in relation to planned results and performance indicators (provided in the project’s Performance Management Plan and workplans)?
 - a. Main data sources: project documents, key informant interviews, mission surveys
2. What have been Fistula Care’s challenges to achieving results? What are the most important lessons learned and best practices (both technical and managerial) identified?
 - b. Main data sources: key informant interviews, project documents, field visits
3. How has Fistula Care supported the sustainability of strategies and interventions to build capacity for fistula prevention, treatment and reintegration (emphasis on IRs 1 & 2)?
 - c. Main data sources: key informant interviews, project documents, field visits including service delivery record reviews
4. What contributions has Fistula Care made to global leadership, to advancing research and innovation, and to transferring new technologies to the field (emphasis on IRs 3 & 4)?
 - d. Main data sources: key informant interviews, field visits, project documents
5. Has Fistula Care been responsive to USAID Missions, USAID regional bureaus, and other global stakeholders?
 - e. Main data sources: mission surveys, field visits, key informant interviews

6. What are the assessment team's expectations regarding the project's future progress? Is it on course to achieve its intended results by the end of project? Are there ongoing challenges identified?
 - f. Main data sources: key informant interviews, field visits

TASK 2: Make recommendations to improve implementation of the Fistula Care project and to inform follow-on project(s)

(Estimated level of effort –30%)

1. What recommendations does the team have for Fistula Care to enhance achievement of technical results before the end of project? If the team identifies any initiatives, activities or approaches that are not achieving the expected results, the team will recommend how/if these can be modified to result in the targeted achievement, or if they should be discontinued.
 - a. Main data sources: key informant interviews, mission surveys
2. What recommendations does the team have for the Fistula Care implementing partner to enhance management of the project?
 - b. Main data sources: mission surveys, field visits, key informant interviews
3. What recommendations does the team have for how the USAID management team can improve its management of Fistula Care during the remainder of the project?
 - c. Main data sources: mission surveys, field visits, key informant interviews
4. What are the key initiatives, activities and approaches that warrant additional investment in the future, beyond the end of the Fistula Care project?
 - d. Main data sources: key informant interviews, field visits, mission surveys
5. What are other promising fistula program models and approaches, not addressed by Fistula Care, which should be considered for future investment?
 - e. Main data sources: key informant interviews, field visits, mission surveys

IV. SUGGESTED METHODOLOGY

The assessment team shall use a variety of methods for collecting information and data. The following essential elements should be included in the methodology as well as any additional methods proposed by the team.

Document Review: HIDN/MCH and PRH/SDI and/or Fistula Care will provide the assessment team with a package of briefing materials related to the Fistula Care assessment. This documentation will include:

- Fistula Care annual reports, workplans and management reviews which are developed and reviewed as part of the continuous monitoring of the project
- Fistula Care technical, advocacy and research program documents

The team also is expected to review Fistula Care's website, which includes a database of project sites, indicators and activities (see <http://www.fistulacare.org/pages/index.php>). *An initial list of background documents is attached in Annex 2.*

Team Planning Meeting and Development of Data Collection Tools: The assignment work will commence with a two-day Team Planning Meeting (TPM) in Washington, DC and *may* include travel to New York City to meet with the Fistula Care project staff in person. This meeting will allow the team to meet with the USAID HIDN/MCH and PRH/SDI Fistula Care Management Team to be briefed on the Fistula Care Agreement and the project activities. It will also allow

USAID (and the partners) to present the team with the purpose, expectations and plans for the assignment. In addition, the team will:

- Clarify team members' roles and responsibilities
- Review and develop final assessment questions
- Review and finalize the assignment timeline (including milestones and deliverables and clear due dates) and share with USAID
- Develop data collection methods, instruments, tools, guidelines and analysis for submission to USAID for comment and approval
- Review and clarify any logistical and administrative procedures for the assignment
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Develop a preliminary draft outline of the team's report, and
- Assign drafting responsibilities for the final report.

Once the assessment team has developed the data collection tools (questionnaires, interview guides, etc.) based on the agreed upon assessment questions and approaches, they will present them to HIDN/MCH and PRH/SDI for discussion and approval prior to their application in order to verify their appropriateness. These tools will be used in all data collections situations, especially during country field visits, in order to ensure consistency and comparability of data.

In addition to formal briefing and debriefing meetings, the assessment team may contact the USAID Fistula Care management team as necessary to provide updates on their progress and obtain additional guidance on logistics, additional data and information sources, etc. And vice versa, USAID may contact the assessment team as necessary to monitor progress and provide additional guidance.

Email/Telephone Mission Surveys: The assessment team should design and implement an email and/or telephone survey of USAID regional and country missions that have bought into or worked with Fistula Care regarding their level of satisfaction and experiences with the project. This will be informed by the 2010 email survey of missions, and will update it to seek input from new mission personnel or those who did not previously respond, and to reflect more recent experience with the project and current needs within USAID MCH & FP programs. This may be done by email or telephone, based on missions' preferences. The assessment team should also design and implement an email and/or telephone survey to poll outside organizations that have partnered with Fistula Care (such as UNFPA, WHO, CDC, and FIGO) regarding their level of satisfaction and experiences with the project. Both survey questionnaires will be reviewed and approved by HIDN/MCH before the surveys are implemented.

Key Informant Interviews: The assessment team will conduct qualitative, in-depth interviews with key stakeholders and partners (*a preliminary list of stakeholders and partners is attached in Annex 3, but the assessment team should add to this list as necessary*). Whenever possible, the assessment team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. Fistula Care and USAID staff will give advance notice to several key informants, and then GH Tech will follow-up to schedule the interviews in coordination with Fistula Care and USAID staff.

Key informants should include, but not be limited to:

- Fistula Care project staff
- Fistula Care's partner IntraHealth International staff

- USAID/Washington (HIDN/MCH and PRH/SDI) Fistula Care project management staff, and Legislative and Public Affairs staff
- USAID Missions, in countries in which Fistula Care works or collects data
- Fistula Care in-country partners, including public sector and NGO/FBO entities (e.g., Mercy Ships, Gloag Foundation, REF Niger)
- Beneficiaries
- Experts with a variety of perspectives on fistula programs, including those from UNFPA's Campaign to End Fistula, WHO's Special Program of Research, Development and Research Training in Human Reproduction, Centers for Disease Control and Prevention, and international professional associations, such as FIGO and the International Society for Obstetric Fistula Surgeons

Field Visits: The assessment team is expected to travel in two teams (Team A and Team B) to a total of four countries, with each team visiting two countries in which Fistula Care implements substantial activities. Team A will visit Guinea and Nigeria (West Africa) and Team B will visit Uganda and Ethiopia (East Africa). The assessment teams are expected to interview project staff, USAID Mission PHN staff, other implementing organizations, and Fistula Care partners (including local NGOs, public sector representatives etc.) and beneficiaries in these three countries, and review a sample of service delivery records in health facilities. Points of contact for each country will be identified by USAID and Fistula Care staff.

In addition to the two key tasks outlined in Section III, Statement of Work, Team B will also help the Uganda Mission answer a few key questions that will assist the mission in follow-up step from their CDCS review. These questions include:

1. How is the Fistula Care program linked with the mission's MNCH and FP programs? Could there be better linkages through referrals, etc?
2. What is the organizational capacity of the Fistula Care program's on-the-ground implementers, like Medical Missions of Mary? Are they most capable in the area of surgery and recovery? Are they the right people to also do community mobilization/prevention?
3. What balance should the mission strike in terms of investment of prevention v. surgeries?
4. Who are the best orgs to address Fistula prevention? Should this be Fistula care or our other Implementing Partners working more broadly in MNCH and FP?

Janex Kabarangira, the activity manager from the Uganda Mission, would assist with this task. She could in-brief and out-brief with the evaluators, and may also spend 1-2 days in the field with Team B.

Data Analysis: As the team reviews the documents available and interview lists and develops the data collection tools, they will ensure that they will in fact have the data they need to adequately respond to the assessment questions. Once all data is collected, several days will be spent on carefully compiling, reviewing and identifying key findings prior to making a presentation of preliminary findings to USAID.

V. DELIVERABLES

Approved Workplan: The assessment team will prepare a workplan, including milestones and deliverables with due dates clearly established during the Team Planning meeting, to be provided to USAID for approval. This plan will include, but not be limited to, the following items:

- Key assessment questions, methods, and tools
- Timeline for key activities, including product due dates

- Schedule of interviews, both internal and external
- Schedule of informal and final debriefing presentations to USAID and Fistula Care

This workplan (including questionnaires, etc.) will be approved prior to initiation of key informant interviews and site visits.

