

**FISTULA CARE
Associate Cooperative Agreement
GHS-A-00-07-00021-00**



**Annual Report
October 2009 to September 2010**

Submitted to
United States Agency for International Development
Washington, DC

November 18, 2010



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This publication is made possible by the generous support of the American people through the Office of Maternal and Child Health, U.S. Agency for International Development (USAID), under the terms of associate cooperative agreement GHS-A-00-07-00021-00. The contents are the responsibility of the Fistula Care project and do not necessarily reflect the views of USAID or the United States Government.

Printed in the United States of America. Printed on recycled paper.

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ACRONYMS AND ABBREVIATIONS

AAFH	Addis Ababa Fistula Hospital
AMREF	African Medical and Research Foundation
AMTSL	Active Management of the Third Stage of Labor
ANC	Ante Natal Care
AWC	Aberdeen Women’s Centre
BCC	Behavior Change Communication
CAT	Community Action Team
CBO	Community-Based Organization
CSO	Civil Society Organization
CHUK	Central University Hospital of Kigali
COPE®	Client-Oriented, Provider Efficient Services
DHS	Demographic Health Survey
DRC	Democratic Republic of the Congo
ECSA	East, Central and Southern African Health Community
ECSACON	East, Central and Southern African College of Nursing
ESD	Extending Service Delivery
FC	Fistula Care
FMOH	Federal Ministry of Health
FP	Family Planning
FRS	Fistula Repair Surgery
GFMER	Geneva Foundation for Medical Education and Research
HC	Health Center
HEAL	Health, Education, Community Action, Leadership Development
IEC	Information, Education, Communication
IP	Infection Prevention
MAP	Men As Partners®
MCH	Maternal & Child Health
MCCI	Maternal and Child Care Initiative
MDM	Medecine du Monde
M&E	Monitoring and Evaluation
MIS	Management Information System
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières
NGO	Nongovernmental Organization
OAA	Office of Assistance and Acquisitions
Ob/Gyn	Obstetrics/Gynecology
OC	Obstetric Care
OFWG	Obstetric Fistula Working Group
OJT	On-the-Job Training
PMP	Program Monitoring Plan
QI	Quality Improvement

RCQHC	Regional Centre for Quality of Health Care
RCT	Randomized Controlled Clinical Trial
REF	Network for the Eradication of Fistula
RH	Reproductive Health
RLAC	Religious Leader Advocacy Champion
RVF	Recto-vaginal Fistula
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
USG	United States Government
VVF	Vesico-vaginal Fistula
WHO	World Health Organization

Executive Summary

This annual report presents key accomplishments and activities for the third year (October 2009-September 2010) for the Fistula Care Project. The Project is managed by EngenderHealth in collaboration with international and national partners. In FY 09/10 USAID support for fistula repair was provided in 12 countries—Bangladesh, Benin, DR Congo, Ethiopia, Guinea, Mali, Niger, Nigeria, Rwanda, Sierra Leone, Togo, and Uganda. Key accomplishments under each of the four project results included:

Result 1: Strengthened capacity

- 32 facilities supported for repair and 45 prevention only sites in 12 countries
- 4,972 repairs performed
- 63 surgeons trained in fistula repair to varying levels of competency
- 241 providers trained in fistula care management and counseling
- 320 providers trained in quality assurance
- Collaboration with FIGO on finalization of international fistula surgeon curricula
- Screening for fistula job aides produced for providers
- Provider brochure on informed consent for fistula services was developed

Result 2: Enhanced community and facility practices to prevent fistula

- 286 providers trained in family planning
- 525 providers trained in obstetrics care
- More than one million persons reached through community mobilization efforts with key messages about fistula treatment and prevention.
- Partograph monitoring tool piloted tested
- Job aids for providers and patient FP materials finalized

Result 3: Use of data for decision making

- Uganda retrospective cesarean record review study completed
- Partograph literature review completed
- Data collection for prospective observational study on determinants of fistula completed
- Collaboration began with WHO on randomized controlled clinical trial study

Result 4: Strengthening the environment for fistula

- 7 country programs participate in national, regional and international fora on a range of policy issues
- 20 presentations made at 8 international conferences about Fistula Care supported programs and research

Key Accomplishments with Support from USAID

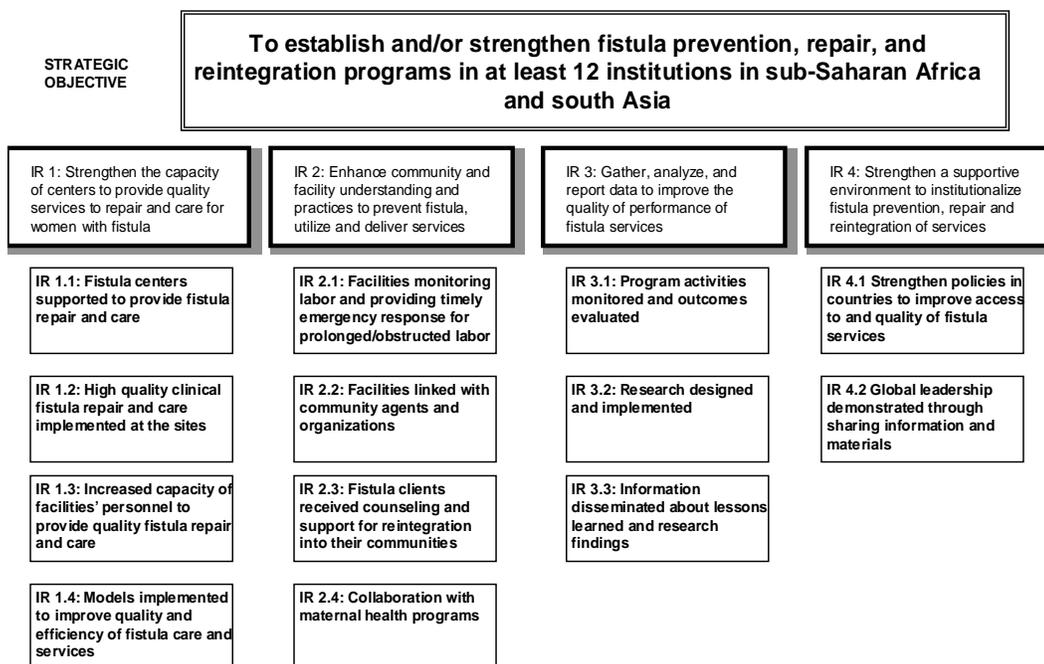
- 17,780 repairs performed at supported sites in 14 countries in Sub Sahara Africa and South Asia between January 2005 and September 2010
- Since October 2005 the following training has been accomplished (no. persons trained):
 - Fistula repair surgery: 279
 - Pre & post operative care and fistula counseling: 954
 - Family planning services: 484
 - Obstetric care: 840
- First prospective research study on the determinants of fistula outcomes undertaken
- More than two million persons reached with messages about fistula treatment and prevention

I. INTRODUCTION

This annual report represents a summary of accomplishments for the third year (October 1, 2009-September 30, 2010) of the Fistula Care Project, a five-year Associate Cooperative Agreement (No. GHS-A-00-07-00021-00) supported by USAID. In this report we present trends on selected indicators for the last three years as well as special reviews of additional surgeries performed in support of fistula repair and surgeon trainee follow up (see Result 1). The annual report is organized into four sections: Performance Data, Global Accomplishments by Results, Country Reports, and Management.

