FISTULA CARE

Associate Cooperative Agreement No.

GHS-A-00-07-00021-00

Annual Report
October 2007 – September 2008
Executive Summary

Submitted November 24, 2008

to

United States Agency for International Development

Washington, DC

By

EngenderHealth

for a better life

USAID

FROM THE AMERICAN PEOPLE

FistulaCare

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ACRONYMS AND ABBREVIATIONS

AAFH	Addis Ababa Fistula Hospital
ACQUIRE	Access, Quality and Use in Reproductive Health
AMTSL	Active Management of the Third Stage of Labor
AWARE-RH	Action for West Africa Region – Reproductive Health
BBC	British Broadcasting Corporation
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
CBO	Community Based Organization
CHUK	Central University Hospital of Kigali
COPE®	Client-Oriented, Provider Efficient Services
DRC	Democratic Republic of the Congo
EmOC	Emergency Obstetric Care
ESD	Extending Service Delivery
FC	Fistula Care
FIGO	Federation of International Gynecologists/Obstetricians
FoC	Fundamentals of Care
FP	Family Planning
FRS	Fistula Repair Surgery
FTWG	Fistula Technical Working Group
FY	Fiscal Year
GBV	Gender Based Violence
GFMER	Geneva Foundation for Medical Education and Research
HEAL	Health, Education, Community Action, Leadership Development
IHI	IntraHealth International
IRC	International Rescue Committee
IP	Infection Prevention
IOFWG	International Obstetric Fistula Working Group
ISOFS	International Society of Obstetric Fistula Surgeons
LGA	Local Government Areas
MAP	Men As Partners®
M&E	Monitoring and Evaluation
MIS	Management Information System
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
NGO	Nongovernmental Organization
Ob/Gyn	Obstetrics/Gynecology
PAUSA	Pan African Urological Surgeons Association
PMP	Program Monitoring Plan
QI	Quality Improvement
REF	Network for the Eradication of Fistula

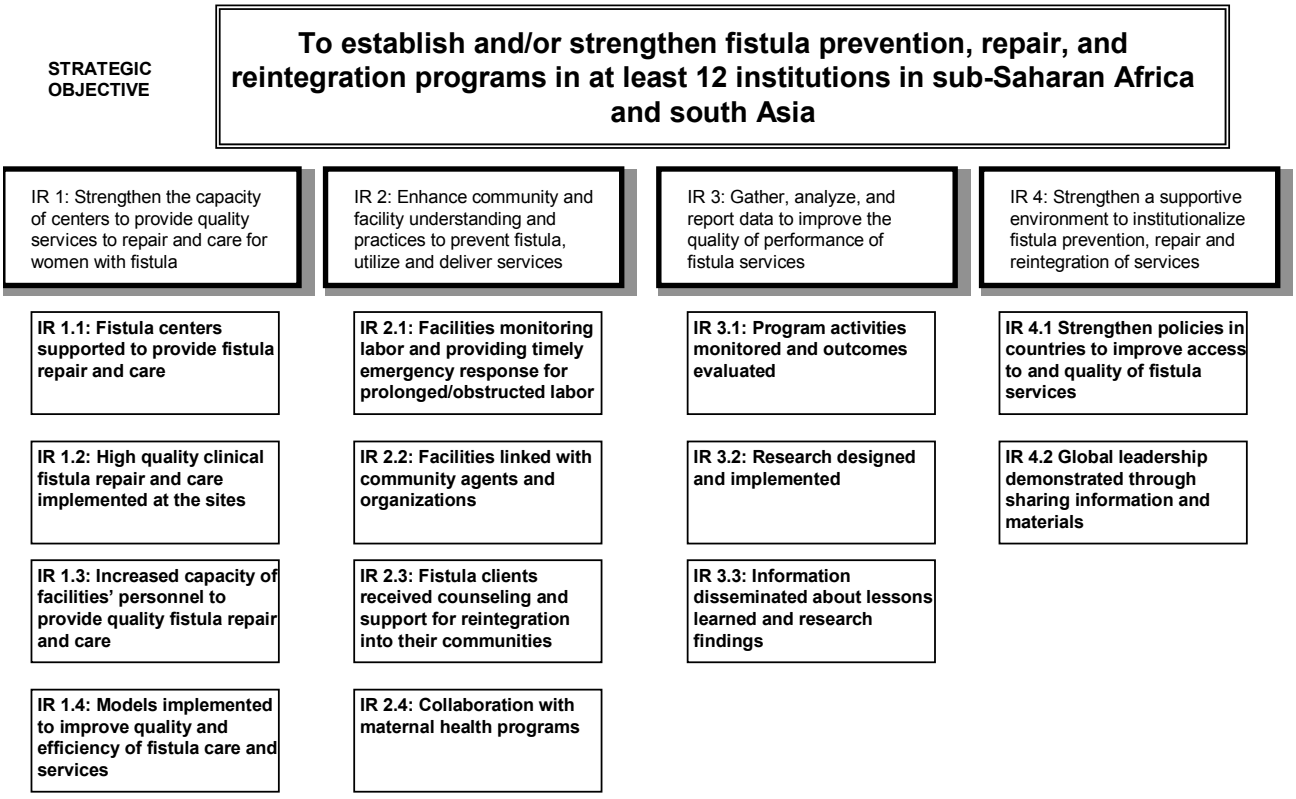
RH	Reproductive Health
RVF	Recto-vaginal Fistula
SM	Safe Motherhood
UNFPA	United Nations Population Fund
USG	United States Government
UTI	Urinary Track Infection
VOA	Voice of America
VVF	Vesico-vaginal Fistula
WHO	World Health Organization

I. INTRODUCTION

This annual report represents a summary of accomplishments for the first year (October 1, 2007-September 30, 2008) of the Fistula Care project, a five-year Associate Cooperative Agreement (No. GHS-A-00-07-00021-00) supported by USAID.

USAID support to EngenderHealth for fistula services began in 2004 under the ACQUIRE Project. The scope of work under the ACQUIRE project was primarily focused on training of surgeons in fistula surgery and strengthening the capacity of sites to provide quality fistula surgery. With the award of the Fistula Care Project, the scope of work has been expanded to include a focus on prevention activities. The goal of the Fistula Care project is to increase and strengthen the number of sites providing fistula services, as well as to support prevention through advocacy, increased attention to the provision of emergency obstetric care, the use of family planning, and to identify ways to support fistula clients post-surgery to reintegrate into their families and communities, if that is their desire and their need. The results framework for the project is shown below in Figure 1.

Figure 1: Fistula Care Results Framework



This report focuses on Fistula Care's inputs, outputs and, in certain cases, results of key interventions from global leadership and country programs. As of September 30, 2008, USAID is now supporting fistula treatment and prevention activities in **37 sites** (includes 4 prevention only sites in Ethiopia,. 1 in Niger and 8 sites in Nigeria) in **10 countries;** see Table 1 and Figure 2 below. Funding for program activities in the final quarter (July-September 2008) continued with ACQUIRE pipelines in all

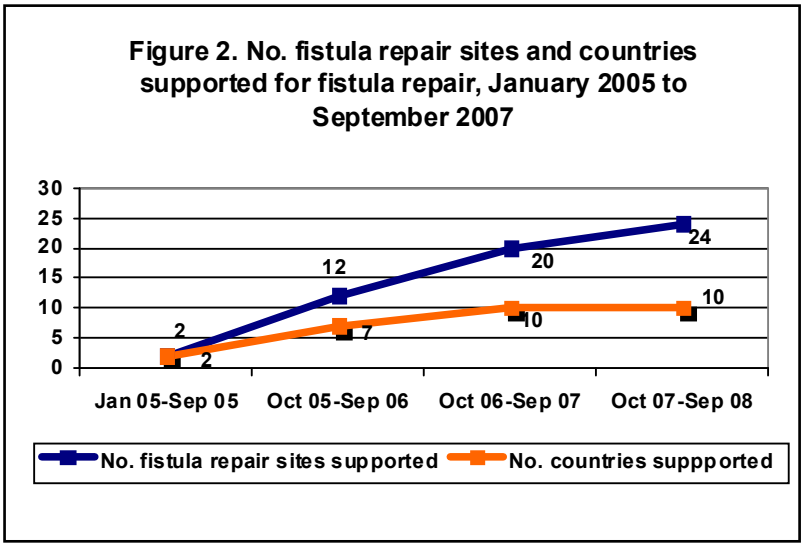
countries except Guinea, Liberia, Niger, Nigeria, and Sierra Leone. Fistula Care funds supported activities in Guinea, Liberia, Nigeria and Sierra Leone this quarter.