Debriefing Meeting: After the completion of data collection, the consultants will hold an informal debriefing meeting solely with the USAID Fistula Care management team prior to documenting major findings and recommendations, in order to provide a preview and highlight any issues. The assessment team will then hold a second day of debriefing meetings with HIDN, PRH and Fistula Care to present the major findings and recommendations of the assessment. This will be done prior to the presentation of the draft report. The debriefing meeting will involve an oral presentation and written summation of the findings. Succinct briefing materials appropriate for the audience will be prepared and distributed during the briefings. The meetings will be planned to include time for dialogue and feedback.

Draft Report: The assessment team will provide HIDN/MCH, PRH/SDI and Fistula Care with an electronic copy of the draft report that includes all the components of the final assessment report. USAID and Fistula Care will provide written comments on the draft report to the assessment team leader within 10 working days of receiving the report.

Final Assessment Report: The contractor is then required to submit a final report within 10 working days after USAID has provided its feedback on the draft report. The final assessment report should include, at minimum, the following: executive summary; scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); lessons learned (implications for future designs and for others to incorporate into similar programs); and recommendations (proposed actions for management based on the conclusions) for the current project and for future activities.

The report should be no longer than 30 pages, excluding annexes. As portions of the report may contain procurement sensitive information, the assessment team will work with USAID and GH Tech to produce a version that is suitable for public distribution to be posted to the DEC in a timely fashion. *A proposed report outline is attached in Annex 4.*

GH Tech will provide the edited and formatted final document approximately 45 days after USAID and Fistula Care provide final approval of the report. The final report is to be submitted to HIDN/MCH both in hard copy (5 copies) and in electronic form.

VI. TEAM COMPOSITION

GH Tech will recruit two team members. Between them, the team members should have substantial and demonstrated knowledge of fistula treatment and prevention issues as well as international public health in the fields of maternal health, FP and reproductive health. Specifically, team members should have between them:

1. 5-10 years of experience in international public health in the fields of maternal health, family planning and reproductive health.
2. 7-10 years of experience in the fields of maternal health, family planning and reproductive health in developing country settings including expertise in several of the following areas. There should be complementary in the skills sets of the team members.
 - Research, monitoring and evaluation
 - Fistula care
 - Clinical service delivery, including counseling

- Capacity building of health workers and institutions
- Community-based activities (e.g., behavior change communications and social support)
- Quality improvement

In addition, each team member should have, at minimum, the following skills and experience:

1. An advanced degree in Public Health or other relevant course of study.
2. Demonstrated skill in written and oral communication.
3. Demonstrated knowledge of USAID policies and procedures.
4. Ability to work effectively in, and communicate with, a diverse set of professionals.

One of the team members will be designated as the Team Leader. Additional qualifications/responsibilities of the Team Leader include:

- Strong organizational skills to ensure the team stays on schedule
- Excellent English language skills (both written and oral) as s/he will take the lead role in finalizing the written report
- Strong interpersonal, including negotiation, skills to facilitate working with a wide variety of individuals at USAID, Fistula Care, GH Tech and in the field in the completion of this assignment
- Experience in program evaluation

In addition to the two team members recruited by GH Tech, two staff members from the USAID's PRH Office will act as full team members (full time during team planning meetings and country visits) to facilitate introductions with key informants, provide briefings about the project, participate in field visits and contribute knowledge of USAID policies and procedures and of maternal health, FP and RH. USAID staff will not be responsible for report writing but will coordinate their own travel plans, country clearances, other logistics, and expenses will be provided separately by the PRH Office.

Team A will consist of Trish MacDonald from PRH and the team leader. Team A will visit Guinea and Nigeria (West Africa).

Team B will consist of Erin Mielke from PRH and the team member. Team B will visit Uganda and Ethiopia (East Africa).

VII. DURATION, TIMING AND SCHEDULE

It is anticipated that the period of performance of this assessment will be approximately 13 weeks from the beginning of work to the submission of the final report to GH Tech for editing and formatting, including the 10 days during which USAID and Fistula Care will provide comments on the draft report. The assessment team will be authorized to work a six-day workweek when in-country.

The following is a sample schedule. The assessment team should propose a schedule and exact dates for the assessment prior to initiation of the assignment. It is hoped that the assessment will commence in mid June 2011.

Task/Deliverable	LOE*		Potential Dates
	Team A	Team B	
Review background documents	3 days	3 days	June 8 – 10
Consultants travel to DC	0 day	2 day	June 11 -12
Team Planning Meeting	2 days	2 days	June 13 - 14
Development of data collection tools, including email survey	2 days	2 days	June 15 -16
USAID review & approve workplan while consultants are in DC	1 day	1 day	June 17
Information and data collection. Includes interviews with key informants, domestic field visits	5 days	5 days	June 20 -24
Travel to country	2 days	2 days	Team A: July 9-10 Team B: June 25-26
<i>2 Country Visits</i>	<i>14 days</i>	<i>14 days</i>	<i>Team A: July 11- 26 Team B: June 27 – July 12</i>
<i>Return home after Travel</i>	<i>2 days</i>	<i>2 days</i>	<i>Team A: July 27-28 Team B: July 13-14</i>
<i>Travel to DC for debriefings</i>	<i>0 days</i>	<i>2 days</i>	<i>Team B: July 30-31</i>
<i>Data Analysis</i>	<i>3 days</i>	<i>3 days</i>	<i>Aug 1 - 3</i>
<i>Debriefs with HIDN/MCH, PRH/SDI and Fistula Care team</i>	<i>2 days</i>	<i>2 days</i>	<i>Aug 4-5</i>
<i>Draft assessment report</i>	<i>5 days</i>	<i>5 days</i>	<i>Aug 8 -12</i>
<i>Consultant travels home</i>	<i>0 days</i>	<i>2 days</i>	<i>Aug 13-14</i>
<i>USAID and Fistula Care provide comments on draft report</i>	<i>0 days</i>	<i>0 days</i>	<i>Aug 29</i>
<i>Prepare final assessment report</i>	<i>4 days</i>	<i>2 days</i>	<i>Aug 30 – Sept 2</i>
<i>Editing and formatting by GH Tech</i>	<i>0 days</i>	<i>0 days</i>	<i>October 7</i>
<i>Total # days</i>	<i>45 days</i>	<i>49 days</i>	

*NOTE: LOE in each column reflects the team member recruited by GH Tech. The team member from the PRH office does not need to account for LOE, as their salary is provided by PRH, not GH Tech.

VIII. RELATIONSHIPS AND RESPONSIBILITIES

Overall Guidance: The USAID Fistula Care Management Team will provide overall direction to the assessment team.

HIDN/MCH Contact: Mary Ellen Stanton, Senior Maternal Health Advisor and Agreement Officer's Technical Representative for Fistula Care will be the official contact for the assessment team.

Responsibilities:

GH Tech

- GH Tech will be responsible for logistics for travel, including obtaining country clearances, for GH tech consultants. They will also assist with setting up interviews, meetings, etc. as needed.
- GH Tech will also work with the consultants to produce a report that does not include procurement sensitive information and is suitable for public distribution.
- Consultants will be responsible for coordinating and facilitating assessment-related field trips, interviews, and meetings as needed.

USAID HIDN/MCH and PRH/SDI

- USAID will provide overall technical leadership and direction for the evaluation team throughout the assignment and will undertake the following specific roles and responsibilities:

Before Work

- Documents: Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.
- Site visit preparations: USAID will negotiate with mission health officer to ensure approval for the visit, and will provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.

During In-Country Work

- USAID Point of contact: Throughout the in-country work, ensure constant availability of the Point of contact person(s) and provide technical leadership and direction for the team's work.
- A USAID PRH/SDI staff member will participate in site visits including in daily debriefing and analysis with other team members, but will not be responsible for report-writing. This member will serve as a resource person, providing the team with information and clarifications (on finances, background discussions, USAID regulations, etc.) that those in the field would not be able to provide, and information that would take longer to get from USAID Washington. At the start of the TDY, the team will identify any meetings at which the USAID staff member will not participate. This person's background knowledge of Fistula Care will offer a different lens through which to observe the interviews, and will provide insight into the project, which the evaluation team might not have otherwise.

