FISTULA CARE

Guinea Fistula Care Program Evaluation

June 2013

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Contents

Acronyms and Abbreviations

ASFEGUI	National Midwives Association
FC	Fistula Care
FP	family planning
GFMER	Geneva Foundation for Medical Education and Research
MoHPY	Ministry of Health and Public Hygiene
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Acknowledgments

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Executive Summary

EngenderHealth has been working on fistula prevention and treatment in Guinea since 2005, first through the ACQUIRE Project (2005 to 2007) and since 2007 through Fistula Care, both funded through the United States for Agency for International Development (USAID). The Guinea program has grown from one treatment and prevention facility in 2005 to three in 2011, along with six district hospitals providing prevention services.

In 2011, Fistula Care undertook a two-part evaluation of the Guinea program: 1) to assess the accomplishments and effectiveness of the facility-based prevention and treatment services (i.e., the supply side); and 2) to explore whether the establishment and support of village safe motherhood committees at the community level had led to measurable change in knowledge and use of maternal services at the population level. Findings from the community evaluation are presented in a separate report.

The supply-side evaluation used multiple data collection methods, including site assessments, observation of services, record reviews, interviews with key stakeholders, and interviews with a convenience sample of fistula patients. A three-person team from Fistula Care's global group and three staff from the Guinea Fistula Care team visited the nine supported facilities in May and June 2011. They conducted site assessments to determine the facilities' readiness to provide services and interviewed 70 key informants about the program. A research firm was contracted to conduct record reviews at the treatment sites. Nurses at the treatment sites conducted interviews with a convenience sample of women who were being discharged and returning for follow-up visits.

Findings

Fistula treatment services. Access to fistula treatment services has grown steadily since 2005. As of September 2011, three facilities were providing routine fistula repair services. The annual number of repairs increased from 199 in fiscal year (FY) 2005–2006 to 497 in FY 2010–2011. Between October 2005 and September 2011, Fistula Care supported 1,887 fistula repair surgeries. While demand for services (i.e., the number of women needing surgery) continues to grow, there is still a backlog of women awaiting treatment. Surgical capacity at Fistula Care–supported sites has increased, with a total of 12 surgeons actively providing simple repair services at three sites. Two surgeons are now competent to do intermediate repairs. More complex repairs continue to be performed by senior surgeons based in Conakry.

In addition to training surgical teams in fistula repair, Fistula Care has supported training in other key aspects of the fundamentals of care, including infection prevention, counseling, facilitative supervision, and the COPE® quality improvement approach. Equipment and supplies have been provided for fistula repair services.

Prevention services. Prevention activities have included a focus on strengthening the quality of comprehensive emergency obstetric services; integrating family planning (FP); and strengthening the consistent and correct use of the partograph. Nearly 200 providers have attended training in obstetric services and about 100 in FP counseling and method

provision. The number of clients provided with FP methods has steadily increased. In FY 2010–2011, 2,449 clients obtained FP methods from nine supported sites.

Institutionalization. In 2005, EngenderHealth helped the Ministry of Health and Public Hygiene (MoHPY) to form a national steering committee to guide fistula work and to ensure that activities would be integrated as part of MoHPY and Ministry of Women and Social Affairs routine work plans. The guiding principle of the committee has been to ensure that the program is integrated within the national public health program. In addition to this committee, a reintegration committee was formed in partnership with the Ministry of Social Affairs to foster social reintegration of fistula patients. As a result of the work of these committees, a national network to eliminate fistula has formed, which includes representatives from several national and international organizations.

To enhance training for surgical teams, EngenderHealth has partnered with the Geneva Foundation for Medical Education and Research (GFMER). GFMER has sent experienced surgeons to Guinea on a quarterly basis to help build the capacity of Guinean surgeons in fistula repair and has provided equipment and supplies to Fistula Care–supported repair sites.

A network to eradicate fistula in Guinea has grown out of the national technical working group and its committees; members of this network include representatives from EngenderHealth, the United Nations Population Fund, GFMER, the World Health Organization, and in-country nongovernmental organizations such as the National Midwives Association (ASFEGUI).

The Guinea program has taken a holistic approach to addressing fistula prevention, treatment, and reintegration services that has also included a focus on strengthening community linkages. From working with the mayors of Urban Development Communes in Kissidougou and Labé to strengthening village safe motherhood committees and supporting "waiting homes" for women in need of surgery, the program has successfully engaged a range of stakeholders in support of these services.

The evaluation team interviewed 70 program partners to obtain their perspectives on progress towards institutionalization of fistula prevention and treatment services through the Fistula Care program, successes, and challenges remaining. All key informants spontaneously cited training as a key accomplishment of the program, which has strengthened capacity to provide treatment and prevention services. With the generous support of USAID, the costs of fistula surgery, transport for patients, and all other associated hospitalization costs were recognized as a major contribution of the project. Remaining challenges cited include health financing issues for maternal health services and maintenance of facilities and equipment.

Patient perspectives. A total of 195 postsurgery fistula patients from Jean Paul II Hospital, Kissidougou, and Labé were interviewed to obtain their perspectives about the care they received, as well as to understand more about their social circumstances. Most women from Kissidougou and Labé reported receiving counseling about how to care for themselves postsurgery, while fewer than half of the women interviewed at Jean Paul II Hospital reported being counseled. About half of all women said they wanted to wait about two years before having another child. The majority of women at Kissidougou were provided with an FP method, while women at other sites were not. Counseling at Jean Paul II Hospital needs to be strengthened, and more needs to be learned about barriers to providing women with FP methods prior to discharge.

Conclusions

Findings from this review show that capacity for fistula treatment has increased over time, and there is some evidence of an increased enabling environment for sustaining services at the policy and program levels. Financial sustainability remains an issue at the present time. Between 2006 and 2011, more than 1,800 repair surgeries have been performed, and more than half (and an increasing proportion) of these procedures were performed by Guinean surgeons.

Many key informants cited the medical monitoring and facilitative supervision led by the Guinea team as a strength of the program. It is, however, resource-intensive, and monitoring processes and tools need to be streamlined. Interrater reliability issues emerged when the evaluation team used the quality score checklists that are more routinely used by local supervisors. Increased resources dedicated to review and analysis of supervision reports and action plans would facilitate longitudinal analysis.

Providers may need continued training to strengthen their skills to help women assess their reproductive health needs and need for FP.

Introduction of FP at regional hospitals and linkages with supplies to avoid stock-outs is clearly a program accomplishment. Overall, the number of clients accepting an FP method increased at all sites. Method mix could most likely be further expanded to include more long-acting and permanent methods of contraception. Observations of counseling undertaken during routine medical monitoring and facilitative supervision visits indicate that providers need refresher training to be able to effectively discuss side effects; ensure that clients are understanding the information provided; and make better use of job aids.

The Guinea team has worked to strengthen the ability of district-level hospitals to provide quality fistula prevention services such as FP and partograph monitoring. This work needs to be replicated at the primary health care level with appropriate and timely referral to district and regional health facilities for obstetric complications and emergencies.

1. Introduction

1.1 Guinea context. Guinea, a francophone country in West Africa, shares borders with Guinea-Bissau and Senegal to the north, Mali and Côte d'Ivoire to the east, and Sierra Leone and Liberia to the south. The Atlantic Ocean lies to the west. Guinea has a population of approximately 11 million people belonging to 24 ethnic groups, the most prominent of which are the Fula/Peul/Fulɓe, the Mandinka, and the Susu. Sixty-five percent of the population lives in rural areas (UNFPA, [no date]). Guinea has had three leaders since it gained independence from France in 1958, with its current leader chosen in the country's first democratic election in 2010. Although Guinea's mineral wealth gives it the potential to be one of Africa's richest countries, 70% of its people were still living on less than US$1.25 per day in 2003 (UNFPA, [no date]).

According to the most recent United Nations estimates, Guinea has made progress on reducing the maternal mortality ratio, but it remains high, at approximately 610 deaths per 100,000 live births (range of uncertainty: 380–1,100) (WHO, 2013). Access to quality obstetric care remains low: A Guinean woman has a one-in-26 lifetime risk of death from maternal causes (WHO, 2010). In 2005, the total fertility rate was 5.3 lifetime births per woman; the prevalence of modern contraceptive use among women aged 15–49 was 4%; and 38% of births were attended by a skilled professional (WHO, 2010).

The Guinean health system is decentralized, in accordance with the recommendations of the Bamako Initiative (UNICEF, 2007, p. 36). Facility-level cost recovery is supplemented by transaction taxes, such as the air ticket solidarity levy on all flights taking off from national soil (instituted June 2011 to generate contributions to UNITAID for HIV, tuberculosis, and malaria medications) (UNITAID, 2011). For most health care services, clients are required to pay fees for consultations and hospitalizations. The cost of a hospital stay, excluding anesthesia medicines, surgical or post operative drugs and consumables, is approximately 180.000 Guinea francs (about US$257) per week (Personal communication, Moustapha Diallo, June 2012). Frequent drug shortages cause price inflation. Hospital patients are usually required to obtain their own food, which is often provided by relatives who visit the hospital daily. If the relatives have come from far away, then they need to stay nearby so they can cook for the patient. These circumstances make it particularly difficult for poor people to receive the health care they need. Many women with obstetric fistula are unable to access treatment because they cannot afford the costs of drugs and care.

1.2 Obstetric fistula. The prevalence of obstetric fistula is difficult to estimate. The most commonly cited estimate is 2 million women and girls worldwide, with 50,000 to 100,000 new cases annually (Stanton, 2007). Approximately 8% of maternal deaths are due to obstructed labor (Dolea & AbouZahr, 2003). For those women who experience obstructed labor but who do not die, perhaps the most serious sequela is obstetric fistula. Because hard fetal head tissue presses against soft pelvic tissue during prolonged labor, a hole—or more accurately an opening—develops between the bladder and the vagina, allowing for the persistent and continuous leakage of urine. Most often, the baby dies,

and the mother is stigmatized by a condition that leaves her unable to continue her daily life as before. Many women with obstetric fistula are no longer able to make an economic contribution to the family, and some are abandoned. Most women lack the resources to find help.

Obstetric fistula requires surgical treatment. Finding a facility and a surgical team with the capacity to provide this service has been challenging for women historically. In most African countries, major teaching hospitals conduct fistula surgery. However, with few surgeons and many patients who present with more urgent needs, hospitals are not inclined to prioritize fistula. Even if a woman who lived in a rural area were to find her way to an urban teaching hospital, she might wait for months or even years for fistula repair surgery. In some countries, faith-based or mission hospitals provide the service when they are able to secure the services of visiting surgical teams. In Ethiopia, Nigeria, Sierra Leone and a small number of other countries, facilities that specialize in fistula repair draw women from neighboring countries. Nonetheless, it is widely agreed that resolving the backlog of cases waiting for repair, as well as responding to the new cases that occur on an ongoing basis, remains a herculean task.

Establishing services for fistula repair is complex. Fistula repair is major surgery requiring a high level of surgical skill, even for uncomplicated cases. Training surgical teams is a necessary but not sufficient condition for enabling women to gain access to fistula treatment services. Decentralization of fistula repair services to all sites capable of surgical services is neither practical in terms of safe and sustained provision of services nor cost effective or feasible with the resources currently available. (Many facilities experience supply chain disruptions for items as basic as sutures.) Fistula surgery usually requires a minimum of three weeks of postoperative care in the hospital, in addition to prescreening and treatment for accompanying conditions. The availability and skill levels of physicians, the number of operating theaters available for elective procedures, and the number of beds available for long-term hospitalization all play a part in determining how many fistula surgeries can be performed at each site. Efforts to provide women with access to quality fistula services are further complicated by the fact that many women are too poor to pay.

It is therefore necessary to expand access to fistula repair services in a phased manner. Before increasing awareness of service availability, it is important for program to partner with local governments and health facility administrators as well as communities to ensure that the health system is capable of responding to identified needs and to build commitment to the continuous provision of services.

1.3 Fistula care in Guinea. Between 1986 and 1993, 186 patients with obstetric fistula were admitted to the Urology Department at Ignace Deen University Teaching Hospital in Conakry (Guirassy et al., 1995). Following the International Conference on Population and Development in 1994, Guinea convened a national forum to define priority elements of reproductive health care. Obstetric fistula was included in the national health policy. However, action to address the condition was limited (UNFPA, 2010). In 2003, the MoHPY Campaign to End Fistula, a campaign spearheaded by the United Nations

Population Fund (UNFPA) that comprises partners from around the world, including EngenderHealth, , in an effort to end fistula. In 2005, with funding from the U.S. Agency for International Development (USAID), EngenderHealth partnered with the Ministry of Women and Social Affairs to develop a program that would provide fistula repairs for women in Guinea.[1]

The USAID funded Fistula Care program supports the strengthening of fistula treatment and prevention activities at nine facilities across Guinea (Figure 1). Three facilities currently engage in both fistula prevention and fistula repair, while six facilities focus their efforts on facility-based prevention interventions. Table 1 provides more information about the facilities.

Table 1. Fistula care facilities in Guinea

Name	Location	Date when USAID support began
Prevention and repair facilities		
Jean Paul II Hospital	Conakry	April 2008
Kissidougou Prefectoral Hospital	Kissidougou	January 2006
Labé Regional Hospital	Labé	February 2009
Prevention-only facilities		
Boké Regional Hospital	Boké	December 2008
Faranah Regional Hospital	Faranah	February 2009
Ignace Deen University Teaching Hospital	Conakry	January 2006*
Kindia Regional Hospital	Kindia	December 2008
Mamou Regional Hospital	Mamou	February 2009
N'zerekoré Regional Hospital	N'zerekoré	February 2009

* Ignace Deen University Teaching Hospital functioned as a repair facility until June 2010, when a lack of bed space for fistula patients led to the discontinuation of this service.