The annual report is organized into three sections: Overall accomplishments by Results, Country Reports, and Management.

Table 1. Number of Countries Supported by USAID for Fistula Repairs by Status October 2007-September 2008

Country	Active Oct 2007-Sep 2008	Programs Under Development	Completed
Bangladesh	X		
Benin*		X	
Democratic Republic of Congo (DRC)	X		
Ethiopia	X		
Ghana			X
Guinea	X		
Liberia*	X		
Mali		X	
Niger	X		
Nigeria	X		
Rwanda	X		
Sierra Leone	X		
Uganda	X		

*Fistula repair activities will be carried out in these two countries aboard the Mercy Ships *Africa Mercy* while docked in those countries. Support of fistula repairs in Liberia began August 1, 2008. The Africa Mercy will move to Benin in early 2009.



II. Global Accomplishments

During the first year of the project considerable effort was put into assuring a smooth transition from the ACQUIRE Project to Fistula Care, and developing new programs. Global staff worked with all the country programs to support the development of workplans and strategies and the development and management of sub-awards. During the past year a total of 10 sub-awards were managed by the New York based team and six by the EngenderHealth country office in Bangladesh (see Table 2).

Table 2. Sub-awards, October 2007 through September 2008

Country	Name of Institution	Where managed	Purpose	Start Date	End Date	Total Amount Obligated to date
New York Managed Sub-awards						
Bangladesh	LAMB Hospital	EH/NY	Global research	1/1/2008	11/30/2008	2,205
Bangladesh	Kumudini Hospital	EH/NY	Global research	1/1/2008	11/30/2008	1,352
Bangladesh	Memorial Christian Hospital	EH/NY	Global research	1/1/2008	11/30/2008	1,279
Bangladesh	LAMB Hospital	EH/NY	Program Services	7/1/2005	12/31/2007	79,373
Sierra Leone	Mercy Ships	EH/NY	Program Services	1/1/2007	3/31/2008	353,679
Sierra Leone, Liberia & Benin	Mercy Ships	EH/NY	Program Services	7/1/2008	6/30/2009	701,840
Uganda	Kitovu Hospital	EH/NY	Global research	12/1/2007	8/31/2008	5,107
Uganda	Kagando Mission Hospital	EH/NY	Global research	12/1/2007	8/31/2008	3,308
Uganda	Center for Digital Storytelling	EH/NY	DVD development	8/1/2007	12/31/2007	25,562
Uganda	Mulago National Referral Hospital	EH/NY	Program Services	1/1/2005	12/31/2007	2,225
Field Based Managed Sub-awards						
Bangladesh	LAMB Hospital	Field office	Program Services	3/1/2007	12/31/2007	15,543
Bangladesh	LAMB Hospital	Field office	Program Services	1/1/2008	11/30/2008	53,489
Bangladesh	Kumudini Hospital	Field office	Program Services	7/1/2005	12/31/2007	75,691
Bangladesh	Kumudini Hospital	Field office	Program Services	1/1/2008	11/30/2008	55,115
Bangladesh	Memorial Christian Hospital	Field office	Program Services	3/1/2007	12/31/2007	9,724
Bangladesh	Memorial Christian Hospital	Field office	Program Services	6/1/2007	06/30/2008	19,976

Fistula Care global staff, EngenderHealth staff, and consultants provided in country technical assistance visits to 9 countries during the October 2007 –September 2008 period. The focus of the technical assistance included (see Table 3):

- Training of research teams for the global prospective study on fistula (Bangladesh, Nigeria, Rwanda)[1]
- Skills training for providers in counseling and infection prevention (Bangladesh and Nigeria)
- Development of new program materials—traumatic fistula counseling and fistula nursing materials (Tanzania, DRC, Uganda)

[1] Training for the research teams in Guinea and Uganda was accomplished under the ACQUIRE project in FY 2006-2007.

- Program development and support (Mali, Niger, Nigeria, Rwanda)
- Data management (Nigeria)
- Program evaluation (Sierra Leone)

Table 3. International Technical Assistance October 2007-September 2008

Country	Purpose	Who	When
Bangladesh	Research Training for global study	Mark Barone	October 2007
Bangladesh	Field test of fistula curriculum	Levent Cagatay	June 2008
Democratic Republic of Congo	Key informant interviews for development of traumatic fistula curriculum	Elizabeth Rowley (consultant)	September 2008
Mali	Program Development	Karen Beattie Sita Millimono	February 2008
Niger	Program support	Carrie Ngongo	April 2008
Nigeria	Research Training for global study	Mark Barone	December 2007
Nigeria	Data management	Evelyn Landry	December 2007
Nigeria	Fistula Counseling Training	Fred Ndede	January 2008
Nigeria	Workplan and budget development; medical monitoring	Karen Beattie, Joseph Ruminjo	July 2008
Nigeria	Program Development: integration of family planning & community engagement	Betty Farrell, Nancy Russell	July 2008
Nigeria	Infection prevention training	Fred Ndede,	October 2007
Rwanda	Program Development	Karen Beattie Joseph Ruminjo	June 2008
Rwanda	Research Training for global study	Vera Frajzyngier	September 2008
Tanzania	Workshop for development of nursing curriculum for fistula care	Isaac Achwal	September 2008
Sierra Leone	Program Evaluation	Evelyn Landry Grant MacClean (Mercy Ships)	February 2008

Fistula Performance Data

Fistula Care had several discussions with USAID about development of a performance management plan (PMP). USAID/W approved the PMP in October 2008. A total of 15 core indicators were identified organized by the four project results. Table 4 below shows the Fistula Care accomplishments for the year. Proposed benchmarks for FY 08/09 are under review and will be submitted separately by December 31, 2008.

Table 4: Fistula Care Achievements and Benchmarks

	Baseline 06/07	FY 07/08	FY 07/08	FY 08/09
	Actual	**Planned**	**Actual**	**Planned**
SO To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in sub-Saharan Africa & south Asia				
1. # of sites supported	23	37	37	TBD
▪ # fistula repair only	n/a	9	10	
▪ # fistula repair and FP	n/a	16	14	
▪ # FP only	n/a	12	12	
▪ fistula repair & EOC	n/a	n/a	n/a	
▪ Fistula repair , EOC, FP	n/a	n/a	n/a	
▪ EOC only	n/a	n/a	n/a	
▪ EOC & FP	n/a	n/a	n/a	
▪ unknown	n/a	n/a	1	
2. # of women receiving fistula repair surgery	3,106	3,882	4,061	
IR 1Strengthen the capacity of centers to provide quality services to repair and care for women with obstetric and traumatic gynecologic fistula				
3.#/% of women who received fistula surgery who have a closed fistula & are dry upon discharge	87%	75%	79%	TBD
4 % of women who had fistula surgery who experienced complications	8%	≤20%	4%	TBD
5 # of people trained, by type of training	603	1,800	4,858[2]	TBD
IR 2 Enhance community and facility understanding and practices to prevent fistula, utilize and deliver services for emergency obstetric care, and support women's reintegration				
6. # of community outreach events about fistula prevention	513	625	1,323[3]	TBD
7. # of persons reached in outreach events about fistula prevention	239,675	350,000	442,534	TBD
8. % of all labors with partographs correctly completed & managed according to protocol	NA	NA	NA	TBD
9. Number of births at FC supported sites	NA	NA	NA	TBD
10. Number/Percent of births that were by c section	NA	NA	NA	TBD
11. Number/Percent of c-sections that that were a result of obstructed labor	NA	NA	NA	TBD
IR 3. Gather, analyze and report data to improve the quality and performance of fistula services				
12. % of supported sites reporting and reviewing quarterly fistula monitoring data for improving fistula services	NA	45%	48%	TBD
13. # of evaluation & research studies completed	0	1	0	TBD

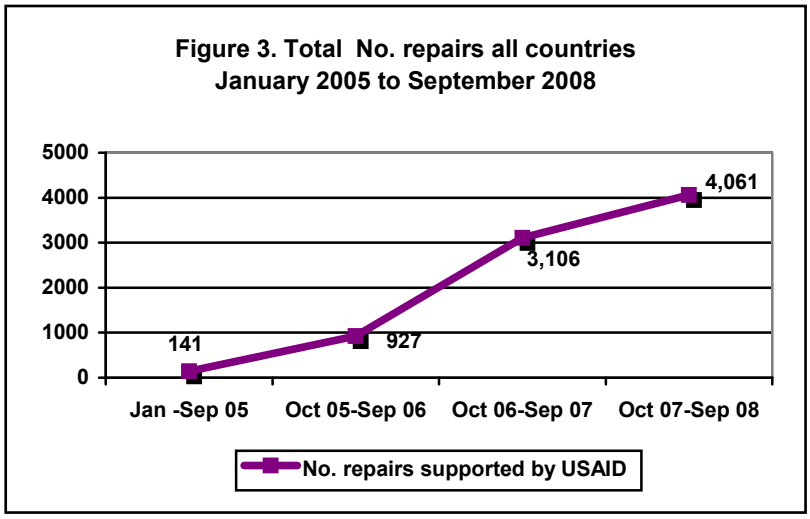
[2] 84% of training was for training of community volunteers; 97% training of community volunteers was in Ethiopia.
[3] Data on number of events missing from Guinea for all quarters; from Ethiopia pre repair centers missing for three quarters; for Ethiopia/AAFH missing for all quarters.