USAID support to EngenderHealth for fistula services began in 2004 under the ACQUIRE Project, 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 (FC) 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



In FY 09/10 the project was implemented with a variety of partners in 12 countries: the public sector in Ethiopia, Guinea, Mali, Niger, Nigeria, Rwanda; private and mission hospitals in Bangladesh, Benin, the DR Congo, Ethiopia, Sierra Leone, Togo, and Uganda; and via national and international NGO partners (IntraHealth International, the Gloag Foundation and Mercy Ships). See Annex 1 for a full listing of all supported sites by country.

During FY 09/10 USAID supported fistula treatment and prevention activities in **77 sites** in **12 countries**; see Table 1. These sites include those supported directly by the Fistula Care Project as well as those supported through other USAID funding mechanisms at the country level. During this FY, the *Africa Mercy* hospital ship was docked in Benin and Togo. Fistula Care supported training for both entry and advance level surgeons on the ship.¹

Table 1. Number of Countries Supported by USAID for Fistula Repairs and Prevention by Status, October 1, 2009 thru September 30,2010

Country	Active in FY 09/10	Number of Sites in Active Countries			Number Programs Completed
		Repair ² Sites	Prevention only Sites	Total Sites	
Bangladesh	X	4	0	4	
Dem. Republic Congo *	X	3	0	3	
Ethiopia**	X	3	4	7	
Guinea	X	4	5	9	
Mali	X	1	4	5	
Niger ³	X	4	1	5	
Nigeria	X	6	22	28	
Rwanda	X	3	0	3	
Sierra Leone	X	1	0	1	
Uganda	X	2	9	11	
Africa Mercy (Hospital Ship)***					
Benin	X	1	NS	1	
Ghana		NS	NS	NS	X
Liberia		NS	NS	NS	X
Togo	X	1	NS	1	
Total	12	32	45	77	2

*USAID/DR Congo funds Project AXxes to support repairs with visiting surgeons at 5 sites; since capacity does not exist at these 5 sites for fistula surgery we are counting the support by this project as one site. . FC supports 2 additional repair sites.

**USAID/Ethiopia directly supports repairs at three sites through Addis Ababa Fistula Hospital (AAFH).

***Fistula repair activities were carried out in these countries aboard the Mercy Ships hospital ships *Anastasis* (Ghana) and *Africa Mercy* (Liberia, Benin, Togo). FC support to Mercy Ships ended in August 2010. The ship was docked in Benin and Togo in calendar years 2009 and 2010, respectively. The Africa Mercy is only counted once as a supported site.

NS: not supported by USAID funds

¹ While the ship was in Benin and Togo, FC supported training of six surgeons from five countries (Benin, Nigeria and Rwanda, Sierra Leone and Uganda) with field support funds from the trainee home country (including Benin). The training costs included the costs for fistula surgery.

² All but 8 fistula repair sites include 1 or more prevention intervention such as FP counseling and/or methods, and/or obstetric care services (either basic emergency obstetrics care or comprehensive) or community outreach about prevention and treatment.

³ A fourth repair site in Niger was added in the fourth quarter following a site assessment.

II. Fistula Care Annual Performance

The Fistula Care Performance Management Plan (PMP) was developed in the first year of the project and includes a total of 15 core indicators organized by the four project results. Table 2 below shows the Fistula Care accomplishments for each project year compared to the proposed benchmarks and includes proposed benchmarks for FY 10/11.

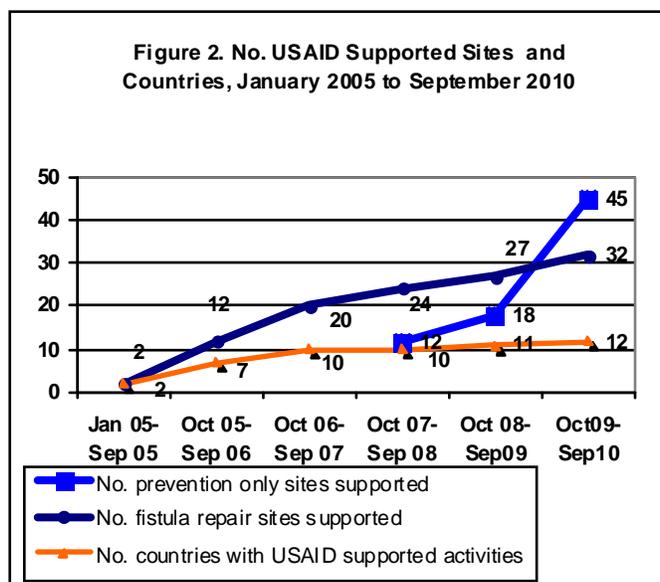
During FY 09/10 we modified how we report on the number of repairs performed at USAID supported sites. The indicator is number of women repaired. While this is an accurate description of services provided during a confined reporting period (e.g., on quarter), when the data are aggregated across quarters there may be double counting: some women will require an additional surgery in order for the fistula to be closed and/or to achieve continence. We have therefore modified our language in reporting on repairs to state the number of repairs performed instead of the number of women receiving fistula repair services.

Table 2 is a summary of planned and actual benchmarks for all indicators for each FY. During FY 09/10, we met our planned benchmarks for 8 of the 15 indicators; we did not meet benchmarks for four indicators and three indicators do not have annual benchmarks⁴. Below is a brief discussion of the project’s overall accomplishments against these planned benchmarks, highlighting factors contributing to success and challenges. Further details about these indicators are described in the Global Accomplishments section of the report. Annex 2 includes a full description of each indicator (definition, source, unit of measure) as well as annual performance summaries for each project year. .

Result I: Strengthened capacity

Five indicators relate to strengthening capacity, including two at the strategic objective (SO) level.