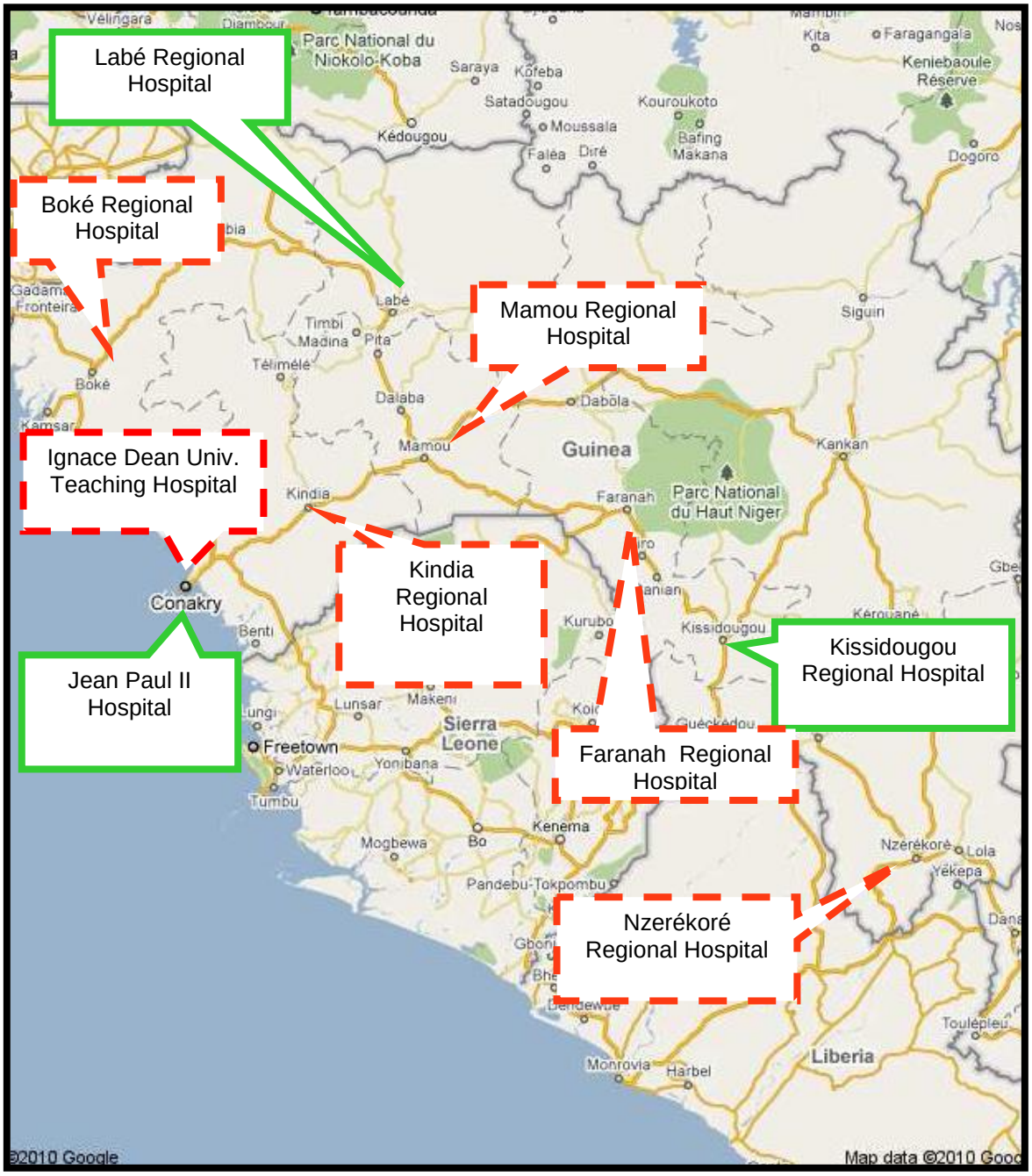
All facilities are regional hospitals except for Kissidougou. Although Kissidougou is a prefectoral hospital (the administrative equivalent to what might be called a district hospital in other contexts), it acts as a referral center for a large number of people, due to the difficult forested terrain of that part of Guinea.

Hospitals supported by the Fistula Care program serve as referral centers for more than 8.6 million people, or more than 85% of the population. These facilities provide comprehensive emergency obstetric care services, including cesarean surgery; assisted delivery care; management of pregnancy-related disorders; gynecology services; postnatal care; postabortion care; infertility treatment; adolescent reproductive health; family planning (FP)[2]; treatment for HIV and sexually transmitted infections; and diagnosis and referral for fistula repair.

[1] USAID support was first through the ACQUIRE Project (2005-2007) and later through Fistula Care (2007-2013).
[2] Strengthened and/or introduced by Fistula Care at all supported sites.

In addition to strengthening facility-based prevention and treatment services, the Fistula Care program conducts community engagement activities with a focus on prevention in the hospital catchment areas of Kissidougou and Labé. This report describes key program accomplishments from a supply-side perspective over a six-year period (2006–2011), with a focus on access to treatment and prevention services, institutionalization, and client perspectives. Fistula Care conducted a separate evaluation of community engagement activities (Fistula Care, 2013).

Figure 1. Fistula Care facility locations



2. Study Objectives

The goal of the evaluation of Guinea's Fistula Care program is to assess progress made in implementing obstetric fistula prevention and treatment activities. Specifically, the evaluation sought to capture:

- Preintervention and postintervention[3] capacity at supported health facilities, including institutionalization of said capacity and measures of quality of care
- Client satisfaction with fistula care services
- The extent to which postrepair clients are engaged in raising awareness about fistula in their communities, as well as the impact of a social reintegration intervention

3. Study Design and Methodology

The evaluation employed multiple qualitative and quantitative methods, including a review of existing monitoring information, as well as a secondary analysis of data from two global studies conducted by Fistula Care. Data collection activities are summarized in Table 2.

3.1 Desk review. The Guinea program has amassed a wealth of program data since it began offering fistula repair services in early 2006. The evaluation began with the compilation and review of programmatic, supervision, and special study data, including training reports; service statistics; quality indices assessed through medical monitoring and facilitative supervision; and qualitative data in program reports. We undertook this review between September 2010 and September 2011. Included in the desk review are selected findings from two global Fistula Care studies in which Guinea-supported sites participated. One was the "Multi-center retrospective record review of data collection procedures and data quality of indications for cesarean deliveries." The other was a prospective study: "Determinants of post-operative outcomes in fistula repair surgery." Secondary analysis of selected findings from these studies helped illuminate the Guinea program's strengths and challenges. Selected service statistic data from quarterly reports are shown for fistula surgeries, family planning services, training, and partograph reviews through September 2011. Information on training of surgeons in fistula repair are shown through September 2012.

3.2 Facility assessment. Prior to the initiation of program activities, EngenderHealth/Fistula Care staff performed facility assessments at the nine supported hospitals. These preintervention assessments were conducted using a draft version of the Fistula Care site assessment tool (Fistula Care 2011a). This tool was adapted for use for the postintervention assessment. It was designed to measure capacity to provide maternity, fistula repair, and FP services, including the availability of standard equipment and supplies. Postintervention assessments were conducted between June and July 2011

[3] "Post-intervention" refers to the period from April to July 2011. Program activities at supported sites will continue through June 2013.

Table 2. Data collection activities, by site

Site	Site assessments	Program partner key informant interviews	Fistula client record review	Repair client interviews (discharge)	Repair client interviews (follow-up)	# of provider/site assessment data points from checklists, June–July 2011		
						Counseling	FP	Infection prevention
Prevention and repair facilities								
Jean Paul II	X	4	348	31	25	5	6	6
Kissidougou	X	18	838	32	25	8	4	11
Labé	X	12	222	43	39	5	6	6
Prevention-only facilities								
Boké	X	3				0		0
Faranah	X	7				5		0
Ignace Deen	X	3				2		0
Kindia	X	6				2		5
Mamou	X	4				3		0
N'zerekoré	X	5				4		4
Other								
Technical working group members		6						
Geneva Foundation for Medical Education and Research		2						
TOTAL	**9**	**70**	**1,408**	**106**	**89**	**34**	**16**	**26**

by three two-person teams. Each team was made up of a staff member from the global Fistula Care team and a staff member from the Guinea Fistula Care team.

In addition to capturing details about site-level capacity, the evaluation investigated client-provider interactions using quality-of-care checklists developed by the Guinea team in collaboration with the Ministry of Health and Public Hygiene (MoHPY). These checklists, which have been routinely used during quarterly joint MoHPY/Fistula Care facilitative supervision visits since 2010, assess infection prevention practices, pre- and postoperative counseling, and provision of FP services (Annex I). Additionally, the following data were extracted from all fistula patient records at the three repair sites: the patient's place of residence, any referrals, and whether the operating surgeon was a Guinea-trained surgeon or a visiting surgeon. All data collection tools are available upon request from EngenderHealth.

3.3 Key informant interviews. Two groups of key informants were identified and interviewed regarding their perspectives on fistula prevention and treatment activities: fistula patients and program partners.

Between April and June 2011, interviews were conducted with a convenience sample of postrepair fistula patients at the three repair facilities. One hundred and four women who had undergone fistula repair surgery were interviewed prior to their discharge, and 89 women were interviewed when they returned for a three-month or six-month follow-up visit. Interviews were conducted by trained hospital staff using a standard questionnaire adapted from the prospective study "Determinants of post-operative outcomes in fistula repair surgery." All women were asked about their fertility intentions and about whether they had been counseled about and/or received FP services. The predischarge group was asked about their satisfaction with hospital services and was also asked to identify any challenges they anticipated in the coming months concerning reintegration into home communities. The follow-up group was asked about their satisfaction with the waiting house and host family care received (if applicable), as well as about participation in community fistula awareness-raising activities. Key informants in the follow-up group were further asked about changes they experienced in acceptance by family/community; ability to perform routine chores; fertility intentions; sexual activity; and/or FP methods (if applicable).

For the program partner interviews, key informants were selected through purposive sampling of multiple actors, including technical working group members; site-level service providers; regional health management teams; local government representatives; and host families. A total of 70 key informants were interviewed in June and July 2011 by global Fistula Care team members, using an open-ended interview guide. The interviews explored key informants' views on project accomplishments and challenges; the institutionalization of project activities; and unforeseen results of the project, including whether other dimensions of the health system may have been strengthened through Fistula Care interventions. Key informants were also asked about fistula related polices, policy changes, and initiatives, including policies intended to institutionalize fistula care service, including FP integration.

The study protocol was reviewed and approved by EngenderHealth in accordance with the agency's standard operating procedures for conducting research and by the Comité National d'Ethique pour la Recherche en Santé, as required by the Republic of Guinea. The hospital director of each participating facility (or his or her designee) gave consent to conduct the record review. All key informants provided informed consent before being interviewed. As part of the informed consent process, all stakeholders interviewed during the course of this evaluation were informed of the purpose of the study and about their right to confidentiality. No personal identifying information was collected during interviews.

Fistula patient interview data were entered into EpiInfo by a Guinea-based research firm. Databases were cleaned and analyzed by the global Fistula Care team, in consultation with the research firm and Guinea program staff. Data analysis was done using SPSS (version 19.0). For categorical data, simple frequencies were used; for continuous data, means were analyzed. The facility assessment findings, quality indices, and results from key informant interviews were captured in MS Excel and MS Word.

4. Findings

Key achievements identified from the evaluation of Guinea's Fistula Care program are presented below. Multiple data sources are used to describe achievements and to identify challenges that need to be met to further strengthen the program.

4.1 Access to treatment services.

Since EngenderHealth's involvement with fistula program, four facilities have been supported to provide fistula surgery: Ignace Deen, Jean Paul II, Kissidougou, and Labé. Ignace Deen and Kissidougou initially received support through the ACQUIRE Project, and this support was maintained via Fistula Care. Support for fistula surgery at Ignace Deen ended in 2010 due to lack of bed space. Fistula surgery continues to be performed with program support at Kissidougou, Jean Paul II (added in 2008), and Labé (added in 2009).

To strengthen and support the provision of quality fistula repair services, Fistula Care has supported training in fistula surgical techniques, pre- and postoperative care, and the fundamentals of quality of care (medical safety, voluntary decision making, and quality improvement mechanisms) (EngenderHealth, 2006). In addition, the program has covered patient costs for treatment-related consumables, medications, meals, and transportation.

In late 2008, the program began to support the following five regional hospitals with the goal of strengthening diagnosis and referral for fistula patients as well as prevention activities: Boké, Faranah, Kindia, Mamou, and N'zerekoré; Labe was added in 2009 and designated to become a repair facility. Baseline assessments of these six facilities indicated that diagnosis of fistula patients was not being undertaken. However, sites were referring women with suspected fistula to Ignace Deen and Kissidougou for final diagnosis and determination on how to treat.

4.1.1 Fistula surgical training. Two strategies have been employed to build surgical capacity for fistula surgery. First, national fistula repair training sessions were organized under the direction of Professor Mamadou Bobo Diallo, director of the urology department at Ignace Deen University Teaching Hospital in Conakry and chairman of the National Steering Committee for Fistula. These trainings lasted for one to two weeks, depending on the availability of hospital beds. Second, the project partnered with the Geneva Foundation for Medical Education and Research (GFMER) to provide fistula repair training for surgeons. GFMER surgeons traveled to Guinea approximately four times per year to lead training sessions and to assess the progress of trainees. When possible, GFMER also provided supplies and equipment to the fistula surgery centers[4].

It takes time for surgeons to acquire fistula repair skills, and depending on the initial surgical skills of the individual, several training sessions over the course of months or years may be needed for a surgeon to achieve competency at each level. Over the life of the Fistula Care program thus far, 16 surgeons have been trained (Table 3). The others participated in a series of training sessions in different formats. Some were group sessions given by national experts and/or by GFMER surgeons; others were routine repair sessions run by the surgeons according to the competence level at which they had been approved to function. The two surgeons deemed "not yet competent".

Table 3. Number of surgeons trained through September 2012

	Simple repair	Intermediate	Not yet competent	Total	No. still providing surgery at Fistula Care–supported site*
Ignace Deen	5	1	1	7	6
Jean Paul II	3	0	0	3	3
Kissidougou	2	1	0	3	3
Labé	2	0	1	3	0
TOTAL	**12**	**2**	**2**	**16**	**12**

*Through December 2012.

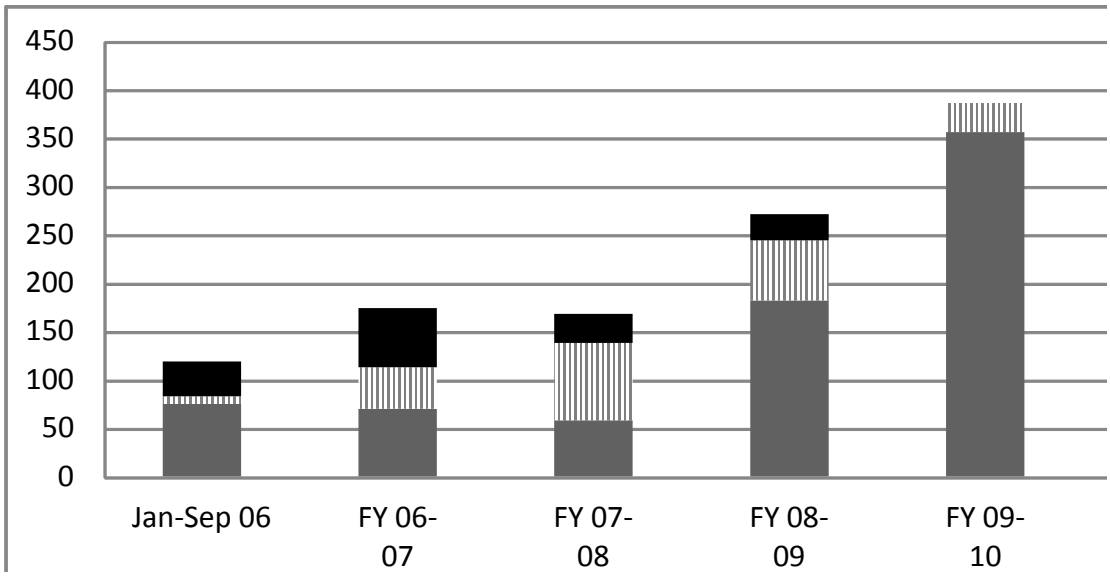
On average, these surgeons have attended approximately 22 training sessions (range= 7-25). The Fistula Care team in New York has conducted two reviews to determine if surgeons who have been trained remain at their home facility, have been transferred, and

[4] In 2013, Fistula Care arranged for two surgeons to receive advanced training onboard the Mercy Ships hospital ship *Africa Mercy* when it was docked in Conakry. Dr. Barry from Kissidougou Hospital received advanced training from Dr. Steve Arrowsmith and Dr. Kindi Diallo from the urology department at Ignace Deen Hospital received advanced training from Dr. Judith Goh.

if transferred, are using their skills. As of December 2012, 12 of the 16 surgeons trained in Guinea were still providing surgery. Those surgeons trained at Ignace Deen are providing surgery at JPII, Ignace Deen and Labé.