	Baseline 06/07	FY 07/08	FY 07/08	FY 08/09
	Actual	Planned	Actual	Planned
IR 4 Strengthen a supportive environment to institutionalize fistula prevention, repair and reintegration programs				
14.. Number of countries receiving support from Fistula Care where governments or supported facilities have revised/adopted/initiated policies for fistula prevention or treatment	NA	TBD	4	TBD
15. Number of facilities using Fistula Care technical products, by product, for improving fistula treatment and prevention services.	NA	TBD	26	TBD

NA=not applicable
TBD=to be determined

RESULT 1:Strengthen the capacity of centers to provide quality services to repair and care for women with obstetric and traumatic gynecologic fistula

Increase in number of Fistula Repairs



The number of women receiving fistula repair surgery in the final quarter was lower than the previous quarter: 931 in July-September compared with 976 in the April-June 2008 period (6% decreases). This was partly a result of delays in funding in the transition from ACQUIRE to Fistula Care. As shown below in Table 5, the total number of women receiving repairs reported for the year was **4,061** from 24 repair sites in 10 countries[4]; the project benchmark was to support 3, 882 repairs. The number of repairs supported this year exceeds last year's performance by 31% (see Figure 3); the increase is primarily due to the increase number of sites supported by the project and increased capacity at some sites. Just over one third of all procedures were performed at the Nigeria supported sites (35.4%).

Table 6 is summary of key indicators for all countries reporting services in FY 07/08.

- **Number seeking and requiring fistula surgery:** Overall the majority-77% or more-- of women seeking fistula repair surgery were in need of surgery. Exception was the DRC where about 70% of women who were seeking services required repairs.
- **Percent who received surgery:** Some country programs are experiencing backlogs—women who need surgery but were unable to get surgery during the reporting period. In Guinea 54%f

[4] Fistula repair services were not provided at one site in Niger--Issaka Gazobi; during this FY this site was a prevention only site.

of women needing surgery received it, in Niger 55%, Bangladesh 71% and Rwanda 65%. The rest of the countries were able to provide 80% or more of the required surgeries.

- **Percent of repairs which were first repairs:** In Ethiopia and Sierra Leone about 80% of the repairs were first repairs; in other countries this ranged from 48% in Rwanda, to about half in Bangladesh and the DRC to about two thirds in the remaining countries.
- **Percent of women discharged with closed and dry fistula:** The rates for women who had closed fistula and were dry was 79% overall for all sites, with a range of 67% (Ethiopia) to 93% (Nigeria); see Figure 4. About one fifth (21%) of the clients had either a fistula that was not closed or had residual incontinence at the time they were discharged.
- **Percent of women who experienced complications:** In general, reports on complications remain low across all the program supported sites. Complications varied from a low of 3% to a high of 6%, with a mean of 4%. The Bangladesh program had a high rate in the 2nd quarter – 50%- but this gradually went down to 24% in the following quarter and 12% in the last quarter of the year[5]. Most of the other programs had complication rates varying between 0 and 10%. Most of the complications were in the aggregated group of post-op fever, bleeding and urinary track infection (UTI); the second commonest category was anesthesia related. Guidelines for reporting complications has been updated (following discussion at the Accra Meeting) and distributed to program supported sites.
- **Deaths.** Two deaths were reported in FC supported programs this year. Both deaths were investigated and discussed with the surgeons involved. One death was associated with infection/septicemia arising from surgery, including one temporary colostomy. The second death had excessive bleeding after surgery and succumbed despite blood transfusion.

Table 5.Total number of Women Receiving Fistula Repair Surgery by Country, Site, Year and Projections[6] for FY 08

	FY 05[7]	FY 06[8]	FY 07 Oct 06 - Sep 07					FY 08 Oct 07 - Sep 08						Grand Total
Country	**Total**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**July-Sep**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-June**	**July-Sep**	**Total**	**Proj. FY 2008**	**FY 05 – FY 08**
Bangladesh														
Kumudini	7	22	2	3	5	14	24	12	12	8	25	57	30	**110**
Lamb	4	40	18	14	19	21	72	24	1	13	14	52	40	**168**
MCH	9	31	6	6	2	9	23	8	0	2	3	13	20	**76**
Total	**20**	**93**	**26**	**23**	**26**	**44**	**119**	**44**	**13**	**23**	**42**	**122**	**90**	**354**
DRC														
Heal Africa	NA	53	33	28	110	44	215	103	90	7	n/a	200	NA	**468**
Panzi	NA	NA	92	103	93	83	371	n/a	101	33	n/a	134	NA	**505**
Total	**0**	**53**	**125**	**131**	**203**	**127**	**586**	**103**	**191**	**40**	n/a	**334**	NA	**973**

[5] Actual number of complications was small, 5 in each quarter, with a denominator of 10 and 21 women, respectively (women who had surgery and had been discharged in the quarter).

[3] Projections, where noted, were provided by country programs during the work plan development process.

[7] January to September 2005

[8] October 2005 to September 2006

	FY 05[7]	FY 06[8]	FY 07 Oct 06 - Sep 07					FY 08 Oct 07 - Sep 08						Grand Total
Country	**Total**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**July-Sep**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-June**	**July-Sep**	**Total**	**Proj. FY 2008**	**FY 05 – FY 08**
Ethiopia														
Bahir Dar Ctr[9]	NA	81	54	58	9	18	139	159	214	171	172	716	750	**936**
Mekelle Ctr	NA	n/a	n/a	n/a	n/a	n/a	n/a	35	61	49	50	195	400	**195**
Total	**0**	**81**	**54**	**58**	**9**	**18**	**139**	**194**	**275**	**220**	**222**	**911**	**1150**	**1131**
Ghana[10]														
Mercy Ships	0	21	0	42	0	0	42	NA	NA	NA	NA	NA	NA	**63**
Total	**0**	**21**	**0**	**42**	**0**	**0**	**42**	NA	NA	NA	NA	NA	NA	**63**
Guinea														
Ignace Deen	NA	79	39	15	20	40	114	16	16	16	15	63	90	**256**
Jean Paul II	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	36	36	0	**36**
Kissidogou	NA	120	54	19	65	40	178	32	40	42	16	130	130	**428**
Total	NA	**199**	**93**	**34**	**85**	**80**	**292**	**48**	**56**	**58**	**67**	**229**	**220**	**720**
Liberia														
Africa Mercy	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	59	59	n/a	**59**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**48**	**48**	n/a	**59**
Niger[11]														
Dosso	NA	NA	NA	NA	NA	0	0	3	11	3	0	17	n/a	**17**
Issaka Gazobi	NA	NA	NA	NA	NA	0	0	0	0	0	0	0	n/a	**0**
Lamorde	NA	NA	NA	NA	NA	27	27	12	35	15	8	70	n/a	**97**
Maradi	NA	NA	NA	NA	NA	0	0	52	34	11	26	123	n/a	**123**
Tera	NA	NA	NA	NA	NA	0	0	0	3	0	0	3	n/a	**3**
Total	NA	NA	NA	NA	NA	**27**	**27**	**67**	**83**	**29**	**34**	**213**	n/a	**240**
Nigeria														
BabbarR.	NA	NA	NA	NA	NA	356	356	90	172	118	156	536	n/a	**892**
Faridat Yak.	NA	NA	NA	NA	NA	180	180	22	30	60	38	150	n/a	**330**
Kebbi	NA	NA	NA	NA	NA	102	102	36	38	36	12	122	n/a	**224**
Laure Fistula Ctr.	NA	NA	NA	NA	NA	339	339	115	129	107	122	473	n/a	**812**
Maryam Abacha	NA	NA	NA	NA	NA	104	104	8	56	51	41	156	n/a	**260**
Total	NA	NA	NA	NA	NA	**1,081**[12]	**1,081**	**271**	**425**	**372**	**369**	**1,437**	**1,385**	**2,518**

[9] Data for Bahir Dar are under reported for all quarters prior to October 2007. There was no formal reporting mechanism in place with Engender Health for reporting data. For periods prior to October 2007, the number of women receiving surgery is based on information provided by the pre-repair centers

[10] Fistula Care is no longer supporting services in Ghana

[11] Repairs in Niger reported in the April to June & July to September quarters were not supported with USAID funds.