After In-Country Work

- Timely Reviews: Provide timely review of draft/final reports and approval of the deliverables.

Fistula Care (Engender Health)

Before Work

- Documents: Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.
- Site visit preparations: Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.

During In-Country Work

- Meeting Arrangements: Fistula Care will support consultant(s) in coordinating meetings with stakeholders.
- Formal and Official Meetings: Fistula Care will assist with arranging key appointments with national and local government officials, if appropriate.
- Other meetings: If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.

After In-Country Work

- Timely Reviews: Provide timely review of draft/final reports and approval of the deliverables.

IX. RESTRICTIONS

The prime contractor, sub-contractors, and any consultants are subject to the restrictions set forth in USAID CIB 99-17, under evaluation.

X. LIST OF ADDITIONAL DOCUMENTS/ANNEXES

Annex 1: Brief Description of Fistula Care project

Annex 2: Background Documents

Annex 3: Key Stakeholders, Partners & USAID Contacts

ANNEX I: BRIEF DESCRIPTION OF THE FISTULA CARE PROJECT

Fistula Care is a five-year, worldwide cooperative agreement to support fistula prevention, repair, and reintegration; and monitoring, evaluation and research. Fistula Care will assist USAID/Washington to monitor fistula activities Agency-wide and report on this area of Congressional interest.

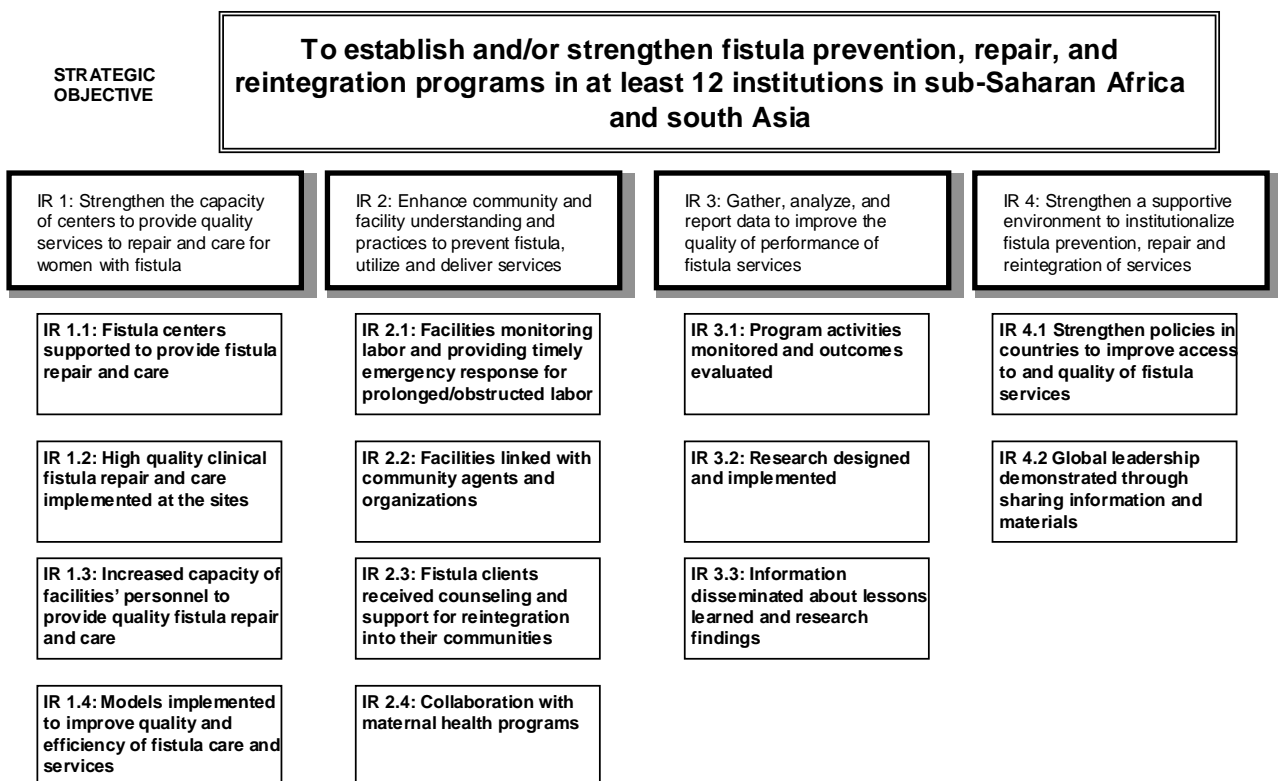
This GH/HIDN/MCH agreement is an Associate Award through the ACQUIRE Project, and accepts both MCH and POP funds.

Services Provided:

Fistula Care aims to:

- Strengthen the capacity of surgeons and hospitals to provide fistula repair
- Increase access to emergency obstetric care
- Increase understanding about obstetric fistula and steps to prevent it
- Conduct research to strengthen the quality of fistula services

Figure I: Fistula Care Results Framework



Priority activities for achieving these results include upgrading facilities and providing medical equipment and supplies; training providers in clinical and counseling skills; enabling health facilities to continuously monitor and improve the quality of their services; supporting transportation and hospitalization costs for fistula clients; working with communities to increase awareness about the causes of fistula, to increase access to preventive services, to reduce stigma, and to identify and refer women for treatment; strengthening facility-based birthing and

emergency obstetric care for prevention of fistula; partnering with other institutions to support women's rehabilitation and reintegration into family and community life; and conducting clinical and programmatic research to improve the safety and efficiency of care.

Fistula Care is implemented by EngenderHealth in partnership with IntraHealth International³⁵. The project works with public sector, private sector and non-governmental and faith-based institutions, both national and international, to provide a full range of fistula care services.

³⁵ The ACQUIRE Cooperative Agreement was awarded to EngenderHealth as the lead implementing organization, in partnership with IntraHealth International, CARE, Meridian Group International, Adventist Development and Relief Agency (ADRA) and Society for Women and AIDS in Africa (SWAA). Under the Fistula Care Associate Award, EngenderHealth remains the lead implementing partner, with IntraHealth International providing technical assistance and leadership in two countries. All other partners are country-specific service provision partners, e.g., Mercy Ships, REF in Niger, Gloag Foundation in Sierra Leone, private hospitals, and Ministries of Health.

ANNEX 2: BACKGROUND DOCUMENTS

These will include, but not be limited to:

1. Fistula Care Associate Cooperative Agreement
2. Fistula Care workplans Years 1-4
3. Fistula Care Quarterly and Annual Reports
4. Fistula Care Performance Management Plan
5. Fistula Care Management Reviews and Memos
6. Technical Briefs
7. Research Reports
8. Other Fistula Care Project Documents
9. Fistula Care advocacy materials
10. 2010 Fistula Care Mission Survey
11. USAID Evaluation Policy
12. <http://www.fistulacare.org/pages/index.php>

ANNEX 3: KEY STAKEHOLDERS, PARTNERS AND USAID CONTACTS

The assessment team should add to this preliminary list of stakeholders and partners as necessary.

U.S. Agency for International Development/Washington DC

Mary Ellen Stanton, Agreement Officer's Technical Representative, Health, Infectious Disease and Nutrition (HIDN)/Maternal and Child Health Division (MCH) Fistula Care Management Team

Trish MacDonald, Senior Technical Advisor, Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) Fistula Care Management Team

Erin Mielke, Technical Advisor, Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) Fistula Care Management Team

Chelsea Smart, Program Assistant, Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) Fistula Care Management Team

Elizabeth Fox, Deputy Director, HIDN Front Office

Scott Radloff, Director, PRH Front Office

Ellen Starbird, Deputy Director, PRH Front Office

Neal Brandes, MCH Research, HIDN/NUT

Esther Lwanga, MCH Research, HIDN/NUT

Barbara Bennett, LPA

Hope Sukin, Africa Bureau

Karen Fogg, Africa Bureau

Gary Cook or delegate, Asia Bureau

Population Health and Nutrition and Foreign Service National Officers in the Regions

Sukumar Sarker, Bangladesh

Thibaut Mukaba, Family Planning and Reproductive Health Management Specialist, DRC

Premila Bartlett, Senior Family Planning and Reproductive Health Advisor, Ethiopia