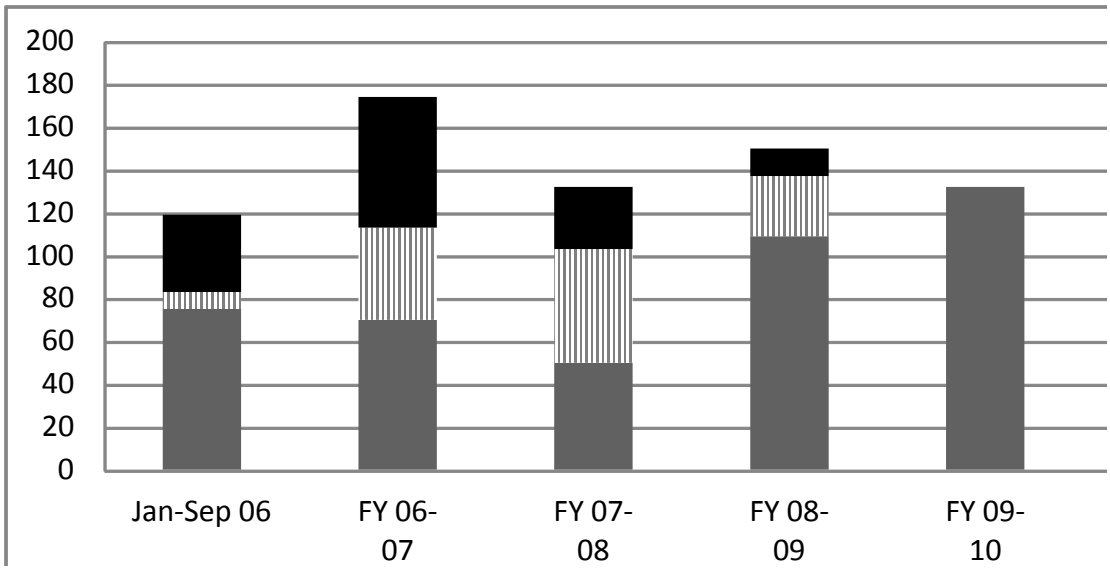
As an indicator of the success of this approach in building service capacity, evaluators abstracted data from the fistula repair client registers regarding whether surgeons were facility-based or whether they were visiting surgeons (project trainees) increased during the evaluation period, as reflected in Figure 2 illustrates the extent to which the proportion of fistula repair surgeries performed by facility-based surgeons has increased in comparison to those done by visiting surgeons. (2011 is incomplete, with data only analyzed through May 2011.) Evaluators performed a separate analysis of only the Kissidougou records, since this is where the program has been supporting fistula services the longest. Again, there has been an overall increase in the proportion of fistula repairs performed by facility-based surgeons (Figure 3).

Figure 2. Number of fistula repair surgeries performed, by type of surgeon and fiscal year (FY), all sites



Note: data for 2011 are incomplete, with surgeries after May 2011 not included in this analysis.

Figure 3. Number of fistula repair surgeries performed, by type of surgeon and FY, Kissidougou



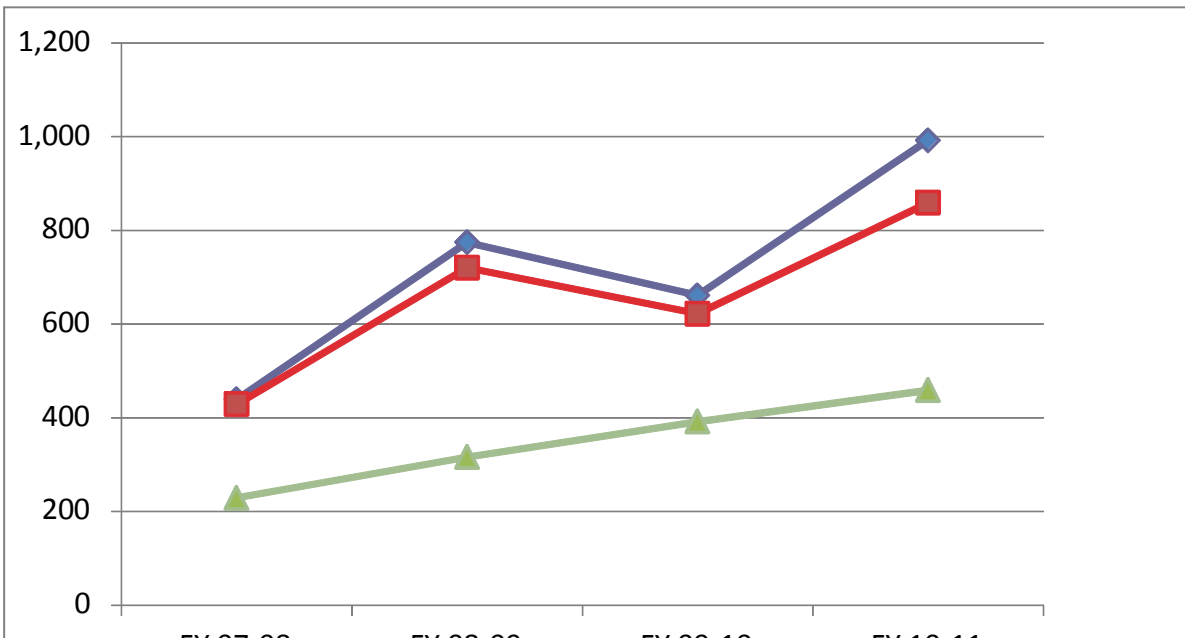
Note: Data for 2011 are incomplete, with surgeries after May 2011 not included in this analysis.

4.1.2 Fistula repair services. The evaluation looked for trends in relation to the following fistula service provision indicators: the number of women seeking care, the number of women needing surgery, the number of women receiving surgery, and the outcome of surgery at time of discharge.

Between FY 2007–2008 and FY 2010–2011, there was increasing demand for fistula treatment services, as demonstrated by the number of women seeking care; however, the supported facilities were not able to fully meet the demand, as shown by the differences between the number of women needing surgery and the number receiving surgery each year (Figure 4).[5]

[5] Information on the number of women seeking and needing surgery was not systematically collected prior to October 2007.

Figure 4. Number of women seeking care, needing surgery, and receiving surgery by FY, all sites



Note: FY 2007–2008 and FY 2010–2011: three sites; FY 2008–2009 and FY 2009–2010: four sites.

The total number of repairs conducted at supported facilities increased from 199 repairs at two sites in FY 2005–2006 to 497 repairs at three sites in FY 2011–2012 (Figure 5). From January 2006 through September 2011, a total of 1,887 repairs were performed. Figure 6 shows the number of surgeries by year. The addition of Jean Paul II and Labé allowed the Guinea program to continue increasing the total number of surgeries performed per year, despite the discontinuation of surgeries at Ignace Deen in 2010.

One of the objectives of the evaluation was to determine if there were changes in referral patterns among women arriving for fistula surgery at the repair sites. Unfortunately, the data extracted from the patient registers yielded no useful information on this issue; they only identified the provinces from which the patients had traveled. Six women came from outside of Guinea for surgery (one from Côte d'Ivoire and five from Sierra Leone).

Figure 5. Number of fistula repair surgeries, by facility and FY

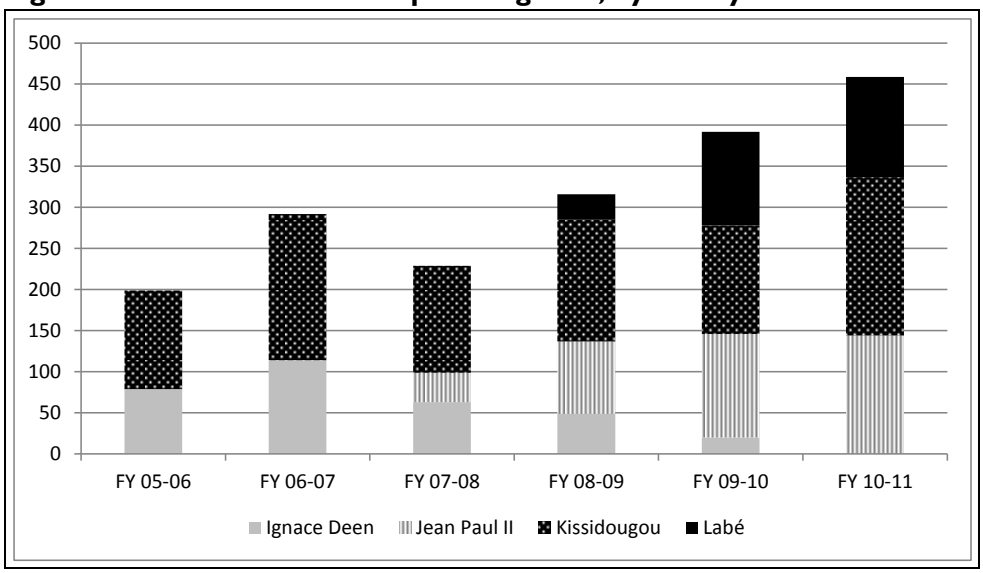
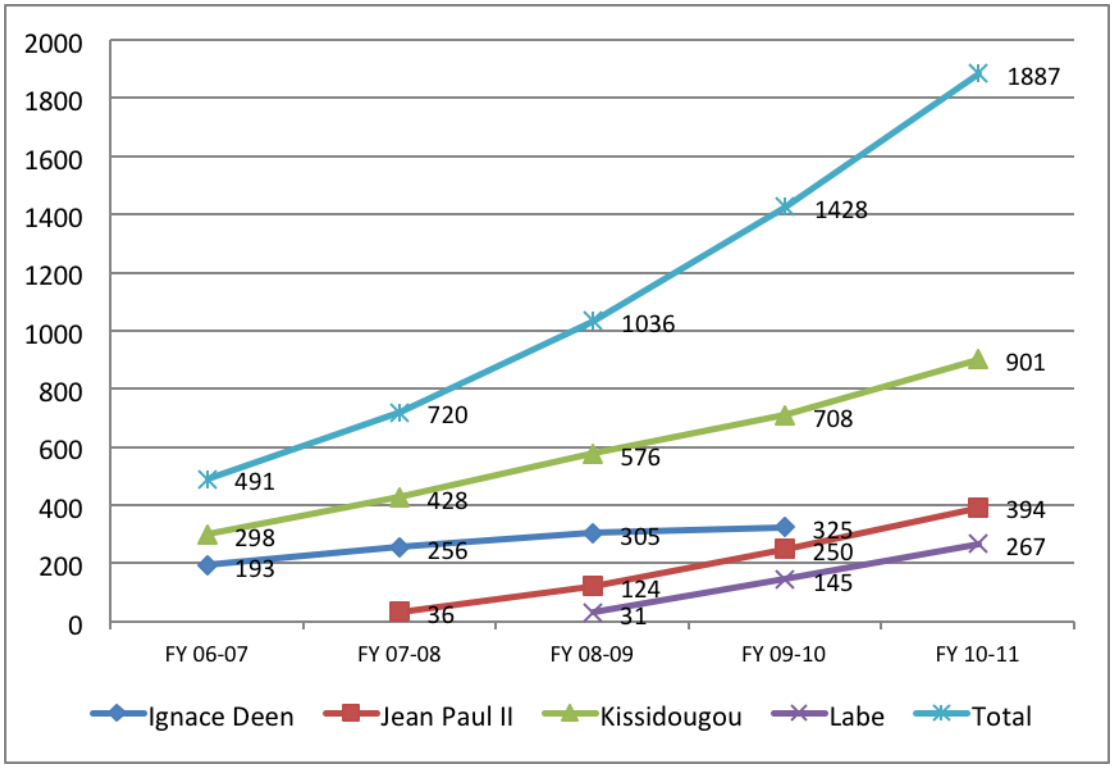


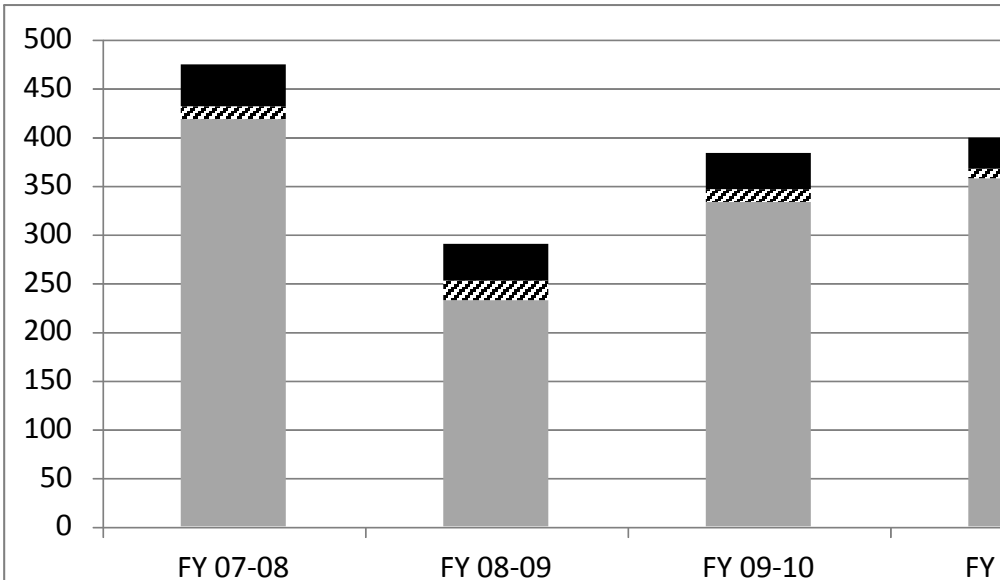
Figure 6. Cumulative number of fistula repairs, by facility and FY



Note: includes 199 repairs supported in FY 2005–2006.

A key reporting indicator for the program is the status of the fistula injury among women who have been discharged: closed and dry, closed with remaining incontinence, and not closed. Because the program uses a quarterly monitoring indicator that tracks surgeries rather than women, there is some double-counting within a year. (Some women require more than one surgery, which means that a woman discharged in one quarter with an outcome of "not closed" could in fact have another surgery later in the year and at her second discharge could be classified as "closed and dry.") It is also difficult to know how to interpret trends in outcomes because it would be reasonable to expect that as surgeons' skills increased, there might be more efforts to perform repairs in complex fistula cases, making the outcome of "closed and dry" more difficult to achieve.is reasonable to expect that as surgeons' skills increased, the proportion of women not closed or closed with incontinence increased, as surgeons treated more women with complex fistula. The closed and dry rate for the program ranged from 76% in FY 2007–2008 to 89% in FY 2010–2011. Figure 7 shows outcomes by FY.

Figure 7. Number of women discharged, by surgery outcome and FY, all sites



4.2 Strengthening facility-based prevention services.

The Fistula Care program aims to enhance facilities' capacity to prevent fistula through training, facilitative supervision, and the provision of equipment and materials such as job aids. Key achievements and observations about facility-based prevention services are described below. Data sources include quarterly reporting; quarterly monitoring visits by the Guinea Fistula Care team using a checklist; patient interview data; and secondary analysis of two global studies.