	FY 05[7]	FY 06[8]	FY 07 Oct 06 - Sep 07					FY 08 Oct 07 - Sep 08						Grand Total
Country	**Total**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**July-Sep**	**Total**	**Oct-Dec**	**Jan-Mar**	**Apr-June**	**July-Sep**	**Total**	**Proj. FY 2008**	**FY 05 – FY 08**
Rwanda														
CHUK	0	45	11	10	27	7	55	10	10	7	9	36	90	**136**
Ruhengeri	0	100	7	62	0	23	92	0	0	47	0	47	145	**239**
Total	**0**	**145**	**18**	**72**	**27**	**30**	**147**	**10**	**10**	**54**	**9**	**83**	**235**	**375**
Sierra Leone[13]														
Aberdeen.	NA	NA	NA	92	109	71	272	85	99	85	94	363	375	**635**
Total	NA	NA	NA	**92**	**109**	**71**	**272**	**85**	**99**	**85**	**94**	**363**	**375**	**635**
Uganda														
Kagando[14]	NA	79	88	25	12	49	174	24	30	29	35	118	n/a	**371**
Kitovu[15]	121	256	43	48	63	73	227	55	71	66	0	192	n/a	**796**
Total	**121**	**335**	**131**	**73**	**75**	**122**	**401**	**79**	**101**	**95**	**35**	**310**	n/a	**1167**
Overall Total	**141**	**927**	**447**	**525**	**534**	**1,600**	**3,106**	**901**	**1,253**	**976**	**931**	**4,061**	**3,455**	**8,235**

NA: not applicable; no services supported by USAID during the reporting period. n/a: not available

[12] Data for Nigerian sites was not available by quarter for FY07. All services for the year were reported under the July to September quarter.
[13] Repairs in Sierra Leone reported in the April to June quarter were not supported by USAID.
[14] Repairs at Kagando reported in the July to September quarter were not supported by USAID
[15] Repairs at Kitovu reported in the April to June quarter were not supported by USAID.

Table 6 Project: Trends Oct. 2007 to Sept 2008 Selected Clinical Indicators

	Bangladesh	DRC[16]	Ethiopia	Guinea	Liberia[17]	Niger	Nigeria[18]	Rwanda	Sierra Leone	Uganda	Total
1. # sites supported for fistula repair	3	2	2	3	1	3	5	2	1	2	24
2. # sites for prevention only services	0	0	4	0	0	1	8	0	0	0	13
3. # women arriving and seeking surgery	202	446	n/a	439	61	440	1,308	141	545	423	4,005
4. #/% of women requiring surgery	171(85%)	308(69%)	n/a	435(99%)	59(97%)	388(88%)	1,287(98)	127(90%)	439(80%)	327(77%)	3,535(88%)
5.Among women who need surgery#/ % getting surgery	122(71%)	334[19]	911	235(54%)	59(100%)	213(55%)	1,437[20]	83(65%)	363/83%	310(95%)	4,061[21]
6. #/% of surgeries first repairs	96(56%)	191(57%)	736(81%)	157(67%)	38(64%)	105(49%)	779/67%	40(48%)	290(80%)	206(66%)	3,455(91%)[22]
7.# discharged[23]	130	334	911	235	59	202	1,069	82	380	316	3,712
8. #/% closed and dry at time of discharge[24]	92(71%)	271(81%)	609(67%)	173(74%)	52(88%)	144/71%	996(93%)	61(74%)	276(73%)	251(79%)	2,924(79%)
9. #/% women with complications[24]	19(15%)	6(2%)	n/a	8(3%)	16(27%)	1(<1%)	51(5%)	4(5%)	38(10%)	8(4%)	155(4%)

n/a=not available

[16] Data for DRC does not include Oct-Dec for 1 site and July-Sept for 2 sites.

[17] Data for Liberia is for one quarter only (Jul-Sep 2008)

[18] Data for Nigeria is incomplete for July to September 2008 for most indicators for 2 site (# seeking services, # requiring surgery, # first repairs, # closed and dry, # complications). Data for items 6, 7, 8 & 9 are based on 1,159 women for whom data is available (data missing for 278 repairs in July to September 2008).

[19] In the DRC the number of women getting surgery exceeds the number of women seeking and needing surgery because of women waiting from the last quarter of 2006/2007.

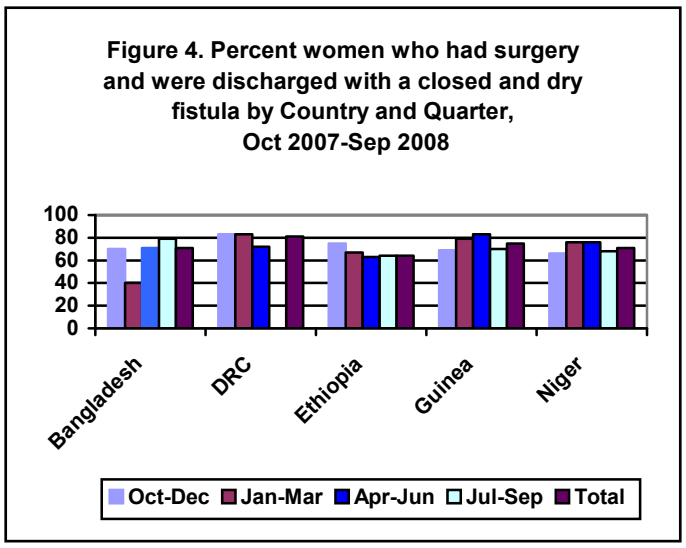
[20] Data for Nigeria is incomplete for July to September 2008 quarter on number of women seeking fistula services and requiring surgery for 2 sites. Therefore the number of repairs done exceeds the number of women seeking services.

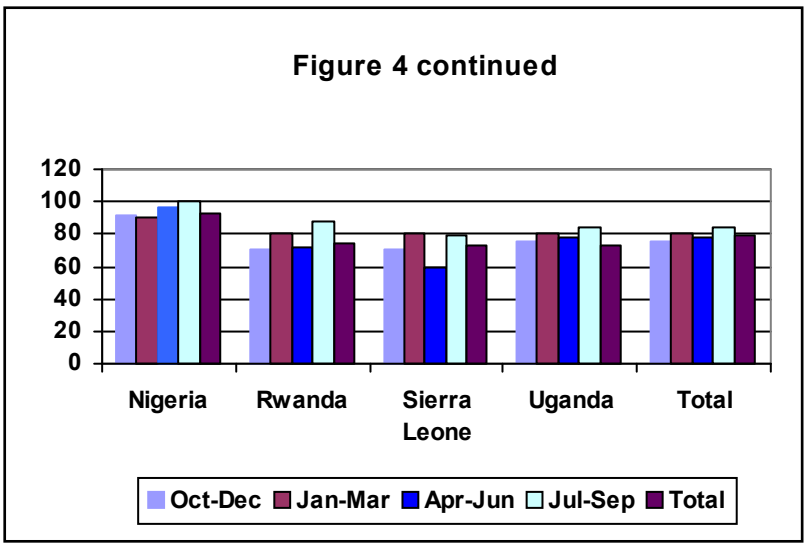
[21] Total number of repairs exceeds the number of women needing repair surgery because data missing for some sites in Nigeria and Ethiopia.

[22] Denominator excludes 278 repairs from Nigeria (no data available for this indicator)

[23] Numbers discharged may not sum to total number women getting repairs since not all women are discharged in the same quarter as the surgery and data missing from 2 sites in Nigeria.

[24] Denominator is number of women discharged.





Increased capacity at Fistula Supported Sites

During this reporting quarter, training for surgeons in fistula repair took place in Guinea, Liberia and Sierra Leone. During this FY a total of **52** new surgeons were trained in fistula repair; **29** surgeons attended follow up training. Other training activities at the country level included FP counseling, fistula counseling, prevention and referral for nurses, emergency obstetric care; see Table 7. See individual country reports for details.