Jett Thomason, Program Office Coordinator USAID Guinea and Sierra Leone, Guinea

Dr. Madina Ba Sangare, Senior Reproductive Health Advisor, Mali

Sharon Epstein, HPN, Nigeria

Mary Skarie, REDSO

Eric Kagame, MCH Specialist, and Mary Kabanyama, Rwanda

Jett Thomason, Sierra Leone

Janex Kabarangira, Uganda

Fistula Care

Karen Beattie, Fistula Care Project Director

Evie Landry, Deputy Project Director

Joseph Ruminjo, Clinical Director

Mark Barone, Senior Medical Associate

Vera Frajzyngier, Senior M&E Associate

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Carrie Ngongo, Senior Program Associate

Bethany Cole, Senior Program Associate

Renee Fiorentino, Senior M&E Associate

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Edith Mukisa, Country Project Manager, Uganda

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Moustapha Diallo, Country Project Manager, Guinea

Fistula Care Consultants

Steve Arrowsmith, Trainer and Research Advisor, formerly with Mercy Ships International

Dr. S. Maguey, Trainer, Senegal

Dr. Tom Raassen, Trainer

Fistula Care Partners

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Prospective Study Principal Investigators

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ISOFS

Dr. Kees Waaldijk

FIGO

H. Rushwan, Executive Director

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Dr. Sinan Khaddaji

The Fistula Foundation

Kate Grant

APPENDIX B. PERSONS CONTACTED/PLACES VISITED

US-BASED CONTACTS: IN-PERSON AND PHONE INTERVIEWS

Name	Title	Institution
FISTULA CARE STAFF		
Mark Barone	Senior Medical Advisor	EngenderHealth/Fistula Care
Karen Beattie	Project Director	EngenderHealth/Fistula Care
Sarah Burgess		EngenderHealth/Fistula Care
Bethany Cole	Senior Program Associate	EngenderHealth/Fistula Care
Iyeme Efem	Nigeria Country Chief of Party	EngenderHealth/Fistula Care
Vera Frajzyngier	Senior Program Associate for Monitoring and Evaluation	EngenderHealth/Fistula Care
Evelyn Landry	Deputy Director	EngenderHealth/Fistula Care
Karen Levin	Program Associate for Monitoring and Evaluation	EngenderHealth/Fistula Care
Mieko McKay	Senior Program Associate	EngenderHealth/Fistula Care
Carrie Ngongo	Senior Program Associate	EngenderHealth/Fistula Care
Joseph Ruminjo	Clinical Director	EngenderHealth/Fistula Care
Kate Stratten		Intrahealth/Fistula Care
Marsha Hamilton		Intrahealth/Fistula Care
USAID/ WASHINGTON STAFF		
Mary Ellen Stanton	COTR	USAID/GH/HIDN/MCH
Erin Mielke	Fistula Care Technical Advisor	USAID/GH/PRH/SDI
Patricia MacDonald	Former Fistula Care Technical Advisor	USAID/GH/PRH/SDI
Ellen Starbird	Deputy Director	USAID/PRH
Gary Cook	Public Health Officer	USAID/ME/TS
Elizabeth Fox	Director	USAID/GH/HIDN
Neal Brandis	Research Advisor	USAID/GH/HIDN
Karen Fogg	Technical Advisor	USAID/AFR/SD
ADVOCACY AND RESEARCH PARTNERS		
Lauri Romanzi	Clinical associate professor in the Department of Obstetrics	New York Presbyterian Hospital-Weill Cornell Medical and International Uro-Gynecological Association
Sara Craven	Director, Washington D.C., Office	UNFPA

Name	Title	Institution
Gillian Slinger	Coordinator of the Campaign to End Fistula	UNFPA
Kate Grant	Director	Fistula Foundation

CONTACTS IN NIGERIA

Name	Title	Institution
Sharon Epstein	Health Office Director	USAID/Nigeria
Celeste Carr	Deputy Team Leader HPN	USAID/Nigeria
Joseph Monehin	MCH Program Manager	USAID/Nigeria
Folake Olayinka	Health Officer	USAID/Nigeria
Dr. Chris Isokpunwa	National VVF Coordinator	Federal Ministry of Health
Dr. Okara Dogare	Medical Officer	Federal Ministry of Health
Dr. P.A.L. Mommah	Head Family Health Department	Federal Ministry of Health
A. O. Akiniani	Outreach Division	Federal Ministry of Health
Dr. Bose Adeniran	Head of Reproductive Health	Federal Ministry of Health
Helen Akhigbe	Senior Nursing Officer	Federal Ministry of Health
Dr. Adamu Isah	Deputy Chief of Party	Fistula Care Project, Nigeria
Ukoh Victor	Finance & Operations Manager	Fistula Care Project, Nigeria
Mary Irite Suton	Monitoring and Evaluation	Fistula Care Project
Janres Kaduna	Procurement	Fistula Care Project
Dr. Bannet Ndyanabangi	Deputy Representative	UNFPA, Nigeria
Ibrahim Bako	Director of Programs	Radio Nigeria
E.K. Okere	Director of Operations	Radio Nigeria
Virgil Oketa	Special Assistant to wife of Governor/member MCCI*	MCCI, Ebonyi State
Cecilia U. Akanu	Member MCCI	MCCI, Ebonyi State
Flora Egwu	Administrative Secretary	MCCI, Ebonyi State
Dr. Law E. Adam	Executive Secretary	State Planning Commission
Dr. Uru Chuwukru	Coordinator community outreach, Public Health Physician	MCCI Ebonyi State
Dr. Asewusi	Coordinator	MCCI Ebonyi State
Joy Eze	Family Planning Coordinator	Ebonyi State Ministry of Health and Environment

Name	Title	Institution
Kate Oboke	Reproductive Health Coordinator	Ebonyi State Ministry of Health and Environment
Felix Uma		Ebonyi State Ministry of Health and Environment
Dr. Innocent	State Director of Medical Services	Ebonyi State Ministry of Health and Environment
Dr. Tsalhatu Maitsaba Moriki	Principal Medical Officer	General Hospital Gusau, Zamfara State
<u>Aluju Gomba</u>	Maintenance Officer	General Hospital Gusau, Zamfara State
Dr. Bashir Kanome	Fistula Surgeon	General Hospital Gusau, Zamfara State
Ames Mufid Kasure	Data Processing Officer	General Hospital Gusau
Sam Salele	A. E. O. Officer	General Hospital Gusau
Tijami Yisem	Physiotherapy	General Hospital Gusau
Lawal Isah Bunjuka	Head of Nursing Services	General Hospital Gusau
Hussaine Abdulsalem	Nurse/Midwife	General Hospital Gusau
<u>Apina Abala</u>	Program Manager	MCHIP, Gusau Office
Abdullahi Moyi Keura	Deputy Administrator	Ministry of Health Zamfara
Salihu Abibecker Avila	Permanent Secretary	Ministry of Health Zamfara
Ahmed Ma-abbe Keku	Director of Public Health	Ministry of Health Zamfara
Yusuf Muse Mekera	Director of Primary Health Care	Ministry of Health Zamfara
*MCCI=Mother Child Care Initiative, Ebonyi State		

CONTACTS IN GUINEA

Name	Title	Institution
Nancy Estes	Mission Director	USAID/Guinea
Neil J. Woodruff	Health Advisor	USAID/Guinea
Robert W. Hanchett	Team Leader, Health	USAID/Guinea
Paul Keita	Mayor	Commune du Kissidougou
Dr Madina Rachid	Director of Reproductive Health	Ministry of Health
Dr P��p�� Bilivogui	Director of Public Hygiene (formerly Regional Health Director, Labe)	Ministry of Health
Dr Ibrahima Sory Diallo	Fistula Surgeon, Dept. of Urology	Ignace Deen Hospital