Table 4 reports the number of staff trained, by prevention topic and by facility, from January 2005 through September 2011. Obstetric care training focused on training providers on partograph use, immediate catheterization after prolonged labor or obstructed labor, and active management of the third stage of labor. Fistula Care has conducted orientations for facility staff on the integration of FP services with fistula

services to address the reproductive health needs of women with repaired fistula and to prevent reinjury. The program has also provided job aids and training resources and has conducted regular medical monitoring visits to help facilities improve the quality of these services.

Table 4. Number of staff trained, by prevention topic and facility, January 2005–September 2011

	Obstetric care*	FP (counseling and methods)
Boké	5	4
Faranah	5	4
Ignace Deen	47	29
Jean Paul II	50	4
Kindia	5	0
Kissidougou	49	40
Labé	0	23
Mamou	5	4
N'zerekoré	10	0
TOTAL	**176**	**108**

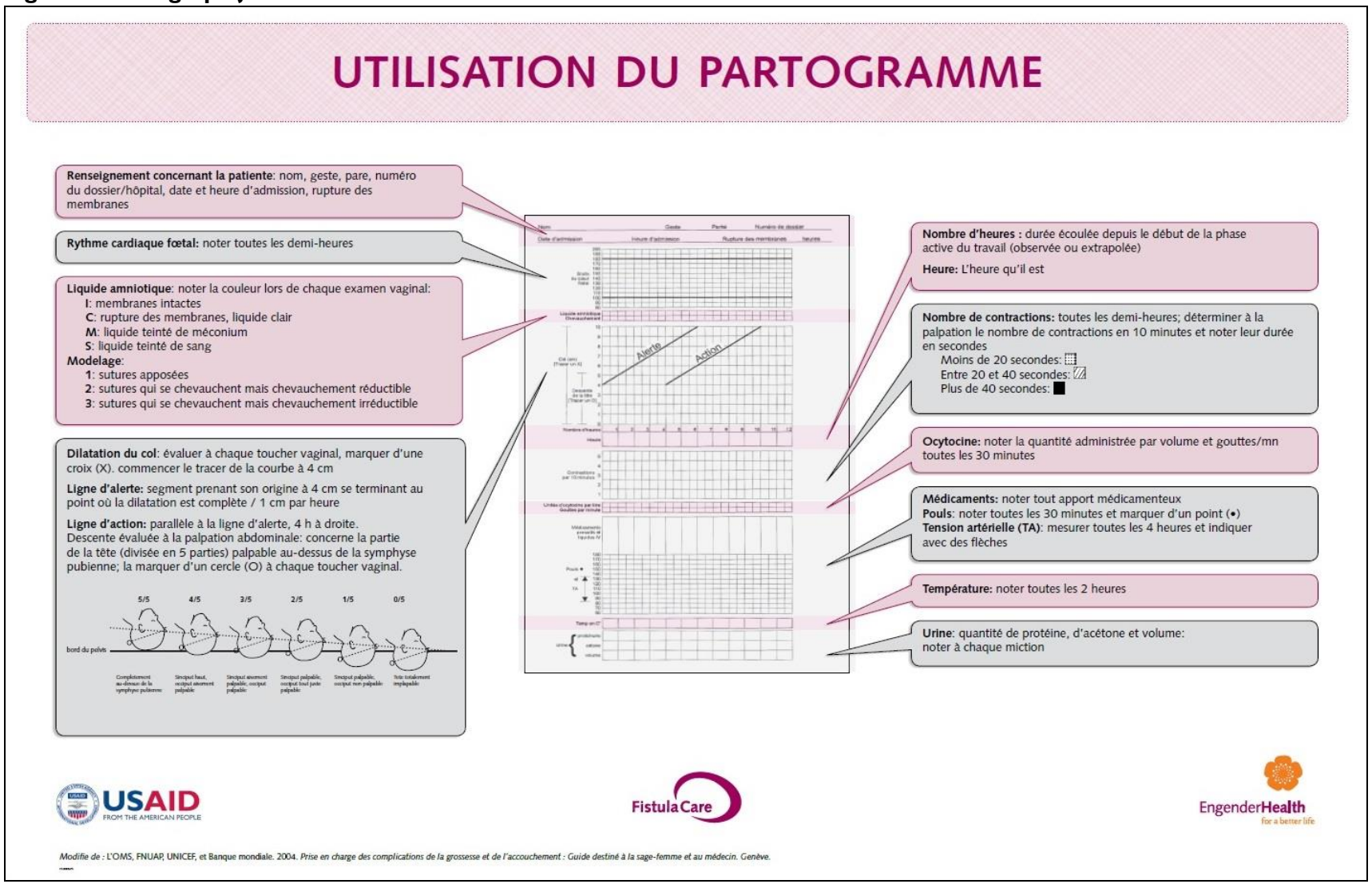
* Training includes emergency obstetric care, active management of the third stage of labor, catheterization, and partograph use. Obstetric care training related to quality improvement efforts is discussed separately later in this section.

4.2.1 Promoting correct and consistent use of the partograph. The partograph is a labor monitoring tool that, if used consistently and correctly, can alert health care providers of the need to intervene (or refer) in an emergency. The partograph also can facilitate clear communication between staff and can serve as a checklist of all of the elements for labor monitoring. Strengthening partograph use in facilities at different levels of the health systems is one of the Fistula Care program's key prevention interventions. The Guinea team created a job aid to assist facility staff with the use of the partograph (Figure 8); this was used in partograph training.

The partograph has fallen out of use in Guinea, as reflected by a retrospective cesarean record review study (Fistula Care, 2012a). The multicenter study found no partograph use in a sample of 653 cesarean deliveries at Kindia Hospital and Kissidougou Hospital in 2008.

Monitoring the use of the partograph is one of 15 core indicators in the Fistula Care program's annual reporting to USAID as part of an annual performance monitoring plan. Routine monitoring of partograph use began at supported facilities in FY 2009–2010. The purpose of the partograph monitoring review is to provide data that can guide programmatic interventions to improve partograph use and labor and delivery services. In FY 2009–2010, Guinea program staff carried out partograph monitoring at only one site (Labé). No partographs were found in the delivery records sampled (Fistula Care 2011 b).

Figure 8. Partograph job aid



As shown in Table 5, the routine annual review for FY 2010–2011 documented some use of the tool, but data were incomplete (Fistula Care 2011a).

Table 5. Partograph monitoring at supported facilities, FY 2010–2011

	% of records sampled that had a partograph	% of partographs completed correctly
Boké	100	4
Faranah	56	0
Ignace Deen	100	0
Jean Paul II	44	55
Kindia	100	13
Kissidougou	32	13
Labé	100	23
Mamou	100	0
N'zerekoke	72	17

4.2.2 Integrating FP. Service data on FP users by method have been collected routinely at the program sites since 2007. Through training and other activities, the program has strengthened existing services and in some instances has helped to institute services. Two of the sites (Jean Paul II and Labé) did not provide any FP services prior to receiving Fistula Care support. In February 2011, staff from the Fistula Care global team held an orientation for regional hospital staff and administrators about the importance of integrating FP services into fistula services.[6] Fistula Care's FP integration strategy is focused on enabling women and couples to delay first births to help prevent fistula and to achieve a successful pregnancy postrepair by allowing women time to heal.

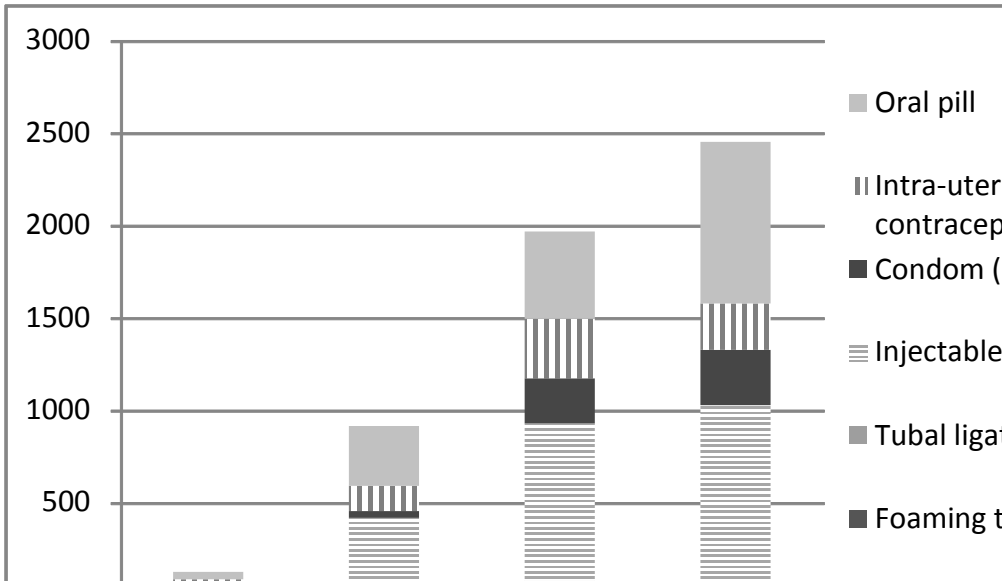
The FP data are not disaggregated by women who have had fistula repair and other women (e.g. women from maternity wards or outpatient clinics). Nevertheless, as shown in Table 6 and Figure 9, there has been a steady increase in the uptake of methods over time, along with improvements in the mix of methods and increases in the number of women receiving FP counseling. (See Annex II for site-level details by year.) During the June 2011 site assessments, none of the facilities reported having had any stock-outs of contraceptive supplies in the previous two quarters.

[6] The Fistula Care global team is undertaking an evaluation of efforts to integrate FP across all programs. The report is expected in July 2013.

Table 6. Number of women counseled and accepting FP, by supported facility and FY

	FY 2007–2008		FY 2008–2009		FY 2009–2010		FY 2010–2011		TOTAL	
	Counseled for FP	FP acceptors	Counseled for FP	FP acceptors	Counseled for FP	FP acceptors	Counseled for FP	FP acceptors	Counseled for FP	FP acceptors
Boké			77	108	474	424	322	271	873	803
Faranah			0	0	453	200	673	379	1,126	579
Ignace Deen	73	69	448	391	416	435	484	365	1,421	1,260
Jean Paul II	0	0	136	48	311	206	278	214	725	468
Kindia			33	40	604	161	574	250	1211	451
Kissidougou	74	145	407	281	479	257	614	559	1,574	1,242
Labé			74	35	234	75	422	103	730	213
Mamou			0	9	204	149	307	240	511	398
N'zerekoré			0	0	283	60	683	68	966	128
TOTAL	**147**	**214**	**1,175**	**912**	**3,458**	**1,967**	**4,357**	**2,449**	**9,137**	**5,542**

Figure 9. Number of FP users, by method, all sites, October 2007–September 2011



Note: FY 2007–2008, two sites (Ignace Deen and Kissidougou); FY 2008–2009, seven sites (all except Faranah and N'zerekoré); FY 2009–2010 and FY 2010–2011, all nine sites.

4.3 Quality improvement for facility-based care

The Fistula Care project has supported provider training in fistula care and treatment to ensure quality services. Activities have included the training of surgeons in repair and the training of health facility teams in pre- and postoperative fistula surgery care and fistula counseling. The project has also supported training in quality improvement approaches cutting across both prevention and treatment services (COPE, fundamentals of care, facilitative supervision, data for decision making, and infection prevention) (EngenderHealth 2003; The ACQUIRE Project, 2006; The ACQUIRE Project, 2008; Fistula Care 2011c; EngenderHealth, 2011b). Table 7 indicates the numbers of providers reached through different training activities**.**

Table 7. Number of health providers trained, by topic and facility, October 2007–September 2011

	Pre- and postoperative care	Infection prevention	Fistula counseling	Quality improvement*	Data management†
Ignace Deen‡	20	20	10	20	11
Jean Paul II	39	33	0	0	0
Kissidougou§	13	31	0	16	0
Labé	16	30	0	0	4
TOTAL	**88**	**103**	**10**	**36**	**15**

* Includes COPE and facilitative supervision.
† Includes data management for research and data for decision-making workshops.
‡ Supported for repairs until June 2010. In FY 2005–2006, under the ACQUIRE Project, 20 additional providers trained in pre- and postoperative care and 90 in infection prevention.
§ Under the ACQUIRE Project in FY 2005–2006 and FY 2006–2007, 40 additional providers trained in pre- and postoperative care and 34 in infection prevention.

4.3.1 Strengthening ongoing quality improvement activities. EngenderHealth's quality improvement approaches and tools, which are aimed at strengthening all service systems from the perspective of clients' rights and providers' needs, have been used by the Guinea Fistula Care program since its inception. Between July 2006 and September 2011, Fistula Care staff conducted at least one annual medical monitoring visit to each of the nine supported facilities. Besides observing facility staff at work, monitoring staff considered the availability and functioning of equipment and supplies and also focused on infection prevention, counseling, and FP. The Guinea Fistula Care team developed separate monitoring tools for these components, to assist in the identification of program improvement needs (see Annex 4). The monitoring tools were designed to assign quality assessment scores based on responses to a series of yes/no questions about services, with answers drawn from observations and/or discussions with providers. At the end of each visit, facility staff developed action plans to address areas requiring attention.

The tools were never formally pretested for interrater reliability. For example, data collected on infection prevention practices (by observation) at one site showed quality scores ranging from 52% to 71% between July 2006 and March 2011 (nine observations). The March 2011 score was 69%; in June 2011, the evaluation team gave a score of 93%. While there may be some interrater reliability issues, these tools appear to indicate increased competence in compliance with service protocols.

During the June 2011 visits to sites, evaluation teams used these same tools to observe services, along with a site monitoring tool to assess the overall availability of equipment and supplies for treatment and prevention services.

The 2011 site assessments revealed that all sites had temporary FP methods available. The availability of long-acting and permanent methods was limited to the intrauterine

device and tubal ligation at all but two sites. All sites had a formal system in place for discussing quality improvement issues; all sites had written protocols for infection prevention; and all but one had infection prevention committees. Privacy was observed in the counseling and examination rooms at all sites.

The evaluation teams identified a range of issues requiring focused attention. Infection prevention issues were lack of soap; poor maintenance of a sterile field during procedures; inconsistent use of gloves, with gloves not always available at some sites; and failure to follow sterilization and decontamination steps. FP counseling issues identified as weak points included discussion of side effects; use of job aids; mention of emergency contraception; verification that clients understood the information provided; and lack of sexually transmitted infection evaluation and prevention counseling. One catheter management issue was the lack of verification of the seal of the balloon or fixing of the bag to the bed, and another was not updating patient charts about catheterization.

4.3.2 Quality assurance structures, information systems, and data use. The Fistula Care project revitalized infection prevention committees that had previously existed in name only. At repair-supported sites, this effort took the form of training and continuous supervision. One indicator of quality improvement capacity is the presence of functional infection prevention committees. According to site assessments done at baseline (January 2006 to February 2009), none of the nine supported sites had functioning infection prevention committees. All sites, with the exception of Mamou, had a functioning committee by the time of the June 2011 follow-up reviews.

To strengthen reporting and use of data to improve services, the program helped sites put into place record-keeping systems and registers where gaps were identified. For example the program assisted with the development of FP registers, fistula patient records, and fistula equipment registers. Between 2008 and 2011, supported sites held 21 data review meetings focused on fistula services. New York-based Fistula Care staff led workshops on data for decision making for the Guinea Fistula Care team, which in turn led these workshops for partners.