Table 7. Training for fistula care by country: Number of persons trained by topic October 2007 thru September 2008

	Bangladesh	DRC	Ethiopia	Guinea	Liberia	Niger	Nigeria	Rwanda	Sierra Leone	Uganda	Total
First fistula repair & care training for surgeons	1	9	17	3	3	3	10	1	1	4	**52**
Follow up fistula repair & care training for surgeons	0	2	0	9	0	4	6	5	3	0	**29**
Fistula nursing care/pre & post operative care	20	8	0	41	3	12	6	0	0	9	**99**
Infection Prevention	0	0	0	45	0	80	10	0	0	0	**135**
Quality Assurance	0	0	0	0	0	60	0	0	0	0	**60**
Fistula Counseling	45	0	0	0	0	0	18	0	13	0	**76**
FP Counseling	0	0	0	0	0	2	40	0	0	0	**42**
Contraceptive Technology Updates	0	0	0	0	0	0	40	0	0	0	**40**

	Bangladesh	DRC	Ethiopia	Guinea	Liberia	Niger	Nigeria	Rwanda	Sierra Leone	Uganda	Total
Men As Partners	0	0	0	120	0	0	14	0	0	0	**134**
Community Outreach & Advocacy[25]	0	0	4,049	0	0	20	36	0	0	0	**4,105**
Data Management[26]	0	0	0	0	0	0	9	0	0	0	**9**
Other[27]	0	0	38	0	0	4	33	0	0	2	**77**
Total	**66**	**19**	**4,104**	**218**	**6**	**185**	**222**	**6**	**17**	**15**	**4,858**

Fundamentals of Quality Care for Fistula Programs

Described below are activities the global team is undertaking in collaboration with country programs and partners to assure quality in the programs.

Facilitative Supervision and Medical Monitoring Tools to Improve Quality of Fistula Services and Trainee Follow-up

A clinical supervision and monitoring system was rolled out to Fistula Care supported programs during the last quarter of the year. This system will facilitate the standardization of services, not only in clinical services but also in counseling, clinical training, quality improvement approaches and training site follow up. The system is the basis for timely and appropriate clinical and programmatic support of country activities and staff. We expect the system to strengthen the capacity of supported sites to provide quality services for repair and care of women with genital fistula; enhance facility and community knowledge and behavior to support prevention and reintegration; enable sites to sites to gather, analyze, utilize and report data to improve service quality and performance and to ensure a supportive environment. The goals of the clinical supervision and monitoring system are to:

- Assure improved quality and standardization on clinical issues in fistula program activities.
- Identify training/development needs and facilitate development of staff, consultants, country counterparts in clinical areas such as counseling, clinical training and quality improvement.
- Facilitate technical capacity in
  - clinical knowledge and skills
  - monitoring and counseling and trainee follow up
  - assessing the quality of clinical training quality and
  - using quality improvement approaches

A component of the monitoring system examines **Medical Waste Management Systems and Practices** according to WHO and USAID standards. The medical waste component of the supervision tool was field tested in Bangladesh, Guinea, Nigeria, and Rwanda in the last quarter

[25] Includes prevention and referral in Ethiopia
[26] Includes training in research methods for the global study.
[27] Other includes: In Ethiopia and Niger: orientation for medical students; in Nigeria grants management/USG policies; in Uganda anesthetists.

(July-September 2008). The medical waste section is currently being revised to reflect current USAID/W reporting requirements.

A **Protocol for Investigating and Reporting Mortality Related to Fistula Surgery** was introduced this year to all FC supported programs. As part of FC's ongoing efforts for programmatic quality improvement and medical audit, it is necessary to investigate and report on all serious complications, including any deaths, which may be associated with fistula surgery or to related clinical procedures (e.g. colostomy, examination under anesthesia). Analysis of the findings from a strictly confidential medical investigation allows causative and contributory factors to be identified and, potentially, the establishment of systems and interventions to minimize similar occurrences in future. An investigation and report are required for all deaths of clients for EngenderHealth/ Fistula Care-supported programs that occur within *42 days* of the last fistula – related clinical procedure or anesthesia. Following the investigation, the clinical staff help determine whether or not the death was attributable to the procedure. The investigation has several objectives:

1) To determine the cause of death
2) To identify contributing factors
3) To ascertain whether the death was attributable to the procedure or anesthesia
4) To determine whether the death was preventable
5) To design a list of recommendations to prevent occurrence of similar events

Secondarily, the data will also be used to determining case fatality rates in FC supported programs.

Fistula Training Strategy and Fistula Surgeon Knowledge Assessment Tool Developed

The number of physicians with the surgical skill to repair fistula is small. Providing quality training is a key element of increasing access to high quality services for repair and care for women living with obstetric and traumatic gynecologic fistulae. Fistula Care's training strategy is designed to help programs implement a uniform training approach which results in improving the quality of training and subsequent service delivery. The approach to training is a holistic, service-oriented, systems approach that focuses on the fundamentals of care—choice, safety and quality improvement. With this focus, the training is intended to contribute to sustainable improvements in quality, availability, access, and use of fistula services. The FC project faces several training challenges:

- There are many, different clinical types of fistula and the widely divergent degrees of surgical complexity encountered both in repair and in training.
- There is a lack of standardization in training, in curricula and reference materials, in duration of training, models for training, and in classification of fistula.
- There are different approaches and skill sets required for service provision and for training
- Training-site resources, including personnel, general surgical and fistula- specific equipment, expandable supplies and training materials differ among countries and sites.
- There is a dearth of evidence-based clinical and operations research data to help physicians determine the best management regimens.

In order to facilitate training we developed a knowledge assessment tool for surgeons who will attend training at FC supported training facilities. The assessment tool is composed of mostly true/ false questions; a perfect score is : 110/110 points with a standard set at 80%. The assessment tool is designed to assess a trainee's understanding of the definition of fistula, epidemiology and

magnitude of the problem. The tool also assesses knowledge of common presentations and classification, as well as complications, management and interventions for reintegration.

Fistula Care is actively engaged in discussions with the Federation of International Gynecologists/Obstetricians (FIGO), the International Society of Obstetric Fistula Surgeons (ISOFS), the Pan African Urological Surgeons Association (PAUSA), and UNFPA about the development of an international fistula surgical training curriculum. Dr. Ruminjo attended a meeting of ISOFS in Addis Ababa in September 2008 where the FIGO curriculum was discussed. The draft curriculum was distributed following this meeting; Fistula Care was invited to review and comment on the curriculum (comments are due in November 2008). PAUSA is also in the process of developing a training curriculum and Dr. Ruminjo is engaged in discussions with leaders of PAUSA about their curriculum (Dr. Ruminjo attended the PAUSA biennial meeting in Dakar, in October 2008; details about his trip will be included in the next FC quarterly report).

Fistula Care is a partner of the Classification Consortium, an international group (convening members include UNFPA, USAID, Fistula Care Project, Johns Hopkins, WHO) that is exploring how to overcome barriers to implementing quality training and services in the absence of an internationally accepted fistula classification system. A classification system which is simple, well accepted and includes crucial elements of surgery is needed which will inform surgical approach, technique and prognosis. WHO will host a meeting of the Consortium in March 2009 in Geneva to review these issues.

Training curriculum produced to prepare health care personnel to provide pre-intra and post treatment counseling to obstetric fistula clients

The Obstetric Fistula Counseling training curriculum is designed to prepare providers to meet the information and counseling needs of obstetric fistula clients before, during and following treatment, including referral for services and issues which may be outside the scope of providers' responsibilities. The training materials focus on counseling clients with *obstetric fistula* caused by obstructed labor. The Obstetric Fistula Counseling training curriculum has been field tested in Bangladesh, Nigeria, Rwanda and Uganda and will be finalized by the end of 2008. Core components of this curriculum are being translated into French and Kinyarwanda.

Counseling Module for Traumatic Fistula under development.

Fistula Care has engaged the services of Ms. Elizabeth Rowley to prepare a module on counseling women who have experienced traumatic fistula. This module will serve as a companion piece to the Obstetric Fistula Counseling Curriculum (funded by USAID/East Africa). During this period Ms. Rowley met with FC project staff, reviewed and updated a literature review previously prepared by EngenderHealth in 2005, contacted organizations who participated in the 2005 Traumatic Fistula Conference held in Ethiopia, participated in the 2008 Reproductive Health in Emergencies Conference in Uganda, and reviewed existing curricula on counseling for women who have experienced gender-based violence. During the next quarter she will prepare and organize a small consultative meeting with representatives from NGOs who provide counseling care to women with traumatic fistula to outline the key themes and content area of the module, based on the review of the literature and other data collected from key informant interviews. We expect the module to be completed by March 2009.

Nursing Curriculum for pre and post operative fistula care management under development.