Name	Title	Institution
Dr Mamadouba Soumah	Director of the Social Medical Center	Jean Paul II Hospital
Mme Bandian Daffa	General Supervisor and Advisor of the Social-Medical Center	Jean Paul II Hospital
Dr Mandian Camara	Fistula Surgeon and coordinator of repair activities at the Social Medical Center	Jean Paul II Hospital
Dr Ibrahima Baldé	Fistula Surgeon at the Social Medical Center	Jean Paul II Hospital
Dr Fodé Camara	Fistula Surgeon at the Social Medical Center	Jean Paul II Hospital
Dr Daouda Kanté	Fistula Surgeon at the Social Medical Center	Jean Paul II Hospital
Mme Diaka Diakite	Minister	Ministry of Social Affairs, Women's Promotion, and Children
Mr Elhadj Mouctar Diallo	Secretary General	Ministry of Social Affairs, Women's Promotion, and Children
Mr Ibrahima Kalil Sacko	Minister's Cabinet Attaché	Mr Ibrahima Kalil Sacko
Dr Ataoulaye Sall,	Hospital Director	Labé Regional Hospital
Dr Fatoumata Binta Diallo,	Regional Chief of Maternity Care (<i>Chef de la maternité régionale</i>)	Labé Regional Hospital
Mme Adama Hawa Diallo	Senior Nurse Maternity Care (<i>Sage femme maitresse de la maternité</i>)	Labé Regional Hospital
Mme Fatou Sow,	Advisor	EngenderHealth
Dr Houdy	Adjunct Regional Health Director for Labé <i>Adjoint au Directeur régional de la Santé de Labé</i>	Labé Regional Hospital
Mr Ahmadou Thiam,	Mayor of Labé	Commune de Labé
Mr Baldé,	Général Secretary of Labé	Commune de Labé
Mr Alpha Oumar Barry	Village Chief	Village Dongol Dayèbhè
El Hadj Abdoulaye Hafía Barry	Head of Religious Leaders in charge of sensitization on obstetric fistula	Islamic League of Labé
Mlle Tiguidanké Baldé	In charge of social immersion/reintegration of clients	Centre Social de Labé ('Karen Beatty')
Mr Safioulahi Bah	Prefect	Labé
Namory Keita	Professor and Chief of Gynecology and Obstetrics Services	National Donka Hospital
Moustapha Diallo	Country Representative	Fistula Care Project

Name	Title	Institution
Dr. Kasse	Medical Advisor	Fistula Care Project
Ibrahima Diakate	Training Advisor	Fistula Care Project
Dr Madina Rashid, MOH	Chief of the Division of Reproductive Health	Ministry of Health

CONTACTS IN ETHIOPIA

Name	Title	Institution
Aynalem Yigaw	Program Manager	IntraHealth, Regional Office, Bahir Dar
Anley Dessie	Regional and Technical Coordinator of Fistula Care Project	IntraHealth, Bahir Dar
Sister Menna Ayalew	Fistula Mentor	Woreta Pre-Repair Unit (PRU)
Gebru	Head of the Woreta Health Office	Fogera Woreta Health Office
Tilahun Yimaldu	Regional Program Manager	Pathfinder Bahir Dar Office, Integrated Family Health Project (IFHP)
Dessie	IFHP Program Officer	Pathfinder Bahir Dar Office, Integrated Family Health Project (IFHP)
Andualem Ayang	Co-head of Woreda Health Offices	Dangla Health Center, EmOC Center and Dangla PRU (all in same compound)
Getachew Zerihan	Co-head of Woreda Health Offices	Dangla Health Center, EmOC Center and Dangla PRU (all in same compound)
	3 Fistula Community Core Team members (one retired public servant now video-show businessman, one female Health Extension Worker, one male school teacher)	Dangla Health Center, EmOC Center and Dangla PRU (all in same compound)
Dr Hiwot Admasu	Obstetrician-Gynecologist Mentor	Dangla Health Center, EmOC Center and Dangla PRU (all in same compound)
	2 pre-repair fistula clients, 1 post-repair client	Dangla Health Center, EmOC Center and Dangla PRU (all in same compound)
Admas	Safe Motherhood Officer	Regional Health Bureau Bahir Dar
Bayih	Health Financing Officer	Regional Health Bureau Bahir Dar

Name	Title	Institution
Bogale	Curative and Rehabilitative Process Owner	Regional Health Bureau Bahir Dar
Wollela Mebrat	Deputy Speaker, Amhara State Council & Dep. Chair, Amhara Regional Women's Association	Amhara National Regional State Council
Bitew Abebe,	Obstetrician-Gynecologist and fistula surgeon	Bahir Dar Hamlin Fistula Hospital
Berthanu Menber	Outreach Health Officer	Bahir Dar Hamlin Fistula Hospital
Premila Bartlett	RH/MCH Advisor	USAID/Ethiopia
Zweditu Kebede	RH Advisor	USAID/Ethiopia
Tilahun Nigatu	Strategic Information Officer	USAID/Ethiopia
Gordon Williams	Professor	Hamlin Fistula Hospital- Addis Ababa
Yohannes Tadesse		Hamlin Fistula Hospital- Addis Ababa
Kashun Musa		Hamlin Fistula Hospital
		Hamlin Fistula Hospital

CONTACTS IN UGANDA

Name	Title	Institution
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Dr. Amandua Jacinto	Commissioner Clinical Services	Ministry of Health, Clinical Services Division
Dr. Amone	Assistant Commissioner for Integrated Services	Ministry of Health, Clinical Services Division
Dr. Opar	Senior Medical Officer	Ministry of Health, Clinical Services Division
Dr. Yusuf Baseka	District Health Officer	DHO Kasese District
Dr. Amos Katemba		DHO Kasese District
Shadrack	District Biostatistician	DHO Kasese District
Rev. Cannon Benson	Executive Director	Kagando Hospital

Name	Title	Institution
Dr. Robert Olupot	Deputy Medical Director and Surgeon, and Project Coordinator	Kagando Hospital
Dr. Asinge	Medical Director of Kagando Hospital	Kagando Hospital
Bira	Nurse in charge of VVF Ward	Kagando Hospital
Dr. Jonathan	Acting Medical Superintendent	Bwera Hospital
	Hospital Administrator	Bwera Hospital
Sister Theresa Namisango	Senior Nursing Officer	Masaka DHO's Office
Sara Biyamkama	Midwife and District focal person for Partograph	Masaka DHO's Office
Jjemba Crescent	Nursing Officer	Masaka DHO's Office
Amy Crescent	Health Officer	USAID/Uganda
Dr. Maura Lynch,	Fistula Surgeon	Kitovu Hospital
About 50 Village Health Team members from Masaka District participated in the orientation on fistula, in which they watched selected digital fistula stories and then had a facilitated discussion	About 50 Village Health Team members from Masaka District participated in the orientation on fistula, in which they watched selected digital fistula stories and then had a facilitated discussion	
Dr. Antony Sikyatta,	Focal Point for Fistula and National Program Officer	UNFPA
Dr. Wilfred Ochan	Assistant Representative, Reproductive Health & HIV/AIDS	UNFPA
Michael Ledong,	Tulane University Student	UNFPA
Dr. Banya Francis		Kisiizi General Hospital, Church of Uganda –
Dr. Kirya Fred		Soroti Regional Referral Hospital
Grace	Senior Program Associate for Monitoring and Evaluation, and Quality Improvement	Fistula Care Program
Dr. Peter Mukasa	Senior Medical Associate	Fistula Care Program
Rose Mukisa		AMREF
Susan Wandera		AMREF
Joshua Kyallo	Country Director	AMREF
Dr. Olive Sentumbwe,	Family Health and Population Advisor	WHO

Name	Title	Institution
Miriam	Senior Nursing Officer	MOH RH Division
Dr. Wanyana	Assistant Commissioner of RH/MOH	MOH RH Division
Megan Rhodes	Health Team Leader	USAID/Uganda
David Eckerson	Mission Director	USAID/Uganda
Allyson Phelps	Deputy Program Office Director	USAID/Uganda
Alice Emasu Seruyange	Founder and Executive Director	Terrewode (Community-based NGO supporting referrals and reintegration)

APPENDIX C. LIST OF DOCUMENTS COLLECTED AND REVIEWED

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APPENDIX D. FISTULA CARE TOOLS