Finally the program worked with supported sites to put into place reference materials, guidelines/protocols, and job aids for emergency obstetric care, fistula services, and FP services, as well as for supervision. Generally, however, facilities lacked written standards, guidelines, protocols, and reference materials for the majority of services.

4.4 Institutionalization of quality services

4.4.1 The Evolution of Fistula Care in Guinea. EngenderHealth's fistula activities in Guinea began in 2005. The first step was the formation of a National Steering Committee to guide the work and to ensure that activities would be integrated into the routine work plans of the MoPHY and Ministry of Women and Social Affairs. The primary role of the steering committee was to create an enabling environment for the smooth implementation of the fistula program and to create a sense of ownership by the MoHPY and the communities in which the program is implemented. A guiding principle of the steering

committee has been to ensure that the program is not a stand-alone model, but rather an integrated program within the national public health program.

Members of the steering committee included the director of Ignace Deen University Teaching Hospital's urology department, two senior surgeons from that department, and the hospital's head of maternity, as well as the head of maternity of National Donka Hospital. The directors and heads of maternity at the program's three fistula treatment sites (Jean Paul II, Kissidougou, and Labé) also served on the steering committee.

The steering committee's mandate was to collaborate with EngenderHealth to plan fistula repair activities, coordinate the training process for in-country surgeons, and participate in the monitoring and supervision of clinical activities, all with technical support from Fistula Care staff.

In partnership with the Ministry of Social Affairs, the program also established a reintegration committee to foster the social reintegration of fistula clients. Members of the working group included three representatives from the National Direction for Social Protection and one representative from the National Direction for the Advancement of Women. The mandate of this committee was to collaborate with EngenderHealth to coordinate social reintegration activities and to assist with the economic reintegration of fistula clients.

To enhance training for surgical teams, EngenderHealth also entered into a Memorandum of Understanding with GFMER. Under this agreement, GFMER agreed to send experienced surgeons on a quarterly basis to help build the capacity of Guinean surgeons in fistula repair, as well as to provide some supplies and equipment to Fistula Care repair sites. EngenderHealth's role was to coordinate the international repair sessions and to provide in-country transportation to GFMER surgeons.

A national network to eliminate fistula in Guinea has grown out of the fistula national technical working group and its committees; members of this network include representatives from EngenderHealth, GFMER, the World Health Organization, UNFPA, and in-country nongovernmental organizations such as the National Midwives Association (ASFEGUI).

As with all program implementation, lessons learned from activities in Guinea and from fistula programs in other countries led over time to programming improvements .

4.4.2 Democracy and Governance in Action. In 2006, EngenderHealth established a holistic approach to the provision of fistula services in the city of Kissidougou, in the Eastern Forest Region of Central Guinea. Kissidougou has a population of approximately 137,000 people, and its district hospital provides a variety of services, including surgery, maternity care, and pediatric care. The holistic approach encompassed building capacity to provide fistula services; creating awareness among the local population regarding fistula prevention and the availability of fistula treatment; and establishing an enabling environment for the provision of sustainable services (EngenderHealth, 2011a).

EngenderHealth began by supporting the development of surgical services for obstetric fistula in Kissidougou District Hospital, including training and follow-up support for a surgical team; provision of essential surgical equipment and supplies; and development of reporting systems. In 2007, after a series of interviews with women who had received repairs from the hospital to gain insight into their needs, a decision was made to engage with the local urban development commune. Building on USAID's Democracy and Governance[7] initiative, EngenderHealth worked with the mayor and his council to review and improve the management of and revenue from the local market and to allocate some of the extra revenue that resulted to support prevention and reintegration activities for obstetric fistula. This became known as the "Market Town Approach" (Fistula Care 2010 b).

The market revenue supported the activities of Village Safe Motherhood Committees, which sought to create awareness about obstetric fistula and other complications of pregnancy and childbirth, as well as to ensure that pregnant women were receiving antenatal care. Their work provided opportunities to identify obstetric fistula cases. The revenue also supported a "waiting home" where women who might have traveled long distances for treatment could stay before and after their surgery. (Many women needed adjunct services before they were well enough to undergo surgery.) This approach was ultimately replicated in Labé and Conakry and is currently being replicated in Boké.

4.4.3 Levels of care. In 2009, the Fistula Care project developed the Levels of Care Framework as a way of addressing some of the limitations described earlier—surgical capacity, bed space, and long hospital stays (Fistula Care, 2009). It was recognized that the effective provision of safe and quality services required a triaged system of care. All facilities, and indeed communities, could participate in addressing obstetric fistula by creating awareness of the condition, its causes, and its prevention. At the facility level, four key prevention interventions were identified: FP, correct and consistent use of the partograph for deliveries, immediate catheterization for women who experienced prolonged or obstructed labor, and timely access to quality cesarean section services for those who need them. At sites where these services were provided, staff should also be able to diagnose and refer obstetric fistula cases. This set of services was defined as a

[7] USAID/Guinea is partnering with Guinea, using a multi-sectoral approach (i.e., health, education, agriculture and natural resource management) to strengthen democratic institutions and practices, fight corruption, help national and local government units become more efficient and accountable, and build the capacity of civil society and the media. (USAID, 2013).

Level 1 facility. Level 2 facilities were those where simple cases of obstetric fistula could be addressed by trained surgical teams and with the appropriate capacity for long hospital stays. Level 3 facilities were those where more complex cases could be handled by surgeons with more advanced skills and where training, mentoring, and coaching could be provided.

Guinea embraced this approach on a limited scale in the areas where fistula treatment services already existed, by working with regional hospitals to establish or improve facility-based Level 1 services. Community awareness about prevention was already being promoted through the market town approach and the village safe motherhood committees.

By 2011, support had grown from two facilities to nine, with community engagement and democracy and governance activities in the surrounding communities. In addition to the three Fistula Care-supported sites providing fistula repair services, a joint site assessment by EngenderHealth, the MoHPY and UNFPA led to the Regional Hospital of Kankan receiving UNFPA support for fistula repair services beginning in 2008. Thus, Guinea has four fistula repair facilities distributed across its four major geographic regions.

4.5 Stakeholder perspectives on institutionalization.

The evaluation team interviewed 70 program partners to obtain their perspectives on the program's progress toward institutionalization of fistula prevention and treatment, as well as remaining challenges. Interviewees included 33 partners at and affiliated with the repair facilities, 29 partners involved in the program at prevention-only sites, six members of the national fistula technical working groups, and two GFMER representatives.

None of the stakeholders interviewed knew of policies being established or changed as a result of the program. However, one regional health director said, "Nothing concrete, but the implementation experience will serve to put policies in place."

Summarized below are comments about the program's strengths and remaining challenges. Three key themes emerged: capacity-building, access to safe and quality services, and reintegration.

4.5.1Capacity-building. When stakeholders were asked about key project accomplishments, the most common spontaneously cited accomplishment was the training of staff and community members. Respondents explicitly mentioned almost all of the types of training that the project offered, including surgical repair as well as facility-based prevention strategies such as partograph use, fistula and family planning counseling, infection prevention and COPE. In relation to counseling skills, a technical working group member observed:

> "Really listening to women permitted us to recruit a large number for this surgery."

And the head of a family planning unit said this about the partograph training:

> "…reinforcing [correct and consistent use] of partograph and responsiveness of staff to know they can make the decision to call the doctor"

4.5.2 Access to safe and quality services.
Many respondents talked about how women who were marginalized by the consequences of obstetric fistula gained greater access to treatment due to support for free and comprehensive care. In doing so, stakeholders specifically cited transport and food as fistula repair-related costs that women needed help meeting. The deputy director of a prevention-only site said:

> "When women return from Conakry healed and satisfied, we are also satisfied because we were involved in ensuring their treatment."

Several interviewees had stories to tell about how the surgery affected women's lives (see box). Many spoke about how the program had raised awareness about fistula. A technical working group member said:

> "The project has brought knowledge and awareness of fistula to many levels, [even] common citizens.… It is no longer a taboo."

"One woman…because of EngenderHealth's work, she was pronounced closed and dry this Friday. Coming into the room, she wanted to open her *pagne* [local fabric] and show me.… All aspects of repair are covered by the project and without this she wouldn't have been able to access services."

– Technical working group member

"To see these women who had lost all hope and who have now come back to life is an incomparable achievement."

– Kissidougou community leader

The simplicity of what some stakeholders identified as project accomplishments speaks volumes about health system needs in Guinea. A service provider at a prevention-only site noted that the program helped provide a line on which to hang surgical robes as an infection prevention measure. The chief medical officer of maternity at a prevention-only site talked about how program staff advocated to the hospital director on the service providers' behalf for the resupply of gloves.

Numerous stakeholders, especially at prevention-only sites, mentioned the need for small investments such as these when asked about remaining challenges. Additionally the chief medical officer at a prevention-only site said that facilities needed to adopt international standards for registers and keep partograph hardcopies in stock.

While access to services has increased, some stakeholders said that having insufficient resources continues to be a challenge. One said: "Bed capacity is an issue, the demand is

higher than the availability of services." In addition, while the program has been able to help meet the cost of fistula surgery, long-term health financing issues need to be addressed. The following quotations from stakeholders further illustrate remaining challenges.

> "Before we achieve sustainability, a few things are still necessary: the problem of equipment for the free [cesarean] sections, and then if we add fistula repair [to what hospitals must cover on their own], the state must increase efforts to mobilize funds for health."[8]
>
> *– Regional health director*

> "The MURIGAs [insurance schemes] work somewhat, but there's a lack of solidarity, the task is huge, people must understand the long-term benefit [of facilitating access to services for this marginalized group]."
>
> *– Technical working group member*

> "Water and electricity in hospitals… the project has to work against this challenge to ensure clean equipment, infection prevention, and other challenges that should not exist. If the system was more stable we would have less costs and debates."
>
> *– Technical working group member*

> "The challenge now is convincing the state to invest in health. The free policies [for maternal care]… conceptually it is a very good idea to remove barriers to access… but we need to categorize deliveries. We did an evaluation... and the cost implementations are high, while the government is still not in a position to cover these things…. Look at our neighbors. Senegal, for example. They did the same thing a few years ago and now have had to reverse it—cesareans are still free for the poorest women, but others pay. According to the [National Transitional Council], 2.8% of our national budget will be for health, meanwhile the Abuja Declaration calls for 15%. Mali is around 8%[9], Burkina Faso is around 10%. In the last four years in Guinea, we have not spent more than 1% annually on health."
>
> *– Technical working group member*

[8] Fistula Care has provided cesarean section kits to supported sites.
[9] This was prior to the current political crisis in Mali.

> "Institutionalization of a program of fistula prevention, repair, and rehabilitation can only truly occur in the context of a serious country socioeconomic development policy, as fistula is a perfect indicator of access to care in the largest sense of the term."
>
> – *Visiting surgeon*

At the same time, another regional health director commented: "At [the] site level, the fact that we're having the conversation about institutionalization is already an accomplishment."

4.5.3 Reintegration. The program has worked with communities in Kissidougou and Labé to establish waiting homes and networks of host families for women waiting for and recovering from fistula repair surgery. The reintegration component of the program is viewed as an accomplishment not only because it is beneficial for the women who spend time with the families, but also because it raises awareness of the problem of fistula and helps communities overcome the stigma associated with the condition more. A technical working group member said:

> "At the beginning, families had reservations about receiving a fistula patient in their house; the work of the safe motherhood committees [changed this]."

While there has been progress regarding the social reintegration of repaired clients, at least one service provider said reintegration remained a challenge.

4.6 Client perspectives

4.6.1Patient profiles. As described in the methodology section, a convenience sample of 194 postrepair women were interviewed regarding their satisfaction with services provided (106) prior to discharge and 89 during three-month or six-month follow-up visits). Data from the prospective study were used to supplement these interviews (Landry et al 2012). Selected demographic variables for women in both groups are shown in Table 8. In the convenience sample, the median age at time of surgery was 35 years and women had a median of two living children. Most women had a low educational level. Women who obtained surgery at Jean Paul II and Labé traveled the longest (more than 24 hours). Interestingly, Kissidougou patients in the convenience sample and the prospective study sample had very different median travel times: six hours and 24 hours, respectively.

Table 9 summarizes women's living arrangements and primary income by group. In both the prospective study sample and the convenience sample, women treated at Labé were less likely to report living with their husbands than women treated at other sites. Women treated at Labé also reported higher levels of reliance on other relatives or on themselves for income. Women treated at Labé traveled the farthest, which may partially account for their reliance on others.

Table 8. Profile of women undergoing fistula repair by data source and site

	Prospective study 2007–2010, Kissidougou (n=251)	Program evaluation convenience sample 2011 (discharge and follow-up groups)			
		Jean Paul II (n=56)	Kissidougou (n=57)	Labé (n=82)	TOTAL (n=195)
Median age at surgery (IQR)	30 (22.0-38.0)	26.0 (20.0–36.5)	35.0 (28.0–40.0)	41.0 (30.0–50.0)	35.0 (26.0–43.0)
Median age at marriage (IQR)	15 (14.0-16.0)	15.0 (14.0–18.0)	15.5 (14.5–16.0)	15.0 (13.0–15.8)	15.0 (14.0–16.0)
Median number of living children (IQR)	3 (1.0–6.0)	0.0 (0.0–2.0)	3.5 (1.0–5.0)	3.3 (1.8–5.0)	2.0 (0.0–4.0)
Primary education or higher	11.2%	5.1%	5.7%	7.7%	6.2%
Median no. of hours to travel to hospital for surgery	>24 hours	48 hours	6 hours	24 hours	12.5 hours

Note: IQR=interquartile range

Table 9. Women's living arrangements and primary income source by data source, site, and time of interview (%)

	Prospective study 2007–2010, Kissidougou (n=251)	Program evaluation convenience sample 2011							
		Jean Paul II		Kissidougou		Labé		TOTAL	
		Interviewed at discharge (n=31)	Interviewed at follow-up (n=25)	Interviewed at discharge (n=32)	Interviewed at follow-up (n=25)	Interviewed at discharge (n=43)	Interviewed at follow-up (n=39)	Interviewed at discharge (n=106)	Interviewed at follow-up (n=89)
At time of admission									
Married	57.0	66.7		48.4		65.1		60.6	
Living with husband*	78.6	63.3		41.9		20.9		32.7	
Primary income source									
Husband	45.0	40.0		41.9		20.9		32.7	
Family members	46.6	33.3		32.3		34.9		33.7	
Others	8.0	4.7		6.7		0.0		3.8	
Self	0.4	20.0		25.8		39.5		29.8	
At follow-up interview									
Married	65.7		68.0		52.0		64.1		61.8
Living with husband*	61.0		35.3		84.6		56.0		56.4
Primary income source									
Husband	51.4		12.0		36.0		17.9		21.3
Family members	42.6		48.0		48.0		48.7		48.3
Others	0.8		12.3		4.0		0.0		4.5
Self	5.2		28.0		12.0		33.3		25.8

* Among married women

4.6.2 Fistula patient experience with counseling and services postrepair. Evaluators sought to assess whether fistula patients were receiving and understanding counseling messages about general health (e.g., nutrition, management of residual incontinence), resumption of sexual activity, planning for the next delivery, FP, and fertility potential. Women in both the prospective study sample and the convenience sample were asked whether they had been counseled on these topics prior to discharge. As shown in Table 10, fairly small proportions of women served at Jean Paul II were likely to recall being counseled on various topics, while all or nearly all of the women interviewed at Kissidougou and Labé recalled being counseled on the same topics.