Supported Sites (SO). The planned benchmark for all supported sites—repair and prevention only—was 70; by September 30, 2010 a total of 77 sites were supported through all USAID funding mechanisms (72 in Fistula Care supported programs and five sites through USAID bilateral projects in DR Congo (Project AXxes, one site) and Ethiopia (Addis Ababa Fistula Hospital, four sites); see Figure 2. We had intended to increase the number of repair sites from 27 in FY 08/09 to 32 in FY 09/10 (this increase included 2 USAID/Ethiopia sites) In FY 09/10 32 repair sites were supported by USAID funding, 28 in the Fistula Care supported programs and 4 in the bilateral



⁴ Indicators 9 (number of births); 10 (percent of births which are cesarean); 11 (percent of cesareans performed for obstructed/prolonged labor).

projects. In FY 09/10 two additional repair sites in Bangladesh and one site in Niger were added to the FC portfolio; USAID/Ethiopia also provided support for a third site and one site from the USAID/DR Congo is included in the total.

Our planned expansion to additional repair sites in Nigeria, Rwanda and Uganda did not occur. In Nigeria the project intended to expand to Bauchi State, at the request of the USAID Mission. Bauchi State is where the T-Ship bilateral is working (also in Sokoto State.) Negotiations have been ongoing with the State Government for more than a year to identify both a site and resources to support the implementation of fistula activities. Site assessments to identify additional repair and prevention sites in Rwanda were conducted in 2008 and 2010. Three prevention sites and two additional repair sites were identified from these assessments, however the project has been in negotiation with the MOH and the USAID mission to determine which sites would be supported by Fistula Care. It has now been resolved that Fistula Care will support a total of 4 treatment sites and 3 prevention sites in the next fiscal year. Planned expansion in Uganda to one additional site will take place in next fiscal year. It was delayed due to negotiations with the MOH for site selection. The assessment has been completed and the recommendations are being discussed.

We planned for expansion of prevention only sites (i.e., for family planning and/or obstetric care (OC)), from 18 in FY 08/09 to 38 in FY 09/10. At the end of September 2010 Fistula Care was supporting a total of 45 prevention only sites. This expansion occurred in Mali (4 sites); Nigeria (12 new sites⁵), and Uganda (9 sites) and includes one site in Ethiopia supported by the bilateral project.

In FY 10/11 we plan to expand from a total of 72 FC supported sites to 85 sites. We have not included in this planned benchmark the sites supported by USAID bilateral agreements in DR Congo and Ethiopia; at the time of the writing of this report we had no information about USAID plans for support in FY 10/11. The planned expansion through Fistula Care includes five repair sites in DR Congo, one prevention site in Ethiopia (pre repair center), one prevention site in Niger, up to two repair sites in Nigeria, three prevention and one repair site in Rwanda, and one repair site in Uganda. Site assessments were carried out in these six countries in FY 09/10 for this expansion.

⁵ The USAID Mission has just requested the Fistula Care project to consider limiting its prevention activities to those sites where treatment is provided, with the explanation that it has other partners working on prevention. This may result in a drop in the number of prevention only sites reported next year.

Table 2: Fistula Care Achievements and Benchmarks by FY

	Base-line 06/07 ⁶	FY 07/08	FY 07/08	FY 08/09	FY 08/09	FY 09/10	FY 09/10	FY 10/11
	Actual	Planned	Actual	Planned	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. Total # of sites supported ⁷	23	37	37	68	45	70	77	85
• Fistula Repair Sites	23	25	24	33	27	32	32	35
Fistula repair only	n/a	9	10	12	7	8	9	5
Fistula repair and FP	n/a	16	14	2	2	4	1	2
Fistula repair & OC	n/a	n/a	n/a	2	2	3	2	3
Fistula repair , OC, FP	n/a	n/a	n/a	17	16	17	20	20
• Non Repair Sites	n/a	12	12	35	18	38	45	50
FP only	n/a	12	12	3	12	16	22	22
OC only	n/a	n/a	n/a	18	0	7	4	4
OC & FP	n/a	n/a	n/a	13	5	14	18	24
Community outreach for prevention ⁸	n/a	n/a	1	1	1	1	1	0
2. # fistula repair surgeries at USAID supported site	3,437⁹	3,882	4,107¹⁰	5,075	4,183¹¹	4,250	4,972¹²	4,500¹³
IR 1. Strengthen 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	98%	75%	83%	75%	74%	75%	73%	75%
4. % of women who had fistula surgery who experienced complications	9%	≤20%	5%	<20%	3%	<20%	3%	<20%

⁶ Baseline year of FY 06-07 was funded by the ACQUIRE Project. ACQUIRE funds continued to be used in selected countries in the first year of the project (Oct 07-Sept 08).

⁷ Total number of sites supported includes sites supported through other USAID bilateral arrangements in DR Congo (n=5) and Ethiopia (2 each year except in FY 09/10 when three sites were supported).

⁸ Yirgam Center in SNNP in Ethiopia. Supported by USAID/Ethiopia funds.

⁹ Updated based on revised data from USAID/Ethiopia support to AAFH for Bahir Dar Fistula Hospital (total number of repairs were 470, representing 14% of all repairs supported with USAID funds in FY 06/07).

¹⁰ Updated with revised data from Ethiopia for Bahir Dar and Mekelle Hospitals and DR Congo Project AXxes; total number of repairs supported by these projects were 1,291, representing 31% of all repairs in FY 07/08.

¹¹ Total number of repairs supported by USAID bilateral agreements in DR Congo and Ethiopia were 905, representing 22% of all repairs in FY 08/09.

¹² Total number of repairs supported by FC supported sites: 3,871; USAID bilateral agreements in DR Congo and Ethiopia reported 1,101 repairs, representing 22% of all repairs in FY 09/10.

¹³ Projected 16% increase at FC supported sites. In FY 09/10 total number of repairs at FC supported sites was 3,871 (78% of all repairs reported)

	Base-line 06/07 ⁶	FY 07/08	FY 07/08	FY 08/09	FY 08/09	FY 09/10	FY 09/10	FY 10/11
	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned
5. # of people trained, by type of training	603	1,800	4,858 ¹⁴	5,000	5,531 ¹⁵	3,050	6,922	7,545 ¹⁶
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 ¹⁷	1,500	4,113	5,000	5,728	3,500
7. # of persons reached in outreach events about fistula prevention	239,675	350,000	442,534	500,000	720,058	750,000	1,026,674	558,000
8. % of all labors with partographs correctly completed & managed according to protocol	NA	NA	NA	80%	NA	80%	39%	80%
9. Number of births at FC supported sites ¹⁸	NA	NA	NA	NA	30,002	NA	58,930	NA
10. Number/Percent of births that were by c section at FC supported sites	NA	NA	NA	NA	34%	NA	40%	NA
11. Number/Percent of c-sections that that were a result of obstructed labor or prolonged labor	NA	NA	NA	NA	NA	NA	NA	NA
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 ¹⁹	NA	45%	48%	80%	20% met 4x; 83% met at least 1x	80%	14% met once/quarter; 97% met at least 1x	80%
13. # of evaluation & research studies completed	0	1	0	3	1	2	3	13

¹⁴ 84% for training of community volunteers;

¹⁵ Of this training total, 77% were trainings for community volunteers and health workers in Ethiopia. A total of 3,509 community volunteers were trained (64% of training total) and 727 health workers and administrators were trained (13% of training total) in fistula prevention and referral. Over half of the community volunteers were receiving refresher trainings.