FISTULA CARE TOOLS	Description/Purpose	# of sites where tool is in use (n=)	Annual or Semi-Annual Report
Quarterly Reporting Tools	Standardized guidelines and forms for reporting service and monitoring data.	60	9/2010
Monitoring/Supervision for Service Delivery Check list	To improve the quality of supervision and monitoring of care.	39	9/2010
Medical Waste Management		27	9/2010
Training Strategy	Uniform training approach to improve the quality of training and service delivery.	6	9/2010
Training Knowledge Assessment Tool	To evaluate knowledge and skills pre- and post-training.	10	9/2010
Monitoring/Supervision for Training Site	Facilitates the supervision and monitoring of training activities.	2	9/2010
Standard Equipment List		3	9/2010
Fistula Counseling Curriculum	Under development.	5	9/2010
Informed Consent Form and booklet	Template for service providers to use or adapt to counsel women before surgery.	3	7/2011
Fistula Diagnosis Job Aid and Diagnosis Poster	Provides a list of questions to help providers to accurately diagnose whether a woman has obstetric fistula, if she requires repair, and complexity of the repair. It also provides advice on how to prepare for obstetric fistula repairs. The poster is the diagnosis job aid in a chart format for posting on the wall.	6	7/2011
Site Assessment Preparation Guidelines and Assessment Tool	Instructions for how to carry out a site assessment and a set of 526 questions to assess the availability and quality of fistula prevention and treatment services; includes a list of equipment and supplies.	2	7/2011
Traumatic Fistula Counseling Module	Under development.		N/A
Nursing Curriculum for Obstetric Fistula	Under development.		N/A
Fistula Death Investigation and Reporting Tool	A tool to standardize the process for inquiries into the deaths from fistula surgery or related causes.	3	7/2011

Data for Decision-making Modules (ver. I)	To support the gathering, analysis, and reporting of data to improve the quality of performance of fistula services.	4	7/2011
Digital Stories Facilitator's Guide	Facilitators guide to "Learn My Story" a sensitization tool for healthcare providers, women with fistula, and community members.	1	7/2011
Family Planning following Fistula Care	A poster for healthcare providers on counseling women and couples following fistula surgery.	2	7/2011

APPENDIX E. FOUR COUNTRY SUMMARY REPORTS

ETHIOPIA: PRE-REPAIR CENTER MODEL

Description of Implementation Model

The goals of the Fistula Care Program in Ethiopia are to educate the community on fistula prevention and care, identify and screen potential clients for fistula repair and provide post repair rehabilitation and promote community reintegration. The project also seeks to build capacity of health care providers

The implementation framework is an innovative approach that links community activities with facility based interventions in a continuum of care model. The project facilitates active participation of communities who form **Community Core Teams (CCTs)** of volunteers from different walks of life (e.g., teachers, healthcare providers, ex-fistula patients), who are trained to inform, educate and mobilize communities about fistula facts, prevention, and identification of clients. They also assist with linking potential clients with an “intermediary” unit- The Pre-Repair Units (PRU), located in existing health facilities to provide physical and psychological support for women prior to referring them for surgery. The PRUs are relatively close at the fistula repair facilities, within 1.5-2 hours distance by car. The PRUs consist of a unit of about 2-4 beds provided with simple living and health facilities for essential needs. The PRUs prepare women for surgery. They screen them, treat other medical conditions that may impact their physical capacity to undergo surgery, provide food, transport to and from hospital, and post-surgical and follow-up care.

Midwives trained on fistula programming and care are employed as *Fistula Mentors* to manage the PRUs and implement clinical services at the PRUs, train local midwives in BEmONC and supervise the CCTs. Fistula mentors train health care workers at health centers and health posts on fistula identification and referral, and prevention including the proper use of partograph to monitor labor.

The FC program established a creative **CEmONC Center in Dangla** close to the PRU, to offer emergency Cesarean sections and other assisted delivery services in the region where previously clients were referred to far away facilities of over 500 km away for operative deliveries. Women now have access to emergency obstetric care closer to home. **Regional Fistula repair centers at Bahir Dar and Mekelle** ensure that clients do not all have to go to Addis Ababa for fistula surgery. The PRUs also receive clients after repair and assist them with re-entry into the community where CCT members champion their social and economic reintegration.

Analysis of Strengths and Weaknesses of the Model

Strengths:

- Increased awareness at community level about fistula: that it is curable and where to get treatment. PRUs report that they are seeing newer and fresher fistula cases and women with older fistula are coming from farther away rather than from surrounding communities.
- The numbers of women referred to health centers for screening has increased over time.
- The highest number of women referred to hospitals for fistula repairs and receiving repairs come from PRUs. The PRUs are more successful at finding women and referring them for repair than Hamlin Hospitals’ outreach program or other community-based RH/FP (e.g., IFHP) projects.

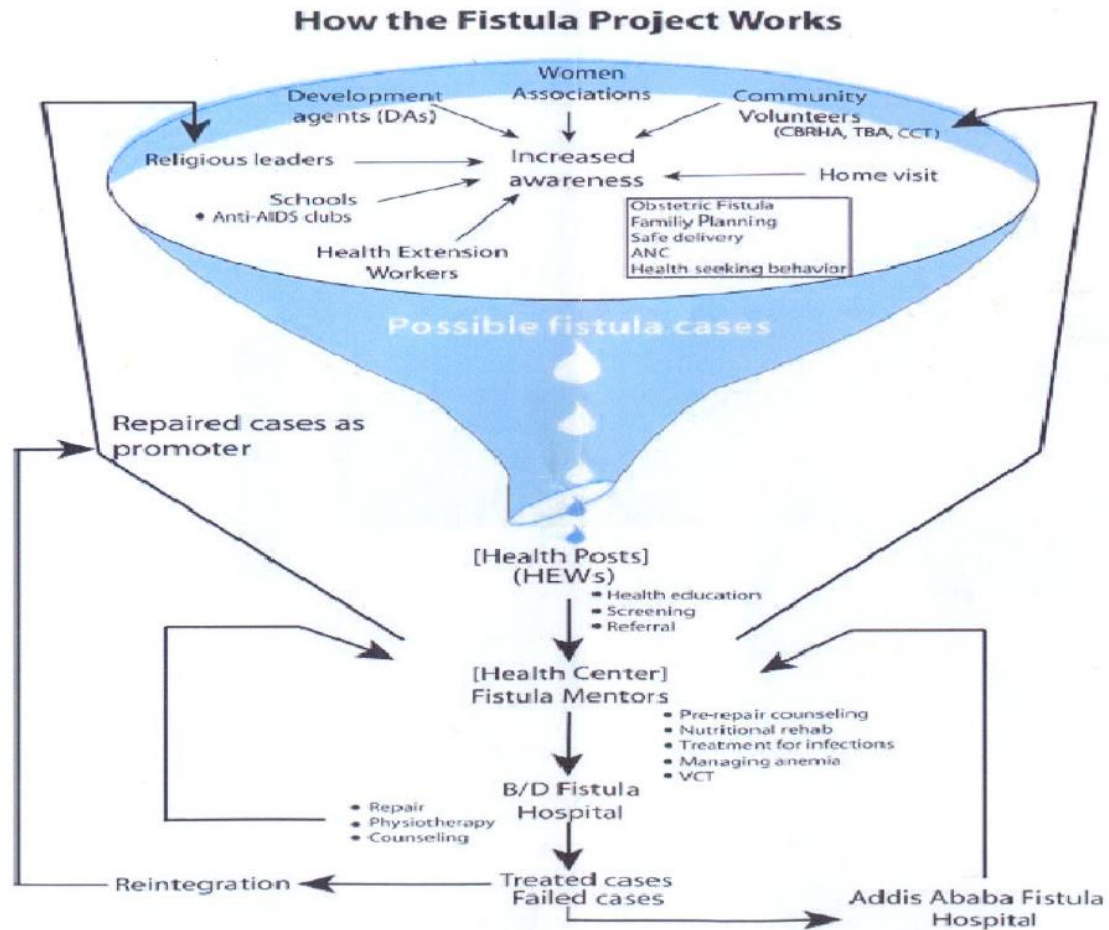
- Strong collaboration among partners (e.g. FC/IH, Hamlin, IFHP, MOH, Regional Health Bureau, Woreda level, and Regional Women’s Affairs and Community Core Team members)
- The capacity of health workers and fistula community core teams has been strengthened
- Efforts are ongoing to create a formal certificate for those who are mentored in the CEmONC center by the OB-GYN so that eventually these health officers will be allowed to do c-sections legally on their own.

Some of the greatest challenges include:

- Shortages of health workers and the difficulty of keeping them in rural areas once they are trained, particularly obstetrician-gynecologists.
- It appears to be necessary to increase the radius of action to increasingly further away from the PRUs in order to find women in need of fistula surgery. It is not clear if the model is flexible enough to work at greater distances and maintain the same levels of community involvement, supervision, and follow-up.
- The great number of women (estimated at 50% or more of women identified for screening) who have other childbirth injuries (e.g. uterine prolapse, cystocele, and other causes of stress incontinence). The Ethiopian health system does not have the capacity currently to respond to the needs of these women.
- Prospects for sustainability and institutionalization of PRUs are unclear. There is some question about their future sustainability without external support.