Some clinicians prefer for women with obstetric fistula to have an extended period of sexual abstinence after surgery. Most women treated at Labé said they were counseled to abstain for six months, whereas most women treated at Kissidougou said the recommended time was three months (from the prospective study sample and the convenience sample). A few women at Jean Paul II reported recommended periods of abstinence as long as one and two years (data not shown). Among women in both the discharge and follow-up convenience samples, the importance of seeking out "assisted delivery" was mentioned across sites. Only a few women (n=12) in the discharge group mentioned the need for cesarean delivery in the future (11 women from Labé and one from Jean Paul II).

In convenience sample interviews, an open-ended follow-up question highlighted some quality issues in relation to women's recollections of the details of messages they had received. For example:

- At Jean Paul II, despite the fact that most women did not recall being counseled about the four key topics, amongst those who did recall being counseled, the most commonly recalled detail was the importance of seeking out assisted delivery for future deliveries.
- The importance of cesarean for future deliveries was mentioned across sites by a few women, but counseling messages may need to emphasize this point more, given the stigma associated with the procedure.

Table 10. Counseling provided to fistula patients prior to discharge by data source, site, and time of interview (%)

	Prospective study 2007–2010, Kissidougou (n=251)	Program evaluation convenience sample 2011							
		Jean Paul II		Kissidougou		Labé		TOTAL	
		Dis. (n=31)	FU (n=25)	Dis. (n=32)	FU (n=25)	Dis. (n=43)	FU (n=39)	Dis. (n=106)	FU (n=89)
Maintain good genital hygiene	99.6	46.7	44.0	100.0	100.0	97.7	100.0	88.5	84.3
Nutrition	99.2	46.7	48.0	100.0	100.0	97.7	100.0	81.7	85.4
Manage residual incontinence	99.6	63.3	28.0	100.0	100.0	97.7	94.9	88.5	77.5
Recognize postoperative danger signs	99.6	43.3	48.0	100.0	10.0	97.7	100.0	82.7	85.4
Pelvic floor exercise	98.8	43.3	24.0	100.0	100.0	85.3	94.9	81.7	76.4
Fertility potential	95.2	40.0	16.0	100.0	100.0	90.7	89.7	78.8	71.9
Resumption of sexual intercourse	99.6	43.3	36.0	100.0	100.0	95.3	94.9	81.7	73.0
Planning for next delivery	94.8	43.3	32.0	100.0	92.0	90.7	92.3	71.8	79.8
FP	94.8	36.7	20.0	100.0	100.0	95.3	89.7	79.8	75.3

Notes: Multiple responses allowed. “Dis.”=discharge. “FU”=follow-up.

Women who have experienced fistula require FP services that take into account certain issues. Usually women who have experienced fistula lost the child, and in many instances it was a wanted pregnancy. For many women, especially those who lost a wanted child, there is considerable concern about future fertility and about the ability to sustain a successful pregnancy. The severity of the fistula injury may determine whether or not women will be able to have another child, and at the present time, with few exceptions, there is little evidence available to help determine future fertility. Many clinicians advise women to abstain from sex for three months following fistula repair before trying to have another child to facilitate the healing process. Some clinicians would prefer a longer period of abstinence to further protect the woman’s health. Provision of family planning counseling and services can play an important role in this period. Family planning can do much more than prevent pregnancy. Family planning is a tool for women, men, and couples to achieve their reproductive intentions for delaying pregnancies until the right time; for spacing pregnancies for optimal health of women and their offspring; and limiting pregnancies when the desired family size has been achieved. Selected family planning

methods can also be used to help couples achieve a desired pregnancy by identifying the fertile phase of a woman's menstrual cycle and offering strategies to facilitate conception. For women following repair of fistula, planning subsequent pregnancies is important to ensure complete healing and access to early antenatal and timely obstetric care. For women who have completed their childbearing, FP is vital to preventing unintended pregnancies with risk of repeat trauma and/or poor obstetric outcomes. Women in the 2011 convenience sample were asked about their fertility intentions. Overall about half of all women want to have another child and want to wait about two years (Table 11).

Table 11. Fertility intentions among fistula patients by group and site, 2011 (convenience sample)

	Jean Paul II	Kissidougou	Labé	TOTAL
Discharge group	**(n=31)**	**(n=32)**	**(n=43)**	**(n=106)**
Would like to have a/another child	16 (53.3%)	19 (61.3%)	20 (46.6%)	55 (52.9%)
If yes, when: months (mean)	34.3	20.1	22.6	24.9
Follow-up group	**(n=25)**	**(n=25)**	**(n=39)**	**(n=89)**
Would like to have a/another child	12 (48%)	16 (64%)	16 (41%)	44 (49.5%)
If yes, when: months (mean)	36	24	18.9	23.8

Because the routine FP services statistics that supported facilities reported to Fistula Care are not disaggregated by patient profile (e.g., fistula patient, postpartum), evaluators asked women in the convenience sample about FP use following surgery. Tables 12 and 13 show that more Kissidougou patients are receiving an FP method compared to women at the other sites, despite women's stated desire to space future pregnancies.

Table 12. Acceptance of FP method at time of discharge, by site and data source

	Determinants study, 2007–2010, Kissidougou (n=251)	Program evaluation convenience sample 2011, discharge group			
		Jean Paul II (n=31)	Kissidougou (n=32)	Labé (n=43)	TOTAL (n=106)
Number (%) who accepted an FP method	182 (73.5%)	1 (3.3%)	26 (83.9%)	0 (0%)	27 (26%)
Method chosen:					
Injectable	74 (40.7%)	1 (100%)	14 (53.8%)	NA	15 (55.6%)
Oral contraceptives	106 (58.2%)	0 (0%)	11 (43.3%)	NA	11 (40.7%)
No information	2 (1.1%)	0 (0%)	1 (3.8%)	NA	1 (3.7%)

Table 13. Number of women receiving FP methods at follow-up visit, by site

	Program evaluation convenience sample 2011, follow-up group			
	Jean Paul II (n=25)	**Kissidougou (n=25)**	**Labé (n=39)**	**TOTAL (n=89)**
Received FP method	1 (4%)	14 (56%)	0 (0%)	15 (16.9%)
Method received:				
Injectable (new)	1 (100%)	2 (14%)	NA	3 (20%)
Injectable (continuing)	0 (0%)	7 (50%)	NA	7 (47%)
Oral contraceptives (continuing)	0 (0%)	4 (29%)	NA	4 (26%)
Oral contraceptives at discharge; injectable at follow-up	0 (0%)	1 (7%)	NA	1 (7%)

4.6.3 Patient satisfaction with fistula treatment services. The women from the convenience sample expressed high levels of satisfaction with the services they received. More than 90% said they were very satisfied or satisfied with services received at the hospital; a similarly high proportion reported being very satisfied or satisfied with services received at the waiting home. More than 90% also said they would recommend the services to other fistula sufferers (data not shown).

All women who had surgery at Labé and who reported staying with a host family before or after surgery (n=8) reported that they were very satisfied or satisfied with the time spent with the family. About two-thirds of women who reported staying with a host family before or after surgery at Kissidougou (n=11) said the same.

In an open-ended question, women were asked what they liked most about the services they received. Common responses included surgical repair or being healed; free care; psychosocial support (from other women); meals; hygiene kits and soap; cleanliness of the hospital; and feeling welcome.

Women were also asked what hospitals could do to improve services. Their suggestions included providing mosquito nets; emptying catheters in a timely manner; repairing toilets; improving the quality of meals.

Women in the follow-up group (n=89) were asked if they were engaged in awareness-raising about fistula treatment and prevention. Forty three percent (42.7%) stated that they had been engaged in awareness-raising activities since their surgery; 63.2% of these women said they were very satisfied contributing to community awareness (Data not shown.)

5. Conclusion and Recommendations

Findings from this evaluation show that fistula treatment capacity in Guinea has expanded, and there is some evidence of a greater enabling environment for sustaining services at the policy and program levels. Financial sustainability remains an issue. Between 2006 and 2011, more than 1,500 fistula repairs were performed, and more than half of these procedures were performed by Guinean surgeons, with the proportion performed by Guinean surgeons increasing over time.

The annual number of fistula surgeries by site indicates that despite challenges—such as the discontinuation of support for fistula repair at Ignace Deen and the political instability that has disrupted Guinea in recent years—and with the addition of support to Jean Paul II and Labé, the total number of repairs has continued to increase. The project has provided for women's transport for surgical repair, which has surely helped to increase access. Women who received services at Kissidougou travel the furthest distances to get this much-needed intervention. There are reports that women cross national borders to obtain services; in the record review of surgeries conducted between 2006 and 2011, six foreign women had surgery at Kissidougou (one from Côte d'Ivoire and five from Sierra Leone). More than 80% of women return home closed and dry following surgery. Lastly, reported satisfaction with services among clients is also very high.

Regarding the ability of sites to meet demand for fistula repair surgery as measured by the indicator "percent receiving fistula repair surgery of those requiring it," the program has struggled with a high backlog each year; consistently 25% or more of the women who arrive at the facility and have been screened as needing surgery do not get the surgery. However, some progress is being made, for example at Kissidougou, where the backlog is steadily being reduced with available resources.

This indicator provides a good example of how more precise information might be generated from information systems built on strong individual-level client records. More complete individual client records would also facilitate retrospective cohort analysis of indicators that seek to capture aspects of care spanning multiple visits.

Medical monitoring and facilitative supervision. The medical monitoring and facilitative supervision led by the Guinea Fistula Care team was cited as a strength of the program by many key informants. This work is, however, resource-intensive, and monitoring processes and tools need to be streamlined. Interrater reliability issues emerged when the evaluation team used the quality score checklists that are more routinely used by local supervisors. Dedicating more resources to the review and analysis of supervision reports and action plans would facilitate longitudinal analysis.

Surgical training.The Guinea program's training data raise the following questions about strategy and the definition of training. Several surgeons have been attending continuing training in fistula repair for several years, however as follow up data indicate only one surgeon has reached intermediate-level competency.

Fistula counseling. The assumption in most fistula programs worldwide is that women living with fistula want the surgery. Most programs provide women with information about their condition and tell them about the surgery. However, there is little evidence of structured attempts to convey to women what will happen during surgery and to engage them in conversation about what the potential outcomes of surgery might be. In one qualitative study, women who had unsuccessfully been treated for fistula refused further treatment after poor experiences, raising the question of whether counseling would have been beneficial (Fistula Care 2012c).

The FP information and needs of fistula patients have been described above. Fistula patients who participated in the prospective determinants study and as well as those interviewed for this program evaluation were asked about the counseling services they received prior to discharge. Women were asked whether they had been counseled about how to care for themselves following discharge—to manage residual incontinence; to recognize possible postrepair danger signs (e.g. leaking/wetness, frequent or painful urination); and to consider the importance of good nutrition. Women's recall of this information was good at all sites except Jean Paul II.

Providers may require continued training to strengthen their skills to help women assess their reproductive health needs and FP needs. Women from the 2011 convenience sample stated that they wanted to delay their next pregnancy for up to two years. However, only one woman from the discharge group and one from the follow-up group at Jean Paul II reported receiving an FP method; none of the women in either group at Labé said they had received an FP method.

The program has trained health providers to enhance their skills to ensure that women undergoing fistula surgery have the information they need to make voluntary and informed decisions about their health, including FP.

Facility-based prevention. The introduction of FP at regional-level hospitals and linkages with supplies to avoid stock-outs is clearly a program accomplishment. Overall the number of FP clients increased at all sites. Method mix could most likely be further expanded to include more long-acting and permanent methods. Observations of counseling services undertaken during routine medical monitoring and facilitative supervision visits indicated that providers need refresher training to be able to discuss FP side effects and ensure that clients understand the information being provided. It also appears as though providers need to learn how to make better use of job aids.

Results from the 2010 cesarean record review showed that partographs were not in use at Kissidougou and Kindia hospitals. Since then, the program has trained staff at all facilities in the use of the partograph and has developed job aids to assist them in using this important labor-monitoring tool. Findings from annual monitoring of the use of the partograph indicate that there is still much room for improvement. Strengthening the use of the partograph should be a focus at the primary health care level for better monitoring and referral.

The Guinea team has worked to strengthen the ability of district-level hospitals to provide quality fistula prevention services such as FP and partograph monitoring. This work needs to be replicated at the primary health care level with appropriate and timely referral to district and regional facilities when there are obstetric complications and emergencies.

Study limitations. Overall, the evaluation was limited by a lack of baseline data. Baseline facility assessments were conducted prior to the finalization of the more complete assessment tools that the project now uses as a standard. The more complete assessment tool was adapted for the "post" assessment. In the future, it is advisable to use facility-level baseline assessments to document needs in terms of not only equipment, infrastructure, and general training, but also specific knowledge, attitudes, and competencies—similar to what checklists used during supervision in Guinea attempt to capture and to capture that data in an easily accessible database for future reference.

Use of routine supervision checklists and data to assess changes in the quality of service provision was limited by the fact that quality scores generated by the checklists appeared to be highly susceptible to interrater subjective judgment. Use of the checklists by external evaluators yielded substantially higher scores, suggesting the need to further test and refine these tools. Clear and concise instructions about how to rate or estimate the steps of service provision are needed to assure interrater reliability. The use or adaptation of tested tools could prove informative.

Provider observation is a difficult evaluation methodology. Capturing provider behavior in an objective and reliable manner may require more testing of tools, along with guidelines for their use, but in general, introducing more intermediary measures of knowledge and attitudes into the evaluation framework would increase the precision of efforts to determine where and how to intervene to achieve behavior change. Collecting more qualitative contextual information about the capacity of the surrounding "sending" facilities and district-level epidemiological, behavioral data (where available) is recommended.

Among postrepair clients, resource and time constraints were such that it was only feasible to interview a convenience sample of these women about their perspectives. Longitudinal monitoring of this aspect of the program could provide a sample size able to deliver more power in exploring, for example, differences between FP acceptors and nonacceptors.

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Annex I. Quality monitoring site visit tools

A. Infection prevention

FICHE DE SUIVI DE LA PREVENTION DES INFECTIONS.