¹⁶ 75% of projected benchmark is for Ethiopia pre-repair centers.

¹⁷ Data on number of events is missing from Guinea for all quarters; from Ethiopia pre-repair centers missing for three quarters; for Ethiopia/AAFH missing for all quarters.

¹⁸ We will not present benchmarks for indicators 9, 10 and 11. We will report on actual achievement by those sites were supporting to improve delivery and cesarean services.

¹⁹ Fistula Repair centers are counted as well at the three pre-repair centers in Ethiopia.

	Base-line 06/07 ⁶	FY 07/08	FY 07/08	FY 08/09	FY 08/09	FY 09/10	FY 09/10	FY 10/11
	Actual	Planned	Actual	Planned	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	5	6	7	6	8
15. Number of facilities using Fistula Care technical products, by product, for improving fistula treatment and prevention services.	NA	TBD	26	68	36 sites using 9 tools	70	64 sites reported using 9 tools	85

NA=not applicable
TBD=to be determined

Fistula Repairs (SO). The overall number of repairs performed in all USAID supported sites in FY 09/10 was 4,972 representing a 19% increase from the previous year. Data on the total number of repairs supported in FYs 07/08, 08/09 and 09/10 were updated this year with reporting from Project AXxes in the DR Congo. Repairs performed through Project AXxes and AAFH accounted for 14% of all reported repairs in FY 06/07, 31% in FY 08/09 and 22% in FY 09/10.

The benchmark for FY 09/10 for the number of repairs was based on past performance at FC supported sites and the planned expansion of sites. We had planned for a 14% increase in repairs at FC supported sites and achieved an overall 18% increase above the previous year's performance at FC supported sites (3,279 repairs in FY 08/09 and 3,871 in FY 09/10). All FC supported country programs, with the exception of Sierra Leone, increased performance over last year (range: 9 % to 67%); the two supported FC sites in DR Congo performed similarly as last year. See Table 3 below for full details by country and site (Section III, Global Accomplishments, Result 1). Contributing factors to this performance include:

- **Bangladesh.** The 9% increase is a result of the inclusion of Ad-din/Dhaka as a newly supported site. Ad-din/Dhaka provides both simple and complex repairs. By the end of the fiscal year it had four trained fistula surgeons (two senior and two junior) and had established a referral system with the National Fistula Center and other facilities offering fistula repair in Dhaka.
- **Guinea.** The 24% increase is attributed to two key programming factors. The training strategy uses a three prong approach for increasing access to services: routine services are now available in supported sites for simple repairs following trainee completion of simple repair surgical training; periodic national sessions are held with national surgeons from the Urology Department of Ignace Deen Hospital for simple to moderate repairs; and period repair/training sessions are held for simple to complex repairs with visiting surgeons from the Geneva Foundation for Medical Education & Research (GFMER). The second important

factor has been the strengthening of referral systems for women with fistula. Through the levels of care framework, there are now five level one facilities capable of screening and referring women in need of surgery, expanding out from the immediate catchment area of the fistula repair facilities. Third, is the training strategy: the approach has resulted in more surgeons who are now able to provide routine simple repairs.

- **Mali.** Although there was a decrease in the number of repairs between FY08/09 and FY09/10 due to difficulty recruiting cases during the rainy season, the project will support one additional fistula repair campaign in FY 10/11. Three surgeons are being trained in fistula repair and the project expects to start routine fistula service delivery in the coming year with these surgeons. The project will also work with community health centers to increase the number of fistula cases reached and referred in addition to the outreach activities conducted by the local NGO GREFFA.
- **Niger.** Overall there was a 35% increase. This year saw continuous support provided to REF to enable it to support services and to build upon its management capacity. Renovations at Maradi were completed at the end of FY 08/09 and routine services are now available with support of three surgeons, although the site has a considerable backlog of potential patients and could provide more services with more space available. At Dosso, there are now two surgeons posted who can provide routine services. Lamordé's increase is a result of patients being transferred from the National Hospital of Niamey to help reduce their backlog.
- **Nigeria.** The 20% increase is a result of the following factors: 1) Effective grass root mobilization of clients in Ebonyi state resulting in the identification of many women in need of surgery. 2) To help reduce the backlog five pooled efforts were conducted at the center in Ebonyi, where 155 repairs were performed (representing 46% of all repairs reported by the site this FY); 7 additional pooled efforts were conducted at other supported sites; the total number of repairs conducted at these pooled effort events accounted for 20% of repairs reported this FY in Nigeria. 3) Sustained, timely and regular supply of theater consumables such as suture materials, anesthetic drugs, antiseptics and disinfectants, surgical gloves and catheters to all supported sites during the FY. This effort helped avoid stock outs and enhanced timely repairs of fistula clients. 4) Generally good availability of surgeons to provide routine services and fewer nursing strikes as compared to other years
- **Rwanda.** There was an overall 55% increase; with the largest increase seen at CHUK. Routine services have commenced again at CHUK as a result of completion of hospital renovations, and having more trained surgeons available for surgery; in addition the site organized two workshops to deal with the backlog of repairs. All three repair sites were provided with additional repair kits. In addition there has been improved planning and coordination at the national level with all partners. Ruhengeri was the only supported site that experienced a decline in performance: routine services are not available and only one outreach workshop was held.
- **Sierra Leone.** During the management transition from Mercy Ships to the Glog Foundation, the Aberdeen Women's Centre saw several changes. First, Fistula Care support was suspended until the handover was legally complete, which meant that AWC did not receive support between September 2009 and June 2010. Second, AWC staffing changes resulted in Dr. Alyona Lewis being the sole fistula surgeon continuously on site, while five of the postoperative nurses opted to leave the fistula unit and join the new AWC maternity unit when it opened in April 2010. (Visiting surgeons assist Dr. Lewis with complex cases, and new postoperative nurses have been identified and trained.) Finally, the Glog

Foundation reduced the number of screening teams made to the provinces so that the strategy behind the trips could be reviewed and to ensure proper recordkeeping and oversight. AWC will increase its client identification activities in the coming year.

- **Uganda.** The 67% increase in Uganda is attributed to community mobilization efforts which are now funded by Fistula Care. These outreach efforts are extending out beyond the hospitals' immediate catchment areas.