With funds from USAID East Africa, the East, Central and Southern Africa Congress of Nurses is developing this curriculum in collaboration with the Fistula Care team. A workshop to develop the curriculum for nurses and midwives was conducted from 22 – 26 September 2008 in Dar es Salaam, Tanzania and attended by 14 participants from Kenya, Uganda, Tanzania and Nigeria. Participants included nursing education and examination officers, representatives of nursing councils, a lecturer from the university school of nursing, a nursing tutor from the Ministry of Health and Social Services, a representative from Women's Dignity Project, a curriculum development specialist, a fistula surgeon and master trainer from the region, and nurses from fistula care health facilities with a wealth of experience in fistula-pre, intra and postoperative care. Staff from EngenderHealth and ECSA facilitated the meeting.

The workshop included review of epidemiology of Fistula in Africa South of Sahara, pathophysiology of fistula, medical/surgical practices in managing patients with fistula and psycho-social aspects of fistula care. A framework for curriculum development (e.g., assessment of training needs, designing and development, implementation and evaluation of the curriculum) was introduced and used to guide the process during the workshop.

The draft curriculum was successfully completed. The curriculum is intended to impart knowledge, attitudes and skills in nursing and midwifery tasks in prevention of fistula, as well as pre, intra, post operative care for women who receive fistula treatment and documentation. The next step will be to develop a facilitator guide and participant handbook including slides followed by conducting a pilot study on the package to complete the process of curriculum development. The curriculum is expected to be completed in the first quarter of calendar year 2009.

Strategic Approach to our work: a Framework for Levels of Care for In Patient Services

In July 2008, FC global staff, along with the Nigeria FC team developed a framework for a network of sites to facilitate prevention, diagnosis, limited treatment and referral, treatment of simple cases, treatment of complex cases and the establishment of a site or sites capable of providing training in fistula. In the coming year, Fistula Care will establish a proof of concept for this framework in three or four countries, starting in Nigeria. At the end of the year, we will assess how this framework is contributing to increased access, with a view to developing a programming guide for fistula management. The following is a description of the three levels of facility-based care that we envisage:

Level 1: Diagnosis, limited treatment and referral[28]

Sites at this level would likely be staffed by surgeons and surgical teams who are at the very beginning of their training in fistula surgery, although it would not be essential for a surgeon to be in training for this level. Over time, as the expertise of surgeons in fistula repair increases, the site would be expected to advance to level 2 and ultimately to level 3. At level 1, the site would be expected to:

- Carry out awareness creation activities for fistula prevention and/or link with community-based organizations to support awareness creation. This may include messages to increase

[28] The components at this level will be partially informed by the documentation of the pre-repair model that is currently being implemented in Ethiopia. Documentation is planned for the first quarter of FY08.

girl's education to the completion of secondary school, delaying early childbearing, FP for delaying, spacing or limiting of pregnancies, men's roles in facilitating women's access to safe delivery, and skilled care for delivery.

- Where services permit, carry out the following additional fistula prevention activities:
    - Provide family planning counseling and methods provision during routine ante-natal care and at discharge or at post-operative follow-up visits for fistula clients
    - ANC – to include health education for timely arrival at delivery facility and for signs of obstructed labor, outreach to families/partners for birth planning, including a transport plan
    - Labor and delivery – to include active and continuous use of the partograph for safe labor and delivery; referral for emergency services not provided at the site; and where provided, management of obstructed labor (including prophylactic catheterization); and safe operative delivery (forceps, vacuum, c/section.)
- Carry out selected rehabilitation/reintegration activities such as fistula counseling and physical therapies
- Have staff with the skills to assess women with a complaint of incontinence; diagnose and classify fistula for appropriate management and referral; and refer to sites capable of providing simple or complex surgeries
- Provide adjunct therapies such as nutrition, physical therapy for foot drop, general hygiene, treatment for dermatitis from urinary leaking, urinary tract infections or anemia, assessment and support for emotional disturbances, e.g. depression
- Offer conservative treatment for selected clients (catheterization for women with urinary leakage post-delivery)
- Provide pre-operative care such as fistula counseling, obtaining informed consent for procedure/surgery, laboratory studies and bowel preparation.
- Routine nursing care would be available twenty-four hours, seven days a week for all in-patient services.

Level 2: Repair of simple fistula cases
Facilities at this level would have staff and surgical teams capable of:

- Providing all of the level 1 activities
- Repairing simple fistula cases, with a surgical team skilled in pre, intra- and post-operative functions to support surgery
- Providing long-term post-operative care, in general approximately of three weeks, including the provision of meals
- Routinely and consistently scheduling simple fistula repairs in the theater and/or during regularly scheduled campaigns.
- Diagnosing, classifying and referring or deferring fistula cases that cannot be repaired at that site

Level 3: Repair of complex fistula cases
Facilities at this would be able to:

- Carry out all the level 1 and 2 functions
- Repair simple and complex fistula cases
- Offer practical experiences in support of training for surgeons and nurses (client volume, trainer on site, etc.)

- Offer individuals who could serve as preceptors or coaches on-site to expand support for surgeons and nurses training.

RESULT 2: Enhance community and facility understanding and practices to prevent fistula, utilize and deliver services for emergency obstetric care, and support women's reintegration

At the global level the FC team focused on developing and identifying appropriate prevention strategies which country programs can implement over the course of the project. During work plan development meetings country program managers identified appropriate interventions for inclusion in the FY 08-09 work plans. The goal is to focus attention on specific activities that could reasonably be expected to result in a reduction of fistulae, as well as other maternal morbidities and mortality. It was determined the interventions most likely to achieve this goal were:

- Integrating FP services to address early births and to assist women to achieve a successful pregnancy after surgery;
- Promoting consistent and complete use of the partograph to enable appropriate referral if a delivery becomes complicated;
- Immediate catheterization for women who experience obstructed labor to both prevent fistula and too treat small fistulae;
- Strengthening c-section services.

During this FY several country programs implemented prevention activities, e.g., expanded access to family planning services in Nigeria, partnered with community groups to raise awareness about fistula prevention (Bangladesh, Guinea, Ethiopia, Niger, Nigeria, and Sierra Leone).

In July 2008, with technical assistance from Ms. Betty Farrell, Senior Medical Associate with the ACQUIRE Project, Fistula Care convened a two day *Family Planning Integration with Fistula Care Stakeholders' meeting* in Kaduna, Nigeria. Using a successful family integration model for HIV services, developed under the ACQUIRE project, Ms. Farrell worked with the FC team to adapt this model for use in fistula programs. With participation from a broad range of stakeholders from the Senate, National Assembly, State legislators, Ministry of Health (Federal and State) and Ministry of Women and Children Affairs, to Fistula Care surgeons, In-charges of Obstetric Fistula units, family planning providers, community-based organization representatives, and representatives from Implementing Partner (IP) robust discussions followed the presentations about the model. At the conclusion of the meeting group members identified what they felt they would do to facilitate FP integration with FC. Selected activities and commitments were identified for inclusion in the FC/Nigeria work plan. The FC global team will work with the Nigeria team to monitor the progress of this model and will conduct similar workshops in other countries in FY 08-09 to engage stakeholders in the dialogue about integration of FP.

RESULT 3: Gather, analyze, utilize and report data to improve the quality and performance of fistula services

Ground breaking multi-country study on the determinants of post-operative outcomes in fistula repair surgery launched.

There is a lack of detailed information on the social causes of fistula and a severe gap in the evidence around the factors and pre- and post-operative techniques that influence the success of fistula repair. To answer some of the most pressing clinical research questions and to inform future interventions and further research, in consultation with USAID/W, ACQUIRE developed the first ever **prospective facility-based study** on the *Determinants of post-operative outcomes in fistula repair surgery*. This study, started under the ACQUIRE project will be completed under the Fistula Care project and will be carried out in 13 sites in six countries: Bangladesh, Guinea, Niger, Nigeria, Rwanda and Uganda. An estimated 1,436 women will be recruited into the study. The primary objective of the study is to determine predictors of complications and success of fistula repair surgery. The study will consider circumstances surrounding development of the fistula (including obstetric history), anatomical and clinical characteristics of the fistula, and pre-, intra- and post-operative techniques used. A secondary objective is to examine socio-structural factors associated with fistula. The study will gather socio-demographic and other background information, details of the circumstances surrounding development of the fistula and explore issues around availability of and access to obstetric services, thus helping us to identify some of the socio-structural factors associated with development of fistula.

A total of 11 of the 13 planned sites for the study began data collection activities during the year (4 sites began recruitment in the July-September 2008 period): 3 in Bangladesh, 2 in Guinea, 3 in Nigeria, 1 in Rwanda, and 2 in Uganda. By the end of September 2008 a total of 399 participants had been enrolled, 372 have had fistula repair surgery and 166 had returned for their three month post-surgery follow-up visit and therefore completed the study. Overall this represents 26% of the total recruitment in terms of surgeries completed relative to the number needed for the study sample size (372 surgeries completed/1436 total sample size). See Table 8 for recruitment details by quarter and study site.