Nom du site :……

Dates de la visite ……

Nom du superviseur : ……

Nom des supervisés : ……/……/……/

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
1	Le personnel est-il conscient de l'importance de la prévention des infections ?						
2	Existe-t-il des directives (guide, brochure, affiches…) concernant la prévention des infections à la disposition du personnel ?						
3	Le personnel suit-il les directives de la prévention des infections ?						
4	La cour est-elle propre ?						
5	Y a-t-il de l'eau (courante ou dans un récipient) et du savon pour les besoins des prestataires ?						
6	Les locaux sont-ils propres ?						
7	Le personnel se lave-t-il les mains selon les normes ?						
8	Le personnel est-il habillé selon les normes ?						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
9	Existe-il de l'eau de javel en quantité suffisante dans les services ?						
10	Le personnel maîtrise-t-il la technique de dilution des solutions concentrées d'eau de javel ou de javel en poudre (hypochlorite) pour avoir la solution chlorée à 0,5% ?						
11	Les instruments et les objets sont-ils décontaminés immédiatement après leur utilisation ?						
12	Le temps de décontamination est-il respecté (10 mn) ?						
13	Les surfaces souillées sont-elles essuyées avec une solution chlorée à 0,5% après chaque procédure ?						
14	Les instruments sont-ils nettoyés avec de l'eau, du détergent et une brosse souple ?						
15	Les instruments et autres objets sont-ils séchés avant d'être stérilisés ou désinfectés à haut niveau?						
16	La DHN est-elle effectuée selon les normes (20 mn après ébullition ou 20mn de trempage dans la solution chlorée à 0,5% ou 0,1%)						
17	Les instruments et autres objets sont-ils correctement stérilisés : le temps, la température et la pression sont-ils respectés ?						
18	Le personnel d'entretien dispose-t-il des gants de ménage ?						
19	Les gants réutilisables sont-ils traités selon les normes (décontaminés, nettoyés, stérilisés ou désinfectés à haut niveau et stockés)?						
20	Des gants stériles sont-ils toujours disponibles en cas de besoin ?						
21	Les seringues réutilisables sont-elles traitées selon les normes et procédures SR avant d'être réutilisées ?						
22	Utilise-t-on la procédure d'une seringue, une aiguille pour une personne ?						
23	Existe-t-il des poubelles ?						
24	Les matériels et objets souillés sont-ils placés dans des récipients séparés et sûrs (objets pointus à part, instruments à part, objets à jeter à part) ?						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
25	Les aiguilles, les lames de bistouris souillées sont-elles décontaminées avant d'être recueillies dans un récipient étanche ?						
26	Le sang et les liquides organiques sont-ils manipulés selon les normes ?						
27	Les déchets sont-ils triés aux points de prestations ?						
28	Les déchets sont-ils incinérés, brûlés ou enterrés ?						
29	La structure sanitaire dispose-t-elle des latrines utilisées uniquement par le personnel?						
30	La structure sanitaire dispose-t-elle des latrines utilisées uniquement par les clients ?						
31	La structure sanitaire dispose-t-elle des latrines utilisées uniquement par le personnel et les clients ?						

Taux d'adéquation = Nombre de oui / 31 X 100 % / / / / / /

La présence d'un non ouvre la voie à : une information/ formation, une ou des recommandations et l'élaboration d'un mini plan d'action

ACTIONS IMMEDIATES DU SUPERVISEURS

1- **Informations/formation sur:**

-

2- **Recommandations**

-

Plan d'action

Problèmes	Causes	Solutions	Par qui?	Dates limites

B. Fistula counseling check list

Fiche d`évaluation des compétences en Counseling dans la prise en charge des fistules obstétricales.

Structure Sanitaire de …….

Nom du superviseur ……..

Nom des supervisés :…… /……/……...

Dates successives :……..……

Note : cette fiche est confidentielle. Elle aide le prestataire à améliorer ses compétences en Counseling lors de la PEC des fistules obstétricales.

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
	Pré opératoire						
1	Parle la première à la cliente						
2	Salue la cliente poliment, suivant les coutumes locales						
3	Invite la cliente à s'asseoir						
4	Respecte les valeurs et coutumes de la cliente						
5	Préserve l'intimité de la cliente durant la session de counseling						
6	Fait preuve de compréhension concernant l'état de santé de la cliente *(physique, émotionnel*						
7	Ecoute attentivement la cliente sans l'interrompre						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
8	Pose des questions de clarification au cours de l'entretien.						
9	A des attitudes et comportements verbaux et non verbaux qui indiquent à la cliente que quelqu'un est en train d'essayer de la comprendre, de l'accepter dans sa totalité.						
10	Reformule les sentiments de la cliente pour la comprendre et pour l'aider à mieux se comprendre elle-même.						
11	Fournit des informations exactes aux clientes sur leur état sanitaire et le processus de soins						
12	Emploie un langage clair et simple au cours de l'entretien (n'utilise pas des mots et des phrases trop compliqués pour les clients)						
13	Ne donne pas trop d'informations à la fois						
14	Se montre respectueuse et dépourvue de partie prise envers la cliente (ne fait pas de jugement de valeur)						
15	Aide la cliente à comprendre sa situation, à chasser les mythes autour des fistules et (corriger les informations erronées) et à atténuer la crainte autour de l'intervention chirurgicale.						
16	Se familiarise avec l'univers des clientes : Par exemple, Son mode de vie, l'étape de sa vie reproductive et ses objectifs dans la vie sont des éléments dont le prestataire doit avoir connaissance.						
17	Utilise des supports visuels (brochures, boîtes à images, échantillons de contraceptifs, posters, etc.)						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
18	Explique le résultat de l'examen à la cliente						
19	Explique la possibilité ou non de traitement et/ou les options thérapeutiques						
20	Explique la durée du traitement et résultats possibles						
21	Ne réprimande pas la cliente lorsqu'elle exprime des émotions						
22	Encourage l'expression des opinions et les discussions franches et ouvertes, même lorsqu'il y a désaccord						
23	Capable de reconnaître les pièges du jugement						
24	Capable de découvrir et de dénouer les obstacles à la communication						
25	Intervient pour rétablir le lien en situation de conflit ou de malentendu relationnel.						
26	Porte son feed-back sur des aspects pertinents et précis.						
Avant d'entrer au Bloc opératoire							
27	Vérifie le consentement de la cliente						
28	Rassure la cliente pour dissiper les craintes liées à l'opération						
29	Explique à la cliente les étapes de la procédure chirurgicale, des dangers et complications possibles de la chirurgie et de l'anesthésie ; et des taux de réussite						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
30	Présente l'équipe chirurgicale						
Au Bloc opératoire							
31	Explique chaque étape de la procédure (si la cliente ne dort pas)						
32	Parle avec la cliente le long de l'opération						
Post opératoire :							
33	Soutien psycho-affectif						
34	Donner des informations sur le résultat (provisoire) de l'opération						
35	Donne des informations sur le rôle de la cliente pour la gestion de la sonde (surtout par rapport à sa position et sa mobilité)						
36	Rappelle à la cliente les effets secondaires possibles, les risques et les signes annonçant des complications (citer quelques signes annonciateurs).						
37	Rôle de la cliente concernant la prise en charge des complications *(de ne pas manger pour éviter les complications)*.						
38	Donne des informations sur le rôle de la cliente dans le traitement (prise des médicaments)						
A la sortie							
39	En cas d'échec, explique la cause et/ou le degré de non fermeture de la fistule						

N°	ITEMS	1		2		3	
		OUI	NON	OUI	NON	OUI	NON
40	Possibilité d'une nouvelle intervention chirurgicale à l'avenir *(possibilité ou impossibilité et dans le premier cas, où et quand)*						
41	Si fistule fermée avec écoulement, explique le pourquoi de perte d'urines.						
42	Des informations sur l'observation de la période d'abstinence nécessaire (3 mois à 6mois selon les cas).						
43	Donne des informations sur la période de conception (la grossesse) environ 1 an après l'opération.						
44	Donne des informations sur la nécessité des consultations prénatales minutieuses et d'un accouchement en milieu hospitalier par césarienne pour les prochaines grossesses						
45	Donne des informations sur l'hygiène personnelle et alimentaire.						
46	Parle de la PF à la cliente en post opératoire et l'oriente vers l'unité PF						
47	Discute ou réfère pour l'infection de l'appareil reproducteur et des infections sexuellement transmissibles, notamment le VIH.						
48	Parle de la nécessité de se présenter au Rendez vous du 3eme mois.						
49	Donne à la cliente des informations écrites.						
	Taux d'adéquation= Nombre de oui /49						

Taux d'adéquation= Nombre de oui /(49 – NA) x 100 = ……..…../

ACTIONS IMMEDIATES DU SUPERVISEURS

La présence d'un « NON » ouvre la voie à l'élaboration d'un mini plan d'action pour améliorer Les compétences en Counseling

Dans la stratégie de formation axée sur la compétence individuelle, il est d'usage d'affirmer qu'un taux d'adéquation > 60% est acceptable.

Acceptable veut dire que les objectifs éducationnels de la formation (en Counseling) ont été atteints et que le participant a intégré les compétences dans ses prestations.

Nous recommandons d'utiliser périodiquement cette fiche d'auto évaluation pour évoluer et pourquoi pas, se préparer avant toute visite de supervision ? Vous serez étonné de constater les résultats.

BONNE REUSSITE

C. Family planning counseling check list

I. COUNSELING AVEC NOUVEL UTILISATEUR DU SERVICE PF

Nom du site …….. Date de la visite ……

Nom du superviseur : ……

Nom du supervisé : ……

ITEMS	OUI	NON	OBSERVATIONS
BIENVENUE			
Accueil chalereux et courtois			
Assure l'Intimité (Ferme porte et tire rideau de la fenêtre			
Se présente à la cliente, ainsi que l'assistant			
Rassure la cliente de la Confidentialité			
Taux d'adéquation = Total de **oui sur (4– total de N/A) x 100**			
ENTRETIEN			
Demande motif de consultation			
Pose une question ouverte			
Ecoute attentivement la cliente			

ITEMS	OUI	NON	OBSERVATIONS
Stimule la cliente à parler			
Evalue les connaissances et pratiques antérieures en PF			
Demande la préférence de la cliente			
Recherche les signes mentionnés sur la fiche PF lors de la première visite			
Evalue l'exposition et le risque des IST chez le client			
Taux d'adéquation = Total de oui sur (8 – total de N/A) x 100			
RENSEIGNEMENTS			
Donne des Informations sommaires sur toutes les méthodes, concernant :			
Efficacité			
Avantages			
Inconvénients			
Prévention des IST			
Commence par la méthode préférée du client			
Donne les informations nécessaires			

ITEMS	OUI	NON	OBSERVATIONS
Utilise des messages clairs et adaptés au client			
Utilise du matériel didactique approprié (Echantillon, Boite à images, Affiches, van des méthodes)			
Taux d'adéquation = Total de oui sur (8**– total de N/A)** x 100)			
CHOIX			
Informe la cliente que la décision pour le choix des méthodes lui revient			
Fourni à la cliente ce qu'il veut, si aucune raison médicale ne s'y oppose			
Evoque les raisons médicales qui suscitent un changement de méthode			
Cherche à confirmer le choix de la cliente avant de commencer l'explication			
Taux d'adéquation = Total de oui sur (4 – total de N/A) **x 100**			
EXPLICATIONS			
Explique l'utilisation de la méthode choisie :			
Quand commencer			
Comment Utiliser			
Conditions d'efficacité de la méthode			

ITEMS	OUI	NON	OBSERVATIONS
Effets secondaires			
CAT en présence d'effets secondaires			
Efficacité de la méthode et prévention des IST			
Corriger les mauvaises informations sur la méthode			
Parler de Contraception Orale d'Urgence			
Vérifier la compréhension en posant des questions ouvertes ou demande de reprendre			
Aide la cliente à retenir les messages en donnant des repères (marché hebdomadaire…)			
Invite la cliente à poser des questions			
Taux d'adéquation = Total de oui sur (11– total de N/A) x 100)			
RETOUR			
Informe la cliente qu'il peut revenir à n'importe quel moment, pour une raison quelconque			
Informe sur la date du prochain RDV			
Vérifie la Compréhension			
Remercie, encourage à revenir et amener d'autres clientes			

ITEMS	OUI	NON	OBSERVATIONS
Taux d'adéquation (Total de oui – total de N/A sur 4 x 100)			

II. COUNSELING AVEC UTILISATEUR REGULIER DU SERVICE PF
(visite de suivi/contact ultérieur)

Nom du site …….. Date de la visite ……

Nom du superviseur : ……

Nom du supervisé : ……

COUNSELING AVEC UTILISATEUR REGULIER DU SERVICE PF (VISITE de SUIVI)	OUI	NON	OBSERVATIONS
Remercie la cliente d'être revenue			
Demande l'évolution du client durant la période écoulée			
Evalue les problèmes observés (effets 2aires ; Signes d'alerte et d'autres inquiétudes) ainsi que la CAT adoptée			
Vérifie l'utilisation correcte de la méthode par le client pour les C O			
Aide la cliente à la prise de décision de continuer ou changer la méthode			
Livre la quantité de contraceptif que le client désire			
Rappel les effets seconsdaires et signes d'alerte et CAT			

COUNSELING AVEC UTILISATEUR REGULIER DU SERVICE PF (VISITE de SUIVI)	**OUI**	**NON**	**OBSERVATIONS**
Remercie, encourage à revenir et d'amener d'autres clientes			
Taux d'adéquation = Total de oui – total de N/A sur (8 – total de N/A) **x 100**			

D. Catheter quality check List

Grille d'évaluation pour la technique de pose d'une sonde vésicale

Nom du site …….. Date de la visite ……

Nom du superviseur : ……

Nom des supervisés : ……/……..……/

……/

N°	ITEMS	1		2		3	
		Oui	Non	Oui	Non	Oui	Non
1	**L'infirmier est tenu de:**						
2	**S'assure de l'identité de sa patiente**						
3	**Vérifie la prescription médicale du sondage (dossiers de soins)**						
4	**Réunir le matériel nécessaire**						
5	**Préparer un plan de travail stérile (décontamination chariot, y mettre tout le matériel nécessaire)**						
6	**Demander une aide**						
7	**Informer la patiente**						
8	**Installer la cliente en décubitus dorsale sur le bassin**						

N°	ITEMS	1		2		3	
		Oui	Non	Oui	Non	Oui	Non
9	Se laver les mains						
10	Porter des gants d'examen						
11	Procéder à la toilette vulvaire						
12	Retire les gants à usage unique						
13	Lavage antiseptique des mains						
14	Met une paire de gants stériles.						
15	Procéder à l'antisepsie de la zone avec un tampon imbibé de solution antiseptique (Bétadine, Chlorexidine…)						
16	Met une deuxième paire des gants stériles.						
17	Place un champ stérile sur le patient						
18	Vérifier l'étanchéité du ballonnet avant d'introduire la sonde						
19	Adapter le collecteur à la sonde						
20	Lubrifier le bout de la sonde et le glisser avec souplesse dans le méat urinaire						
21	Gonfler le ballonnet quand la sonde est en place (volume d'eau selon indication figurant sur l'emballage)						
22	Retirer la sonde (avec souplesse) jusqu'à ce que le ballonnet butte						

N°	ITEMS	1		2		3	
		Oui	Non	Oui	Non	Oui	Non
23	Fixer la sonde sur la cuisse						
24	Fixer la poche de recueil au lit						
25	Termine par un lavage simple des mains						
26	Note la date du sondage dans le dossier.						
TAUX D'ADEQUATION							

Taux d'adéquation= Nombre de oui /40 x 100 = ……../……./……..

*La présence d'un **« NON »** ouvre la voie à un problème et à l'élaboration d'un mini plan d'action pour améliorer Les compétences en Soins infirmiers*
*Dans la stratégie de formation axée sur la compétence individuelle, il est d'usage d'affirmer qu'**un taux d'adéquation > 60% est acceptable**.*
Acceptable veut dire que les objectifs éducationnels de la formation (en Soins infirmiers) ont été atteints et que le participant a intégré les compétences dans ses prestations.
Nous recommandons d'utiliser périodiquement cette fiche d'auto évaluation pour évoluer et pourquoi ne pas, se préparer avant toute visite de supervision ?
Vous serez étonné de constater les résultats.