For FY 10/11 we are projecting an increase of 16% in the number of repairs (calculated based on FC supported sites only; repairs performed in other USAID support programs are excluded from the projection): from 3,871 to 4,500 repairs in 35 FC supported repair facilities. All countries are projected to increase the number of repairs in FY 10/11 with the exception of Nigeria where we are projecting a 10% decrease over this year's performance due to a change in strategy by the USAID/Nigeria mission.

Fistula Surgical Outcomes. The overall percentage of women with a urinary and urinary/RVF fistula who were discharged with a closed and dry fistula was 73%; these rates ranged from 34% (Maradi in Niger) to 90% (Ad Din Dhaka, Bangladesh). The reported complications rate was three percent. These rates vary by country and site, ranging from one percent (Guinea) to 11 percent (Bangladesh); see individual country reports in Section IV of this report for details by site for both indicators. Projected benchmarks for these two indicators will remain as in previous years.

Training. The planned benchmark was to train approximately 3,000 persons; a total of 6,922 persons attended training for fistula treatment and prevention. Nearly three quarters of the persons trained (5,355) were from the Ethiopia program where there was expansion of the community outreach networks to new catchment areas for the pre repair centers; training in Ethiopia also included refresher training for community volunteers as well as health post providers in screening procedures. More detailed discussion about training accomplishments in FY 09/10 are presented below under Section III, Global Accomplishments, Result 1). We are projecting to train 7,545 persons in next year; 75% percent of this benchmark includes the Ethiopia program which is expanding to a new site.

Result 2: Enhanced community and facility practices to prevent fistula

Six indicators relate to enhancing community and facility practices to prevent fistula.

Community Outreach. As shown above in Table 2, we achieved the planned benchmark of sponsoring more than 5,000 outreach events in 7 countries. These events reached more than one million persons. The majority of events and persons reached were in Ethiopia; see country reports for more details. The projected benchmarks for FY 10/11 remain high due to planned expansion in Ethiopia for the pre repair centers.

Maternity Related Services. No benchmarks are set for three of the four indicators: number of deliveries, number of cesarean deliveries, and percentage of cesareans performed as a result of prolonged/obstructed labor. For partograph monitoring, we expect that 80% of all labors would be monitored with the partograph. We report on these indicators only in those sites where we are working to strengthen cesarean delivery services and/or use of the partograph. We agreed with USAID/W we would determine the feasibility of collecting/reporting on the proportion of cesareans for reasons of obstructed/prolonged labor by conducting a record review study. The implementation of this study began in late FY 08/09. Preliminary findings from the retrospective record review are discussed below under Result 3.

Partograph Use. In FY 09/10 we piloted and introduced a monitoring tool to assess the quality of partographs in selected sites. The methodology for the review is described below under the Global Accomplishment Section, Result 2. As shown below among the 522 maternity records which were sampled in 24 facilities, 39% were completed correctly. Country programs are developing action plans to address how to improve the use of the partograph. We expect to see improvement next year.

Vaginal and Cesarean Deliveries. A total of 32 sites reported on these services in FY09/10: nearly 59,000 births were reported in supported facilities; 40% of all births in supported facilities were by cesarean; these institutional rates varied by site, ranging from 6-8% (General Hospitals Kamba, Maiyama and Argungu: Jega in Nigeria) to 67% (42- 67% (N'Zerékoré, Guinea; Maradi, Niger; CHUK, Rwanda; Kissidougou, Guinea; Ad-Din/Jessore, Bangladesh; Ad-Din Dhaka:, Bangladesh). See Table 14 below under Global Accomplishments Result 2 and the country reports for more details.

In FY 09/10 there was an increase in training activities to improve obstetric services: a total of 525 persons attended training from eight countries; see Table 9 under Result 2. This represents a three fold increase in numbers of persons trained in this subject area from last year (n=147).

Result 3: Use of data for decision making

We have two indicators to measure how the project is performing for this result: number of evaluation and research studies completed and routine review of quarterly fistula monitoring data for improving services. For FY 09/10 we projected completing two studies; we completed three studies: two of the country cesarean record review studies and a literature review on the partograph. The partograph literature was completed in September 2010 and will be copy edited and disseminated in the first quarter of the next FY.

The cesarean studies (part of a multi center retrospective study) were completed and findings disseminated with study sites in Uganda (a final report for one site in Uganda was completed and the second report is being edited).

Study reports for Bangladesh were drafted and will be shared with sites for feedback in the first quarter of FY 10/11. Final reports will be produced in the first quarter of FY 10/11.

In FY 10/11 we expect to finalize all remaining site specific reports on the C-section record review (two for Bangladesh, one for Mali, two for Guinea and three for Niger); and prepare the overview report of all study site findings from the cesarean record review. In addition we will complete the analysis and dissemination of the findings from the multi-country prospective study on the determinants of fistula, as well as prepare several papers for publication in peer review journals, finalize a literature review on uterine prolapse, and complete cost studies in at least two countries.

During this FY, 26 of the fistula care supported repair centers and three pre repair centers (29, 90%)met at least once during the project year to review data; an increase from last year. Only 8 sites reported meeting at least once a quarter; fewer sites than last year. A training module on data for decision making was finalized in September 2010 and will be shared with all country programs in order to help strengthen the routine review of data in supported repair sites. We expect to see an improvement next year.

Result 4: Strengthening the environment for fistula

The two indicators for strengthening the environment for fistula are: number of countries that are adopting, revising or initiating policies for fistula prevention and treatment; and number of supported facilities using FC-produced technical products for improving fistula treatment and prevention services. Seven countries reported on activities related to strengthening policies for fistula. In addition, two regional activities were supported through USAID/East Africa. See Result 4, below for more details. A total of 60 sites (including three AAFH supported repair centers) reported use of at least one product during the year —the fistula reporting forms. See Table 18 below under Result 4 for full details.

III. Global Accomplishments

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

Fistula Repairs

As mentioned above, since 2005 USAID has supported 17,780 surgical repairs for women with fistula. The total number of fistula repair surgeries supported in FY 09/10 at 32 USAID supported sites in 12 countries was 4,972; see Table 3 and Figure 3. There was an overall 19% increase in the number of repairs from last year. About one fifth of the reported repairs (22%, 1,101 repairs) were reported from sites supported directly by USAID bilateral agreements in DR Congo and Ethiopia. Just over 40 % of all repairs in FC support program sites this FY were provided by the Nigeria program (42%; 1,612 repairs/3,871 all FC repairs). All countries, with the exception of Sierra Leone, increased performance. While Bangladesh’s and the DR Congo’s increase was less than 10%, the remaining countries increased performance from between 20 and 35% (Ethiopia, Guinea, Niger, Nigeria) or by more than 50% (Mali, Rwanda and Uganda). Reasons for these increases are discussed above under Section 1 of this report. Country program managers express confidence that increases will continue into the next year.