COUNTRY LEVEL RECOMMENDATIONS

- Assess the value-added of PRUs by comparing treatment outcomes for women treated in PRUs with women who go directly to fistula hospitals for surgical repair.
- Data collection on the number of women attending ANC or delivering in healthcare facilities compared to areas not assisted by the project and provenience of women will provide information on impact of prevention activities, and provide insight into incidence in the surrounding areas.
- Assess the feasibility and cost of addressing other causes of incontinence, such as prolapse, particularly as it seems to affect a large percentage of women who are identified through community screening for fistula. If current repair hospitals are under-utilized for fistula repairs, there may be some short- to medium term opportunity for those centers to also address uterine prolapse.
- Longer-term, it would be useful to conduct a country-level assessment of the sustainability of the current model, as Ethiopia is one of the few FC supported countries where the project is not contributing to building surgical capacity for fistula repair, particularly in the public sector. Ethiopia has a critical shortage of OB-GYN specialists which severely constrains opportunities for both fistula prevention and repair, especially in the public sector. An assessment could determine if it is worth developing a training model that would build on the Dangla paired PRU and CEmONC center in other regions not served by PRUs to integrate fistula repair services.



GUINEA: MARKET-TOWN MODEL FOR ENGAGING DISTRICTS AND COMMUNITIES IN FISTULA PREVENTION AND REINTEGRATION

Description of Implementation Model

All countries are faced with the challenge of how to find the resources to fund fistula prevention, repair, and reintegration activities. Most rely on donor support and small allocations from the national health budget. FC in Guinea facilitated an innovative approach to health financing by engaging local government. In the two rural regions where the project works, Kissidougou and Labe, the mayor and district councils met with market sellers to encourage them to be partners in fistula prevention and reintegration. Market sellers, through their unions, agreed to a market tax that would be used to improve market infrastructure as well as to fund outreach to women with fistula, community education to prevent fistula, and reintegration activities to help community help women whose fistulae have been repaired to re-enter the social and economic life of their communities. District government was able to gain both the political and financial support for the idea from market sellers with the understanding that they would also be involved in decision-making about how their taxes would be used.

In both regions District governments reported that revenues from the market increased by 400% (Kissidougou) and 800% (Labe). Five percent of the new resources were channeled to

support village health volunteers who disseminate information about fistula prevention as well as identify women in need of fistula repair. Specifically, the money supports safe motherhood committees and family sponsorship of home stays for post-operative women to help them reacclimatize and adjust to being active participants in their communities suffering the isolation of living with fistula.

The safe motherhood committees work closely with the health services to identify all pregnant women to encourage them to attend ANC consultations and to deliver in a health facility. They promote FP and transmit messages about delaying the age of marriage and against FGC. They also monitor and refer women exhibiting danger signs during pregnancy or labor to a health facility. They engage in first level screening of women in their communities who exhibit symptoms of fistula and refer them to repair sites.

The supported reintegration activities include lodging in prior to surgery in a waiting home where women wait and prepare for surgery. Many return to the waiting home post surgery for some transition counseling and training. Some women, especially those who have experienced severe isolation during the period of time they had fistula, are temporarily adopted by host families who help them to readjust to life post-repair.

Educational outreach by the Safe Motherhood Committees is complemented by similar messages disseminated through religious leaders in their weekly sermons. Both Muslim and Christian religious leaders play an active role in confronting stigma associated with fistula and encouraging women to seek care. They also encourage families to keep their daughters (and sons) in school and to delay marriage until they are 18.

Repairs are handled through Guinea's model of levels of care. Simple repairs are conducted in rural hospitals in Labe and Kissidougou while more complex repairs are sent to the Conakry to be performed at the Jean Paul II Hospital.

Analysis of Strengths and Weaknesses of the Model

One of the most unique aspects of the approach is that the District government of Kissidougou mentored the District government of Labe on how to develop the model. The governance and democracy component of the program creates a strategic alliance among local government, the urban council and village Safe Motherhood Committees which increases ownership of the activities supported by FC.

The model contributes to:

- Building Sustainable financial support for prevention, outreach, and reintegration activities
- Galvanizing social support for women living with fistula and for helping women to take measures to prevent fistula.
- Engaging influential champions such as politicians, union leaders, and religious leaders in reducing stigma and discrimination against women living with fistula.
- Promoting a sense of shared responsibility for the economic and social support for post-operative women.

Some of the challenges include:

- A large burden is placed on community volunteers, some of whom are expected to not only support activities in their own communities but also to mentor volunteers in other communities.
- Maintaining political and financial support for fistula, especially when local authorities change or other priorities arise.

- Women are coming from further away, even from neighboring countries. The reintegration activities may be less effective if they do not involve people from the communities they return to.
- As more women become aware of the services, demand is outstripping the capacity of District-based services to respond.

Country Level Recommendations

1. There are several aspects of the project that should be assessed to gain a better understanding of what is needed to ensure long-term sustainability. These include:
 - What happens to support for fistula activities when the political office holders change
 - How to address the needs of women who come from far away, especially those from other regions. Will there be point where local residents object to having their revenues being used to support women from outside the District
 - Is the reliance on community volunteers from prevention, outreach, and reintegration activities sustainable
2. There were anecdotal reports from the community volunteers that more women are delivering at health facilities. As the areas around the two rural regions with fistula repair and prevention sites are in separate noncontiguous regions, Guinea might be a good country to measure the impact of FC's prevention activities on uptake of FP and delivery with a skilled provider, as there is an opportunity to find control or comparison sites that have likely not been affected by the prevention community mobilization activities. This could be added to the current community-level assessment underway.

NIGERIA: COLLABORATIVE SURGICAL NETWORK OF POOLED FISTULA REPAIR SERVICES

Description of Implementation Model

Unlike many of the countries supported by FC, Nigeria has a history of training fistula surgeons. The challenges in Nigeria were how to: 1) optimally use the existing human resources to address the large demand for fistula repairs, 2) effectively support those already trained, and 3) train new surgeons and nurses.

FC facilitate the formation of a clinical network to assist with pooled efforts at different sites throughout the country. The pooled approach brings together 3-5 surgeons in one site for a period of 5-7 days to perform as many as 8 surgeries per day. The periodic pooled collaboration of fistula surgeons increases availability of different levels of surgical care and increases access to services, especially for women in need of more complex repairs. The pooled effort provides opportunities for training surgeons and nurses at the host site as well as bringing in trainees from other sites. It also ensures that new surgeons have opportunities to develop their skills while being mentored by more experienced surgeons. Similarly, the pooled approach offers nurses experience in pre and post operative care as part of a team effort. More experienced nurses also mentor nurses who are new to fistula care.

As doctors and nurses gain experience and competence at once site, they, in turn, become part of the cadre of providers to provide pooled services at other sites. In between pooled efforts, the fistula team at their home sites continues to perform repairs according to the level of their capabilities. At sites with more junior or less experienced surgeons, routine interim repairs may be limited to simpler repairs, reserving more complex cases for pooled efforts. At sites with an experienced surgeon, pooled efforts help to address backlog by doing more surgeries in a shorter period of time than possible in the period between pooled efforts.

FC provided support for visiting surgeons and nurses' per diem expenses. It assisted with the logistics of organizing the pooled events and with travel. It provided support for supplies and fuel to ensure a power supply, and for outreach activities to make women in need of repairs aware of the timing and availability of services.

Analysis of Strengths and Weaknesses of the Model

The strengths of the model are they provide opportunities for:

- Reducing the numbers of women waiting for surgery being able to schedule surgeries at times when surgeons with the appropriate level of skills are available, while deferring simpler repairs to routine care in between pooled efforts.
- Training and mentoring of new and mid-level surgeons by senior surgeon takes place during pooled events. The surgeons get to know each other and are able to communicate and consult with each other between events.
- Developing teams of nurses and doctors experienced in surgery and pre and post-operative care builds positive and supportive relationships among the team of providers responsible for women's care which contributes to better QOC and more informed decision-making about women's care.
- Raising awareness in the communities surrounding repair centers about the availability of care appears to have addressed much of the backlog in communities surrounding the repair and prevention centers. There was a general sense (not yet validated by evidence) that women were coming from further and further away. The numbers of women from closer by appeared to be diminishing.
- Pooled efforts help to ensure that new trainees (nurses and doctors) have sufficient numbers of cases to develop competency and to continue their training on an ongoing basis.