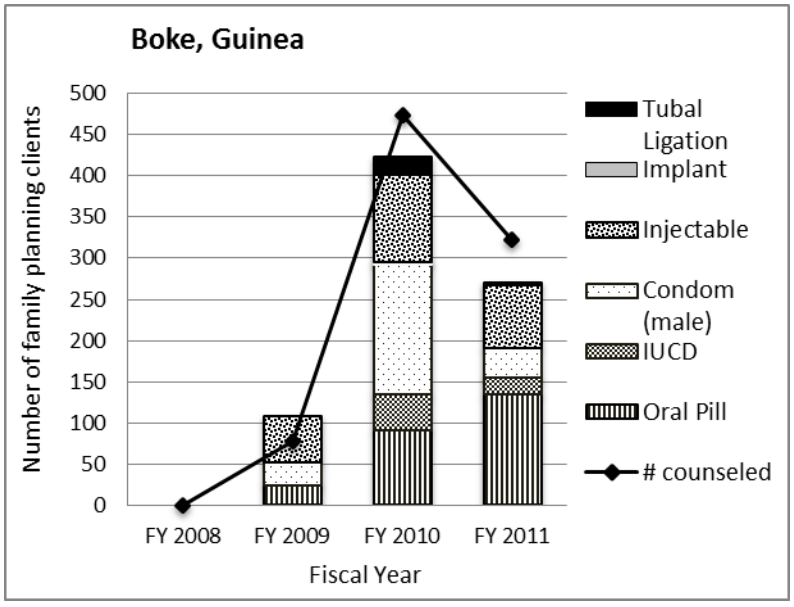
ACTIONS IMMEDIATES DU SUPERVISEURS

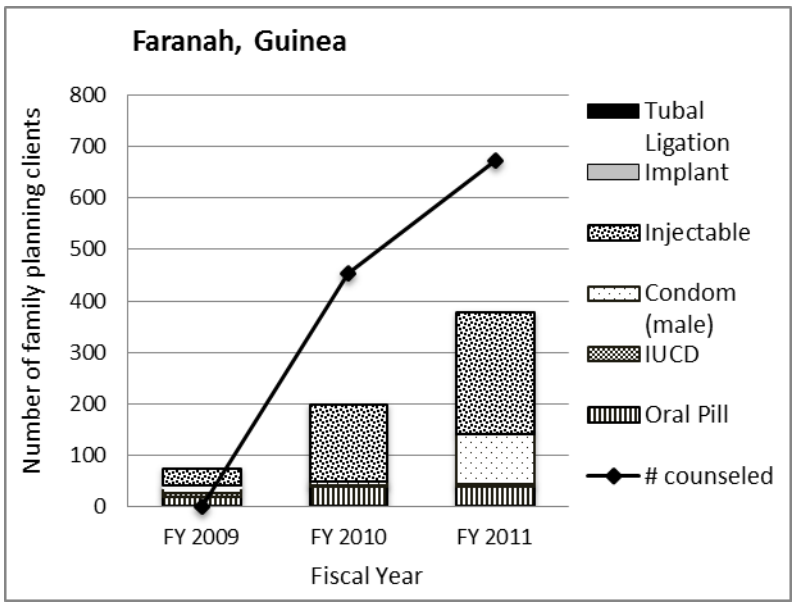
3- Informations/formation sur:

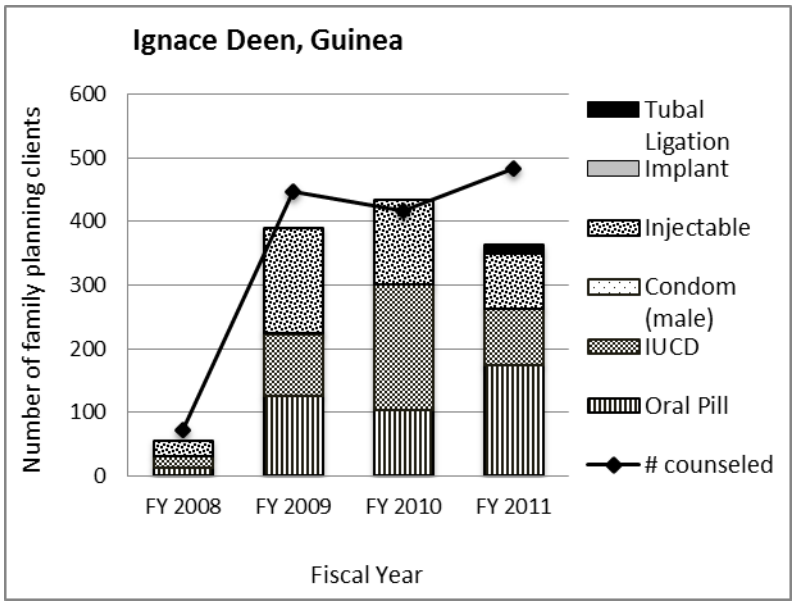
- -

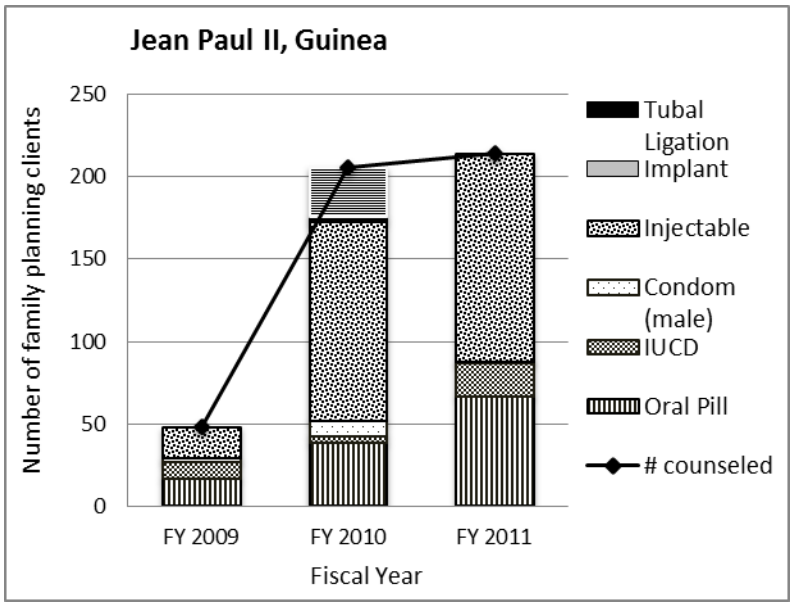
4- Recommandations

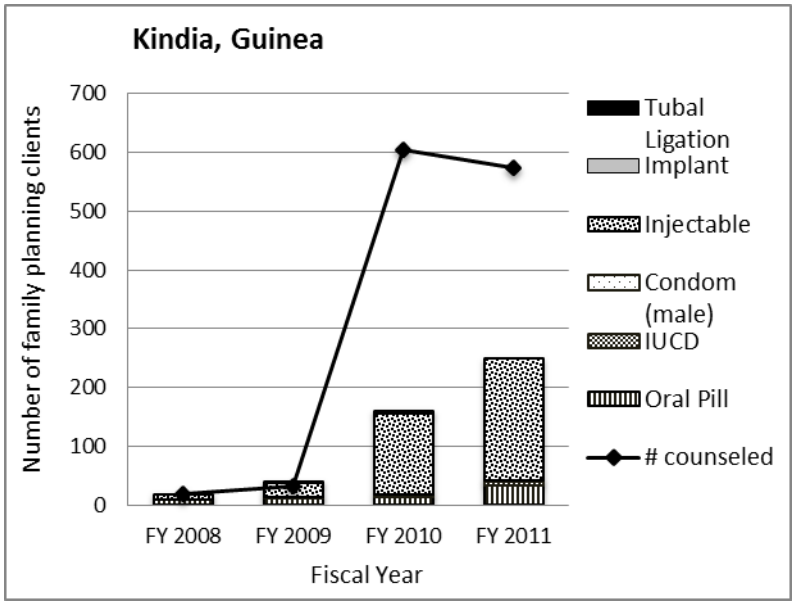
Annex. II Method mix and family planning counseling by site

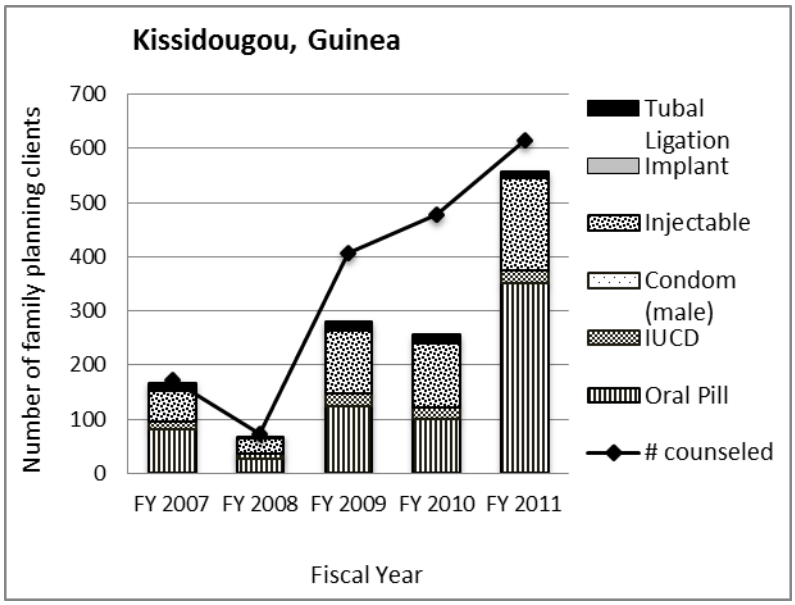


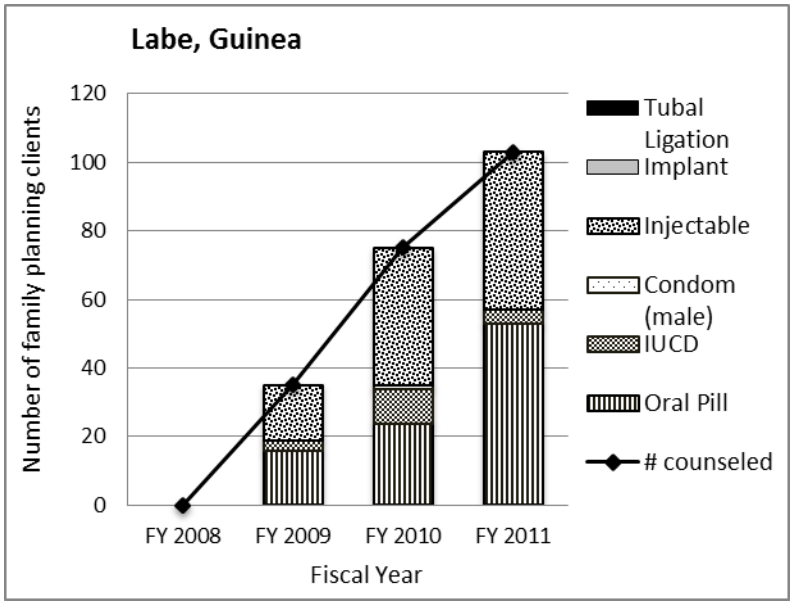


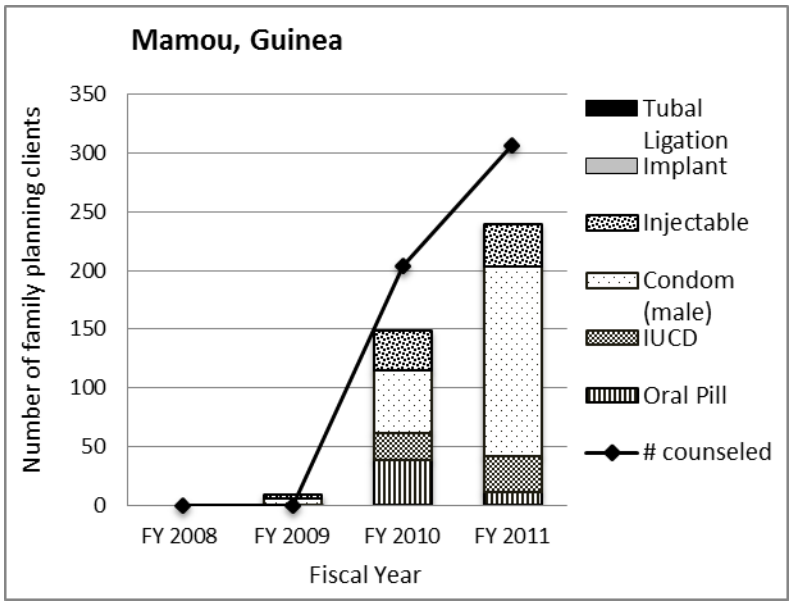

Ignace Deen, Guinea
Number of family planning clients
600
500
400
300
200
100
0
FY 2008
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled

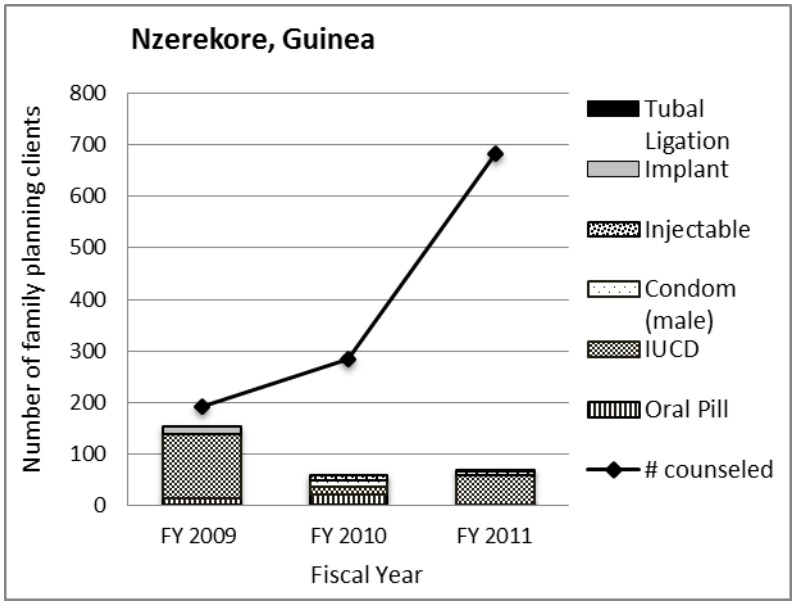

Jean Paul II, Guinea
Number of family planning clients
250
200
150
100
50
0
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled


Kindia, Guinea
Number of family planning clients
700
600
500
400
300
200
100
0
FY 2008
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled


Kissidougou, Guinea
Number of family planning clients
700
600
500
400
300
200
100
0
FY 2007
FY 2008
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled


Labe, Guinea
Number of family planning clients
120
100
80
60
40
20
0
FY 2008
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled


Mamou, Guinea
Number of family planning clients
350
300
250
200
150
100
50
0
FY 2008
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled


Nzerekore, Guinea
Number of family planning clients
800
700
600
500
400
300
200
100
0
FY 2009
FY 2010
FY 2011
Fiscal Year
Tubal Ligation
Implant
Injectable
Condom (male)
IUCD
Oral Pill
counseled