Figure 3. Total No. Repairs, January 2005-September 2010 by Source of Support

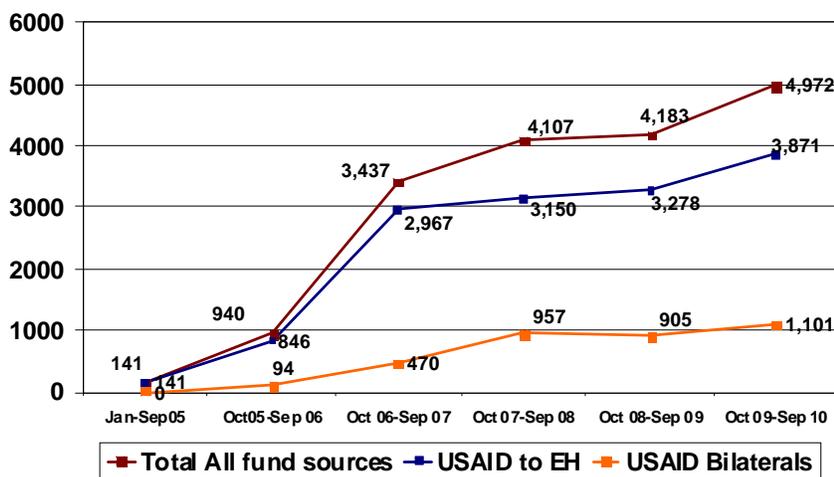


Table 3. Number of Women Receiving Fistula Repair Surgery at USAID supported Sites, Country, Site and Year

Country	FY 04 / 05	FY 05 / 06	FY 06 / 07	FY 07 / 08	FY 09 Oct 08 - Sep 09					FY 10 Oct 09 - Sep 10					Grand Total
	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	July-Sep	Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	Total	FY 05 - FY 10
Africa Mercy															
Benin	NS	NS	NS	NS	NS	44	61	5	110	21	NS	NS	NS	21	131
Ghana	NS	21	42	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	63
Liberia	NS	NS	NS	59	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	59
Togo	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	94	3	97	97
Total	0	21	42	59	0	44	61	5	110	21	0	94	3	118	350
Bangladesh															
Ad-Din Dhaka	NS	NS	NS	NS	NS	NS	NS	NS	NS	7	5	5	17	34	34
Ad-Din Jessore	NS	NS	NS	NS	NS	NS	NS	NS	NS	0	0	0	2	2	2
Kumudini	7	22	24	57	17	16	9	7	49	13	11	8	5	37	196
LAMB	4	40	72	52	19	32	9	21	81	16	22	16	16	70	319
MCH	9	31	23	13	1	NS	NS	NS	1	NS	NS	NS	NS	NS	77
Total	20	93	119	122	37	48	18	28	131	36	38	29	40	143	628
DRC															
HEAL Africa	NS	53	215	200	NS	90	43	81	214	40	65	40	65	210	892
Panzi	NS	0	371	134	NS	85	86	97	268	67	57	82	56	262	1035
Project AXxes	NS	NS	NS	361	70	133	120	119	442	71	116	171	156	514	1317
Total	0	53	586	695	70	308	249	297	924	178	238	293	277	986	3244
Ethiopia															
Arba Minch	NS	NS	NS	NS	NS	NS	NS	NS	NS	13	n/a	14	0	27	27
Bahir Dar Ctr	NS	94	470	596	64	86	86	61	297	98	117	87	81	383	1840
Mekelle Ctr	NS	NS	NS	n/a	42	44	51	29	166	38	57	56	26	177	343
Total	0	94	470	596	106	130	137	90	463	149	174	157	107	587	2210
Guinea															
Ignace Deen	NS	79	114	63	14	11	12	12	49	3	8	9	NS	20	325
Jean Paul II	NS	NS	NS	36	26	24	16	22	88	23	29	50	24	126	250
Kissidougou	NS	120	178	130	30	65	21	32	148	31	32	39	30	132	708

Country	FY 04 / 05	FY 05 / 06	FY 06 / 07	FY 07 / 08	FY 09 Oct 08 - Sep 09					FY 10 Oct 09 - Sep 10					Grand Total
	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	July-Sep	Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	Total	FY 05 - FY 10
Labe	NS	NS	NS	NS	NS	NS	15	16	31	16	32	39	27	114	145
Total	0	199	292	229	70	100	64	82	316	73	101	137	81	392	1428
Mali															
Gao Regional Hospital	NS	NS	NS	NS	NS	13	19	14	46	0	23	0	17	40	86
Total	0	0	0	0	0	13	19	14	46	0	23	0	17	40	86
Niger															
Dosso	NS	NS	NS	17	0	3	3	9	15	0	7	12	3	22	54
Lamordé	NS	NS	27	70	32	15	30	7	84	46	25	20	38	129	310
Maradi	NS	NS	NS	123	3	16	40	0	59	8	35	15	5	63	245
Tassigui Maternity Tahoua	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	6	6	6
Total	0	0	27	213	35	34	73	16	158	54	67	47	52	220	618
Nigeria															
Babbar R.	NS	NS	356	536	83	86	111	51	331	74	89	135	61	359	1582
Ebonyi Fistula Center	NS	NS	NS	NS	NS	72	65	52	189	61	70	98	101	330	519
Faridat Yak.	NS	NS	180	150	55	70	18	44	187	23	29	25	38	115	632
Kebbi	NS	NS	102	122	39	31	42	39	151	45	58	54	50	207	582
Laure Fistula Ctr.	NS	NS	339	473	75	121	97	44	337	83	n/a	98	84	265	1414
Maryam Abacha	NS	NS	104	156	28	57	45	22	152	64	51	53	32	200	612
Other	0	0	0	0	0	0	0	0	0	NS	136	NS	NS	136	136
Total	0	0	1081	1437	280	437	378	252	1347	350	433	463	366	1612	5477
Rwanda															
CHUK	NS	45	55	36	13	9	14	15	51	8	40	14	64	126	313
Kanombe	NS	NS	NS	NS	NS	NS	NS	14	14	11	15	8	14	48	62
Ruhengeri	NS	100	92	47	50	52	0	0	102	0	40	45	0	85	426
Total	0	145	147	83	63	61	14	29	167	19	95	67	78	259	801

Country	FY 04 / 05	FY 05 / 06	FY 06 / 07	FY 07 / 08	FY 09 Oct 08 - Sep 09					FY 10 Oct 09 - Sep 10					Grand Total
	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	July-Sep	Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	Total	FY 05 - FY 10
Sierra Leone															
Aberdeen	NS	NS	272	363	65	69	52	67	253	38	43	50	35	166	1054
Total	0	0	272	363	65	69	52	67	253	38	43	50	35	166	1054
Uganda															
Kagando	NS	79	174	118	19	23	31	12	85	68	58	9	71	206	662
Kitovu	121	256	227	192	38	64	0	81	183	36	110	0	97	243	1222
Total	121	335	401	310	57	87	31	93	268	104	168	9	168	449	1884
Overall Total	141	940	3437	4107	783	1331	1096	973	4183	1022	1380	1346	1224	4972	17780

n/a: not available

NS: not supported (no services supported by USAID during the reporting period)

Trends across countries and reporting years. Table 4 provides an overview of selected clinical monitoring indicators that reflect demand for fistula repair services; Tables 5 and 6 outcomes for fistula repair. Data for all countries from October 2007- September 2010 are presented.