In September, Fistula Care/NY program associate Vera Frajzyngier went to Rwanda to conduct refresher training as well as train the new staff at CHUK who will participate in the study. Recruitment of study participants began while she was at the site. All of the forms for the Niger study sites have been printed and the participant folders prepared. The forms will be shipped to Niger in October and Ms. Frajzyngier is scheduled to go there in early November to conduct refresher training at Lamordé and also to train staff at Maradi (as mentioned in the last quarterly report, we have decided to replace Dosso Hospital with Maradi Hospital given a steadier case-load at the latter site). Both of the sites in Niger are scheduled to begin recruitment while Ms. Frajzyngier is there so that she can provide guidance and review completed study report forms from the first participants recruited. We are in the process of collaborating with REF to identify a monitoring, evaluation, and research assistant in Niger who can function as the study monitor for the sites under the supervision of the REF coordinator Mariama Moussa , as well as assist her in the routine data collection and reporting.

Table 8. Fistula Research Recruitment by Country, Site, October 2007-September 2008

Country	Site	October - December 2007			January – March 2008			April - June 2008			July – September 2008			Percent of total recruitment to date (# surgeries/ sample size at site)
		# enrolled	# having surgery	# completing follow-up	# enrolled	# having surgery	# completing follow-up	# enrolled	# having surgery	# completing follow-up	# enrolled	# having surgery	# completing follow-up	
Bangladesh	Kumudini Hospital	N/E	N/E	N/E	9	9	0	8	8	0	18	18	2	35/40 = 88%
	LAMB Hospital	N/E	N/E	N/E	N/E	N/E	N/E	17	12	1	10	13	18	25/40 = 63%
	Memorial Christian Hospital	N/E	N/E	N/E	N/E	N/E	N/E	2	2	0	3	3	2	5/40 = 13%
Guinea	Ignace Deen Hospital	N/E	N/E	N/E	6	6	0	12	12	0	16	16	0	34/96 = 35%
	Kissidougou Hospital	N/E	N/E	N/E	29	29	6	22	22	15	16	16	17	67/194 = 35%
Niger	Hôpital Lamorde	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	0/107= 0%
	Maradi	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	0/71= 0%
Nigeria	Mariamma Abacha Hospital	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	10	10	0	10/80 = 13%
	Faridat Yakubu Hospital	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	11	11	0	11/214 = 5%
	Specialist Fistula Center Birnin Kebbi	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	10	9	0	9/125 = 7%
Rwanda	CHUK, Kigali	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E	2	0	0	0/116= 0%
Uganda	Kagando Hospital	N/E	N/E	N/E	40	26	0	34	30	30	18	18	12	74/139 = 53%
	Kitovu Mission Hospital	22	17	0	43	42	1	21	14	44	22	29	18	102/174 = 59%
Totals		**22**	**17**	**0**	**127**	**112**	**7**	**116**	**100**	**90**	**134**	**143**	**69**	**372/1436 = 26%**

N/E – not enrolling participants yet

Staff of Kagando Hospital in Uganda have agreed to recruit an additional 22 women into the study for a total recruitment of 139 (an earlier reallocation of numbers at the Nigeria sites left us 22 woman short for our sample size and we were waiting to see how the various study sites progressed to determine which site to ask to recruit the remaining 22 woman). In Bangladesh, unfortunately, Memorial Christian Hospital will no longer have a fistula program because of staffing changes, although they have agreed to continue the follow-up for the participants who were already recruited. We will distribute the remaining 35 women that MCH was to recruit among the two study sites in Bangladesh, probably allocating more to LAMB because their follow-up appears to be better.

Research Agenda for Improving Fistula Surgical Services under development

While the results of the global prospective study will help identify potential new areas of research, the results will not be available until late 2009. In the mean time FC, in consultation with USAID/W and partners has identified three subject areas that may be appropriate for randomize controlled trials (RCT):

- The use of prophylactic antibiotics, to include types of antibiotics available, how they are used, optimal regimen before, during and after surgery etc. As a subsection of this study, in sites where c-sections are conducted we will explore similar information. (We will discuss with other colleagues what information they may have on this particular topic.)
- The role of catheterization in management of fistula. This will include open versus closed drainage, bed rest versus ambulatory management, catheterization for prophylaxis, sole treatment or as adjunct treatment, and the cost implications.
- Stress incontinence after fistula repair and its management. The global study will provide information on the incidence of stress incontinence and some information about predictors, but will not include information on management.

Before embarking on the development of study protocols for RCTs on any of these three issues USAID/W and FC decided it would be best to conduct descriptive qualitative reviews (interviews with key informants) about these issues in order to learn about current practices. Dr. Steve Arrowsmith is assisting the FC to conduct these reviews (design of study protocols and analysis of findings). We expect to have these results by early 2009. During the conduct of these qualitative reviews we will also use the opportunity to ask surgeons and nurses about other issues which they feel are important to research which would have an impact on outcome of surgery/care for women with fistula. Once the study findings are completed we will meet with USAID/W to determine which topics we should proceed with a RCT and convene a consultative review meeting to discuss study protocols etc. with other key international stakeholders such as WHO, UNFPA, JHU, etc. We will also work with USAID/W to identify potential non FC supported sites for a RCT and to identify an organization with the expertise to carry out RCT studies. We expect to launch at least one RCT by September 2009.

Monitoring and Evaluation tools for fistula supported services developed

Reporting forms for clinical indicators, training, community outreach and family planning services were created and revised twice during the first year of the project. The field of monitoring and evaluation of the clinical aspects of fistula services is new and the process for identifying the most appropriate indicators for routine monitoring and reporting continues to evolve. Fistula Care staff are working with the International Obstetric Fistula Working Group on development of fistula indicators (see Result 4 for more information). The quarterly clinical monitoring/reporting tool underwent a

final revision in August following review at the partners meeting in Accra. The quarterly reports have now been translated into French to assist with better reporting from the Francophone countries.

An on-line data base (with data entry via the EngenderHealth Intranet) was created for the clinical indicators, community events and family planning services. Field staff are now able to enter the data directly into the on-line database. Fistula Care partners will have access to the database via the FC web site in 2009. Fistula Care is working with EngenderHealth's corporate M&E team to develop an agency-wide training database.

Procedures and tools for conducting site assessments were revised and updated in September 2008. The Fistula Care Site Assessment tool was expanded to include a review of key prevention services: maternity care, family planning and linkages with communities. This tool will be used for all future needs assessments.

RESULT 4: Strengthen a supportive environment to institutionalize fistula prevention, repair and reintegration programs

Strengthening the Environment

USAID supported 70 fistula providers from 16 countries to meet to discuss their needs, challenges, remaining gaps and successes in fistula repair and care

With support from USAID, the AWARE-RH, ACQUIRE and Fistula Care projects, a Fistula Partner's Meeting was held in Accra, Ghana from April 15-17, 2008. The purpose was to advance the state of the art on fistula prevention and care. The meeting facilitated the exchange of successes and challenges experienced, allowing providers, program staff and partners to share nascent or successful programming models and to engage in smaller working group discussions to give guidance on strategies to improve the quality of care, program indicators, research priorities and advocacy needs to support the sustainability of services. The meeting brought together more than 70 individuals from 16 countries, primarily from the West African region, to provide an opportunity for south-to-south exchange and reflection on the milestones achieved and the direction of fistula care and prevention. Meeting participants contributed to defining essential elements for a quality of care fistula strategy, discussed training needs, assisted in defining, refining program monitoring indicators, and identified key actions which would contribute to a strengthened environment to support fistula prevention, repair and re integration.

Fistula Care Supports national committees meet to discuss obstetric fistula

Fistula Care programs in Bangladesh, Guinea, Nigeria and Uganda worked this year to either establish or revive national committees to work on fistula.

- **Bangladesh**, as well as many other countries, is challenged by a lack of coordination among the donors and public and private sector implementing agencies as well as the absence of a national strategic vision regarding this maternal health problem. During the last year the Bangladesh team, in collaboration with local government policymakers, UNFPA and other stakeholders advocated with the Directorate General of Health Services of the Government of Bangladesh to form the National Task Force on Obstetric Fistula to provide guidance in the development of a national strategic vision and a national action plan for prevention, treatment and rehabilitation of obstetric fistula cases, within the framework of the National

Maternal Health Strategy. The Task Force was formed in August 2008. The task force will facilitate effective coordination between the different stakeholders.

- In **Guinea,** the EngenderHealth/FC team, in collaboration with the Ministry of Health initiated the creation of a national league to halt fistula. The terms of reference for this league is under review by the Ministries of Health and Social Affairs. The FC/Guinea team is advocating for the designation of a national fistula day and re in the process of discussing this idea with the National Assembly Health Committee.