Some of the challenges presented by the approach include:

- The need for an outside entity to organize and support the logistics (i.e. FC) raises questions about who will take on this task on in lieu of the project and whether collaboration will continue in as many sites without the support of the Project.
- There are questions about whether, sites are performing as many surgeries as their capacity and skill suggests they should be capable of performing in between pooled events.
- There is considerable turnover and loss of trained staff, and they do not always leave to go to other fistula repair sites.
- It appears to be difficult to strike the right balance between outreach and the capacity of the pooled efforts to respond. It is hard to gauge how to generate sufficient demand, without raising false expectations of more women than can be served within the timeframe and capacity of the pooled even and the repair site where it is held.
- Given that there are still no verifiable estimates of prevalence and incidence, it is unclear how best to scale up the pooled approach to include a larger number of sites (beyond those supported by the project) to make services more widely available. A related challenge is that without reliable data on prevalence and incidence, it is hard to develop a national level strategy based on the model.

Country Level Recommendations

- I. Map all sites that offer fistula repair services and assess the national capacity to increase the number of repairs from approximately 4-5000 per year to 12,000 per year which is the current estimate of incidence.

2. Assess whether an expanded pooled model is the most effective way to increase availability and access to services in line with striving to perform sufficient surgeries per year to address new cases. Along with this analysis, it would be useful to estimate how many of the new cases could be identified early enough to treat them with catheterization and avoid the need for surgery.
3. FC plans to conduct targeted community screening in select areas as a means of gathering better estimates of incidence and backlog. Pooled events should be planned in areas to be screened in order to be able to address the needs of women identified through the screening.
4. Explore the feasibility of developing State-level partnerships between teaching hospitals which lack sufficient cases to adequately train OB-GYN and Urologist residents on fistula repair and state hospitals which have the demand but lack qualified surgeons. The challenge to this approach is that it requires sharing of human and infrastructure resources across federally funded and state funded facilities.

UGANDA: PUBLIC-PRIVATE PARTNERSHIP MODEL

Description of Implementation Model

The Uganda Fistula Project focuses on a strong Public-Private Partnership developed to provide country-wide availability of and access to fistula care. The model is mainstreamed into the national healthcare system whereby the government provides leadership for a partnership between public and private hospitals. Fistula repair services are available on a routine basis in selected public and private hospitals. In the case of the private, mostly faith-based hospitals, they provide the infrastructure for fistula prevention and repair, while the government hires additional specialists and medical officers to augment the human resources available for fistula prevention and repairs.

The MOH has developed six centers of excellence for repairs and referrals to serve each region. It has a plan to expand to 13 Referral Centers so as to have one center in each District to repair simple to moderate cases. Health facilities in the communities within the Districts will provide preventative interventions including prophylactic catheterization for women with prolonged and obstructed labor. The National and District Referral centers will also conduct trainings as well as lead a fistula research agenda. The framework/model proposed by the government is based on the Levels-of-Care model developed by FC.

The Ugandan model institutionalizes sets of relationships between the public and private sectors that evolved out of a periodic fistula repair camps begun in private health facilities. International teams and national fistula surgeons make quarterly two-week long visits to conduct fistula surgeries during the camps. The model introduced by FC aims to increase the number of repairs performed between camps as by developing in-country capacity to do both simple and complex repairs during and between camps. Currently fistula repair sites conduct, on average, 2-3 repairs per month per site on a routine basis (the number of repairs performed during camps is much higher [e.g., 50-100 cases in a 2-3 week period]).

Fistula Care worked with the MOH, other donors, private and public hospitals, and visiting surgeons to strengthen the training of national surgeons during the camps. FC works with the MOH to train junior surgeons who have been mentored and coached to do intermediate and complex levels of repairs in established training hubs in the North, Central, Western, and Mulago Regions in collaboration with AMREF and UNFPA. In between camps, FC provides support to the hospitals to strengthen the QOC through the adoption and use of FC supervision and monitoring tools. FC also provides training to prevention and repair sites, and prevention only sites on the use of the partograph and EmONC.

At the policy level, FC has helped to identify champions at the district and facility levels who support outreach and reintegration activities. They have partnered with the MOH, other donors, implementing partners, and healthcare providers to form a Technical Working Group to map all fistula services in the country. In response to the efforts of the TWG, the MOH has nationalized the fistula service monitoring tools. The government is in the process of developing a national policy strategy for fistula based on an adaptation of a model ECSA Fistula Policy which was also facilitated by FC.

Analysis of Strengths and Weaknesses of the Model

Fistula is a significant health challenge in Uganda where there are an estimated 240,000 cases. Currently, approximately 2000 women receive repairs per year. One person interviewed during the evaluation estimated that at this rate it would take 200 years just to clear out the backlog. Camps of 2-3 weeks only conduct 50-100 surgeries per camp, depending on the site. The number of surgeries conducted during the camps is limited by the number of beds, availability of operating theaters, and availability of nursing staff, particularly for lengthy post-operative care. Many of the sites have inadequate infrastructure.

The public-private partnership in Uganda appears to be an effective transitional model to move the country toward greater reliance on Ugandan fistula surgeons and nurses rather than on visiting medical teams. The major challenges to achieving the country's prevention and repair objectives continue to be a dearth of trained and skilled surgeons, availability of beds and operating theaters, and the low numbers of women who deliver in healthcare facilities and post-repair women who deliver by c-section.

Almost all stakeholders interviewed for the evaluation agreed that FC's training on the use of the partograph and subsequent supervision and support to staff trained have been very effective in getting staff to use the tool correctly and routinely. The challenge is that not enough women give birth in facilities where the partograph is in use. Although most women receive ANC, only about 40% deliver in healthcare facilities with a skilled provider. Another missed opportunity for preventing fistula is routine screening for fistula symptoms in postpartum women. Women who do not deliver at home are unlikely to go to facilities for postpartum care. Women who do, however, could be screened in order to catch any likely fistula early enough for the women to benefit from catheter treatment so as to avoid the need for surgery.

The work on prevention in Uganda has had mixed results. Village Health Teams, composed of 4-5 people selected by their villages, based on a few basic criteria (can read/write, are interested, and can mobilize others) have been engaged to encourage women to deliver in healthcare facilities. VHTs are trained in RH and other health topics (e.g., immunizations, HIV, primary health care, nutrition). The VHTs sensitize women to come to a health facility for delivery, identify potential fistula clients and help them reach a facility where services for fistula care are available. Many volunteers find that there is a lot expected of them and that the work is too time consuming to be done without compensation. The VHT system in some districts is more fully operational than in other districts.

Another preventive measure, Family Planning, to-date has not had a significant impact on spacing and reducing the number of pregnancies and subsequently on preventing fistula. Contraceptive prevalence rates are low. There is about a 41% unmet need for FP. Challenges include unavailability of commodities, lack of staff, and lack of equipment.

In summary, FC, in conjunction with other partners, has been successful in forging strong public-private partnerships. The government has ownership and exhibits strong leadership in mainstreaming fistula care into the health system. There is progress in increasing the number of repairs and the capacity of surgeons to repair fistula of different levels of complexity. There has

been a lot of enthusiasm for and post-training adoption of the use of the partograph. There is an emerging cadre of well trained and enthusiastic surgeons.

The remaining challenges include inadequate government funding for health services. Community volunteers need greater support and training, particularly in reproductive health, including fistula. Follow up with post-repair women is weak, which means that many are not able to follow through on recommendations for their post-repair reproductive health (e.g., accessing elective c-section delivery and FP).

Currently, there is no established protocol for women who exhibit incontinence from non-fistula causes such as uterine prolapse or cystocele.

Country Level Recommendations

1. Seek new partnerships at the community level to strengthen support to community health volunteers.
2. Strengthen collaboration between FC and other RH/MCH programs to make the link between safe motherhood, family planning, and fistula prevention stronger and more effective. Invest in additional orientation and training for VHTs on RH/FP and fistula prevention and outreach, but be mindful of overburdening them with too many tasks.
3. The new DHS data on fistula may facilitate application of the Nigeria community-based survey methodology to estimate incidence in Uganda as a basis for developing a long-range eradication plan.

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