- ***Percent of women requiring fistula surgery of those seeking it.*** In FY 09/10 the percent of women requiring fistula surgery of those seeking it ranged from 63% in Sierra Leone, 64% in Mali and 66% in Ethiopia to 84% in Bangladesh and greater than 90% in several countries including Guinea and Nigeria. Across years and countries, this number appears to be leveling out — early lower numbers reflecting high turnout for new services, and the 80% average across the past two years, potentially indicating appropriate targeting of messages about available services.
- ***Percent of women who received surgery of those requiring it.*** Some country programs continue to experience backlogs of women who need, but have not yet been able to get surgery. In FY 09/10 in Rwanda 62% of women requiring surgery received it (the same percentage as last year). Fistula care services in Rwanda are primarily provided through outreach workshops with visiting expatriate surgeons. While the project has been able to support more of these workshops over the last year to try and reduce the backlog, local capacity to provide routine services between workshops is still low. At the same time, the numbers of women seeking and requiring care has also significantly increased as awareness of the availability of services has expanded. In Guinea the figure is 63% this year, up from 44% last year; Mali and Niger also exhibited increases. DR Congo and Ethiopia are excluded from analysis of this indicator due to uncertainty of denominator data across multiple quarters. In FY 09/10 the rest of the countries were able to provide more than 90% of surgeries that were needed.
- ***Percent of repairs that were first repairs.*** In FY 09/10 greater than 70% of repairs in Bangladesh, DR Congo, Ethiopia, Sierra Leone and Uganda were first repairs; the proportions were lower in other countries ranging from 34% in Mali, and 42% in Niger to between 60% and 68% in Africa Mercy, Guinea, Nigeria and Rwanda. The seemingly dramatic decline in Mali (from 62% last year) is due to their small caseload. In 6 of the 11 countries this indicator increased from last year, potentially signaling sustained need to reach women who have not yet been in contact with fistula repair services.

**Table 4. Project Trends October 2007 to September 2010,
Selected Clinical Indicators (Demand)**

Country	% Requiring FRS of those seeking it ²⁰			% Receiving FRS of those requiring it ²¹			% First FRS		
	FY 07 / 08	FY 08 / 09	FY 09 / 10	FY 07 / 08	FY 08 / 09	FY 09 / 10	FY 07 / 08	FY 08 / 09	FY 09 / 10
Africa Mercy	97%	83%	78%	100%	87%	91%	64%	72%	60%
Bangladesh	85%	92%	84%	71%	120%	95%	79%	67%	73%
DR Congo	69%	95%	74%	NA	NA	NA	27%	65%	76%
Ethiopia	79%	58%	66%	NA	NA	NA	n/a	87%	90%
Guinea ²²	98%	93%	94%	53%	44%	63%	69%	59%	68%
Mali	NS	68%	64%	NS	72%	98%	NS	62%	34%
Niger	88%	125%	94%	55%	69%	93%	49%	40%	42%
Nigeria ²³	98%	87%	94%	112%	81%	114%	54%	71%	63%
Rwanda	90%	81%	81%	65%	62%	62%	48%	69%	65%
Sierra Leone	81%	75%	63%	83%	95%	97%	80%	64%	80%
Uganda	77%	69%	76%	95%	92%	91%	66%	76%	73%

FRS: fistula repair surgery

NS: not supported (no services supported by USAID during the reporting period)

n/a: not available.

- **Percent of women discharged with closed and dry fistula.** The percent of women who had a closed fistula and were dry was 73% overall for all sites in FY 09 /10 (74% in FY 08/ 09), ranging from 55% in Niger, 67% in Nigeria and DR Congo to 75% or higher in Africa Mercy, Bangladesh, Ethiopia, Guinea, Mali, Sierra Leone and Uganda; see Table 5.

²⁰ Data from Niger may be skewed because of missing data on the number of women seeking care in one or more quarters.

²¹ DR Congo and Ethiopia excluded from % receiving FRS of those requiring it because of missing denominator data.

²² Guinea is currently undergoing a data cleaning exercise by which slight variation in these indicators' values moving forward may become apparent

²³ % receiving FRS of those requiring >100% in Bangladesh in FY 08/09 and in Nigeria in FY 07/ 08 and 09/10 are due to lag time between intensive screening activities and when all those indentified as requiring can be repaired. This lag straddled reporting periods at multiple sites and in multiple quarters. In Nigeria, there are also requiring (denominator) data missing from 2 sites from July-Sept 08 and 2 sites across multiple quarters in FY 09/10.

Table 5. Percent of Women Closed and Dry, Urinary only and Urinary/ RVF Repairs at Time of Discharge, by FY and Country²⁴

Country	FY 07 / 08	FY 08 / 09	FY 09 / 10
Africa Mercy	88%	72%	78%
Bangladesh	71%	71%	76%
DR Congo	81%	60%	67%
Ethiopia	NA	81%	76%
Guinea	75%	80%	87%
Mali	NS	88%	75%
Niger	71%	54%	55%
Nigeria	93%	74%	67%
Rwanda	74%	80%	83%
Sierra Leone	73%	71%	84%
Uganda	79%	87%	79%
Overall Total	83%	74%	73%

NA: not available

NS: not supported

- Percent of women who experienced complications.** Reports on complications remain low across all program supported sites except Africa Mercy Ship in Benin, where it was 33% in FY 09/10; see Table 6. During this FY the senior surgeon on board the Africa Mercy reported seeing many complicated cases. In the two other countries where annual totals are highest (Bangladesh and Ethiopia at 11% and 6% respectively) it has come down since last year in Bangladesh and seems to be driven by one large hospital in each country- LAMB Hospital in Bangladesh and Bahir Dar Fistula Center in Ethiopia with good attention to record keeping. Other countries exhibited small increases, but proportions overall remain quite low. In FY 09/ 10 most of the complications remained categorized as post-operative (e.g., bleeding and urinary tract infection (UTI)) except for in Nigeria where the majority was reported as major surgical complications and in Uganda where they were primarily anesthesia related complications.