- In **Nigeria,** the Fistula Care project staff, partnered with Federal Ministry of Health (FMOH) to convene a stakeholder's meeting of the reconstituted National VVF Task Force. At this meeting FC Project staff advocated for the establishment of state taskforces which would feed upward to federal level. One outcome of the meeting was agreement among the major partners – UNFPA, Fistula Care Project, and Federal MOH –will each support one out of four annual meetings of the taskforce as a way of keeping issues of VVF in the forefront. As a follow up to this meeting , FC project staff visited the Chairman of the Senate Health Committee and made a presentation on the idea of establishing a National Fistula Day in March. The senate is open to considering the suggestion.

  The project, in partnership with Institute of Development Administration of Nigeria, FMOH, UNFPA and Rotary International, organized a National Seminar to highlight the impact of Fistula on National Development. The two day seminar drew participation from a diverse range of people and groups from all over the country. Four state First Ladies, four Senators and several academics were on hand to either present papers or deliver goodwill messages. The seminar was chaired by the Chairman of the Senate Committee on Health and she delivered the keynote address. At the end of the Seminar, participants resolved to form a group to advocate on behalf or the fistula clients. They also requested that the National VVF Task Force prepare a presentation for the legislature on the challenges of fistula in Nigeria and request that a day in March be set aside as Nigeria Fistula day…

- In **Uganda,** the Ministry of Health spearheaded the formation of a Fistula Technical Working Group whose mission was to coordinate fistula activities across partner groups, oversee surgical repairs and the training of providers (including doctors, nurses, and other cadres), advocate for fistula services, formulate fistula policy, provide strategic direction to fistula activities in Uganda including prevention, and monitor fistula activities across the country. In 2006, funding for these meetings had dwindled and this important regulatory and coordinating body had become defunct. Since October 2007, Fistula Care is supporting the meetings of this technical working group. The Technical working group meets biannually to discuss pressing issues in fistula care, including coordination of training activities for local surgeons so that motivated providers receive training. At the meetings, work plans and budgets are shared so that resources can be maximized and synergies can be developed. The Technical Working group is also working to coordinate the collection and reporting of fistula service statistics to better capture the magnitude of the problem in Uganda.

Collaboration

International Obstetric Fistula Working Group (IOFWG). UNFPA serves as the secretariat of the IOFWG. The IOFWG is comprised of four committees: 1) Partnerships and Advocacy; 2) Data, Indicators and Research; 3) Treatment and Training; and 4) Reintegration. Fistula Care senior staff actively participated in several meetings of the IOFWG throughout the year, including the annual meeting which was held in Accra Ghana, April 12-14, 2008 (which Fistula Care co sponsored). The FC team is actively engaged in the discussions for the development of a handbook of program evaluation indicators.

UNFPA/Johns Hopkins University/WHO Study. The Fistula Care team continues to coordinate with the UNFPA/Johns Hopkins University/WHO study on fistula. The study, entitled *Prognosis, Improvements in Quality of Life (QOL) and Social Integration of Women with Obstetric Fistula after Surgical Treatments: A Collaborative JHU/UNFPA/WHO Study,* will be done in collaboration with medical institutions in seven high fistula prevalent countries. The study will examine post-operative prognosis, improvement in quality of life, social integration, and rehabilitation of fistula patients after surgical treatments. The study data will be further utilized for developing a standardized classification system that allows for the predictability of prognosis. Dr. Mark Barone from EngenderHealth, and a principal investigator for the USAID funded global prospective study, participated in a two-day expert panel review of the proposed study along with other international stakeholders in April 2008. Fistula Care will continue to engage in dialogue with this group's study and how the data from the USAID funded global prospective study (see above under Result 3) can contributed to a larger body of data which may lead to the development of a classification system for fistula.

Dissemination

The **Fistula Care brochure** has been developed, designed, and reproduced. The brochure introduces the problem of fistula and describes Fistula Care's comprehensive approach. The content of the brochure was honed through discussions with USAID about how best to describe the project to the intended audience. The brochure is the first publication to showcase the look of Fistula Care materials. It promises to be a useful communications tool for people interested in understanding Fistula Care's work.

The **Fistula Care website** is under development. The website architecture has been established, with sections that introduce fistula, descriptions of supported sites, posting of publications with download links. Part of the architecture will include a link for Fistula Care partners to the on line database of fistula indicators. The visual appearance of the website's pages has been created using the same design of the project brochure. We expect the web site to be completed by the end of 2008 at which time we will seek USAID/W approval before it 'goes live'.

USAID supported work in Fistula highlighted in publications and at international conferences

A total of two articles and eight presentations at international conferences on fistula and USAIID supported Fistula Care work were written/presented in the last year.

Published Papers:

Ruminjo. J. 2007. Obstetric fistula and the challenge to maternal health care systems. *IPPF Medical Bulletin* **:** (Vol. 41, Number 4)

Longombe, A. O.; Claude, K.M. and Ruminjo, J. 2008. Fistula and Traumatic Genital Injury from Sexual Violence in a Conflict Setting in Eastern Congo: Case Studies, *Reproductive Health Matters* (2008;16(31):132–141).

Presentations:

Global Health Mini University, Washington, DC, October 2007. Senior program associate Katie Tell presented on USAID's work to address fistula which included the Uganda digital stories.

Women Delivery Conference, London, October 2007. EngenderHealth staff from NY and from Uganda and Nigeria attended the Women Deliver Conference in October 2007 in London. Presentations were made about the work at Gusau General Hospital in Zamfara State in Nigeria and the Uganda Digital stories:

- "Community, NGO and Government collaboration on Fistula: The Zamfara experience" presented by Dr. Sa'ad Idris (surgeon at Faridat Yakubu General Hospital in Gusau) and Dr. Adamu Isah (EngenderHealth medical associate).
- "Digital stories: the Uganda experience" presented by Dr. Henry Kakande (EngenderHealth)

French College of Ob/Gyns Annual Meeting, Paris, France, December 20007. Professor Namory Keita from the Guinea program presented a paper entitled "Fistula care: The Guinea experience".

Reproductive Health in Emergencies Conference, June 2008 in Kampala, Uganda. Fistula Care supported presentation of 4 papers:

- Traumatic Gynecologic Fistula in Reproductive Health Emergencies by I. Achwal, J. Ruminjo, C. Ngongo [global]
- Voices from the field: Community research on the experiences of survivors and perpetrators of sexual violence by H. Akullu [Uganda]
- La prise en charge des fistules génitales de la femme en RDC: Contexte, ampleur et perspectives by M.A. Kalume, L. Ahuka [DR Congo]
- Psychosocial effects of sexual violence in conflict situations by M. Mungherera [Uganda]

DVD Produced: Experiences of fistula clients used in training for fistula programs

In August 2007, the ACQUIRE Fistula Project collaborated with the Center for Digital Storytelling (CDS) to produce a series of 11 **digital stories** documenting the experiences of fistula clients in Uganda from the perspective of fistula surgeons, nurses, ACQUIRE fistula staff and the women themselves. These stories were collected using interviews and a story telling workshop with 11 fistula clients. The DVD--"Learning From My Story: Women Confront Fistula in Rural Uganda" has been nationally disseminated in Uganda and is now being used in training for surgeons and other health staff in four Fistula Care supported sites. In addition the DVD has been or will be used in the following ways:

- As a prelude to an East African regional nursing curriculum development workshop

- As a prevention and recruitment tool with the community in one program area in Uganda (Kasese) during health talks and played in clinic waiting rooms.
- The Uganda Ministry of Health is disseminating copies of the DVD to MOH facilities.
- The entire DVD is posted on YouTube.com. As of October 26, 2008 various segments of the DVD have been viewed by more than 4,000 persons (each of the 11 women's stories are posted as well as the segments with the providers; one woman's story (Federisi) was posted on the YouTube main page during a special event marking the Millennium Development Goals.
- In FY 08-09 the Fistula Care project will prepare a facilitators guide to accompany the DVD in training.
- The stories will be shown at film festival at the 2008 American Public Health Association meeting in November.
- Family Care International (FCI) and the United Nations Population Fund (UNFPA) have collaborated to create an advocacy publication and CD-ROM toolkit – *Living Testimony: Obstetric Fistula and Inequities in Maternal Health*. The Digital Stories DVD will part of this tool kit. This tool kit will provide guidance and tools to conduct advocacy to promote improved maternal health and highlight how perceptions, knowledge, and attitudes related to pregnancy and delivery affect maternal mortality and morbidity, including obstetric fistula.