²⁴ Q1 of FY 07/08 all repairs was used as the denominator; discharge data (the number used as the denominator subsequently) began being collected in January 2008.

Table 6. Percent Women Discharged with Reported Complications from Fistula Surgery, By Country and FY

	FY 07 / 08	FY 08/09	FY 09/10
Africa Mercy	27%	23%	8%
Bangladesh	15%	31%	11%
DR Congo	2%	1%	2%
Ethiopia	0%	0%	6%
Guinea	3%	2%	1%
Mali	0%	0%	0%
Niger	0%	1%	0%
Nigeria	5%	1%	1%
Rwanda	5%	1%	1%
Sierra Leone	10%	3%	5%
Uganda	3%	1%	3%
Overall Total	5%	3%	3%

Other Surgeries in Support of Fistula Repair. For women who have a urinary fistula and/or a recto vaginal (RVF) fistula, some will require a procedure before or after the repair to improve the outcome of the fistula repair. In FY 08/09 Fistula Care began requesting the reporting of this data following discussions and agreement with USAID that project funds could be used to support these additional surgeries. Summarized below in Table 7 is the type of additional surgeries performed over the last two years (all countries). In total, 1,466 additional surgeries have been reported to Fistula Care (527 in FY 08/09 and 939 in FY 09/10). Some of this data reported from Niger was reported using the wrong definition for wound resuture; those data have been removed from this analysis. Details for each country by year are provided in Annex 3.

We are now able to make some preliminary analysis and reflections on the data for auxiliary or additional surgeries. Some surgeries may be routine in some sites although they may be performed without a good indication. There are some surgeries which raise quality of care concerns, and therefore the need for intervention. Finally, we are also specifically interested in fistula surgery concurrent with pelvic organ prolapse (POP)/uterine prolapse, to the extent that POP has intriguing similarities and contrasts to fistula with regard to epidemiology (determinants/distribution) and management, and there may be synergism and/or competition to be identified in programs that address the two issues.

Summarized below are observations about each additional surgery reported in the last two years.

Table 7. Total Number of Additional Surgeries By Year

	FY 08-09		FY 09/10		Total FY08/09 & FY09/10	
	N	%	N	%	N	%
Examination under anesthesia	132	25.0	265	28.2	397	27.1
Urethral lengthening and other operations for concomitant stress incontinence	83	15.7	303	32.3	386	26.3
3rd/4th degree perineal tear repairs	89	16.9	109	11.6	198	13.5
Ureteric reimplantation, Ureteroneocystostomy, and related surgery	59	11.2	68	7.2	127	8.6
Removal of bladder stones or foreign bodies in viscera	52	9.9	49	5.2	101	6.9
Prolapse IF associated with fistula	34	6.5	10	1.1	44	3.0
Colostomy and reversal colostomy	22	4.2	19	2.0	41	2.8
Wound resuture	17	3.2	7	0.7	24	1.6
Sling Procedures	12	2.3	0	0.0	12	0.8
Abdominal exploration	2	0.4	0	0.0	2	0.1
Other (urethral reconstruction, repair of cystocele, perineorrhaphy, vaginoplasty)	0	0.0	10	1.1	10	0.7
Other **	25	4.7	99	10.5	124	8.5
Total	527	100.0	939	100.0	1466	100.0

- **Examination under anesthesia (EUA) as a discrete activity.** This is a practice that was supposedly on the decline but the data suggests that the trend is upwards. Previously, the standard was to conduct an EUA before scheduling fistula surgery to determine location, size, number, scarring, vaginal capacity and decide on the surgical approach. Over time, this practice seems to have shifted towards doing the EUA at the same time as the definitive surgery, so that a woman does not need to go back to the ward to await another surgical list. However, surgeons need considerable confidence and skill to know that they can deal with whatever class of fistula they find. Also, it can be difficult to complete a proper and thorough exam without the light source, adjustable table and anesthesia found in theater. Most EUAs are done under spinal anesthesia, rarely under general. This trend suggests there is a need for guidelines for EUA.

EUA as discrete surgeries represent the largest proportion of all ‘additional surgeries’ across all countries in FY 08/09 and FY 09/10, 25% and 28.2%, respectively. However, performance of this type of surgery varies across program sites and time. For example in FY 08/09, EUA accounted for half of all additional surgeries reported by programs in Guinea, while no EUA were reported in FY 09/10. In Sierra Leone in the last quarter (July-September 2010), a surgeon with skills for medium complexity fistula repair judiciously used the opportunity to triage and refer or defer the difficult cases classified during EUA to a more skilled colleague, but tackled all the other cases herself. Approximately

40% of all additional surgeries at Aberdeen Women's Centre in Sierra Leone are EUAs.

- ***Urethral lengthening or other operations for stress incontinence.*** Overall for the two years, this category of surgery represents the second most commonly reported additional surgery across both years (26.3%). This procedure is performed to prevent or treat stress incontinence. Stress incontinence is an important marker of perceived "success or failure" of fistula surgery. In FY 08/09, 15.7% of all surgeries were for this reason and in FY 09/10 this had increased to 32.3%. There is considerable variation in reports of this surgery across countries. It is most frequently reported in Ethiopia, DR Congo, Uganda and on board the Africa Mercy (see Annex 3). No information is available about whether these procedures are being done for a specific indication or routinely; whether they are for prophylaxis against stress incontinence or for treatment. Similar considerations apply to the rather less common 'urinary sling operations', another category of "additional or auxiliary surgery". The survey of provider practices conducted last year suggested that surgeons are using these techniques without clear indications, and this could be a useful research topic. While we note the doubling of these procedures in the two years under review, there is no significant safety concern about the use of this procedure at this time.
- ***Repairs of 3rd and 4th degree perineal tears and wound re-suture.*** Severe perineal tears raise concern about the quality of care at labor and delivery; such tears should occur uncommonly/rarely in proportion to the number of vaginal deliveries. They formed 13.5% and 1.6% of all additional surgeries globally for FY 08/09 and FY 09/10 respectively. For a number of quarters, data were being reported from one site in Bangladesh that caused concern, requiring EmOC retraining. A related issue is wound re-suture, a likely sequel to wound infection. Figures from Mali and Bangladesh were of concern, requiring strengthening of infection prevention interventions at supported sites and purchase of an autoclave for one site in Bangladesh.
- ***Ureteric re-implantations, ureteroneocystotomy and related surgery.*** These surgeries are major surgery and often require a skill additional to fistula repair skills. Urologists, for instance, are sometimes more comfortable than OB/GYNs in performing this surgery as the procedure is often, though not always, trans-abdominal rather than trans-vaginal and may require deeper anesthesia, as well as blood transfusion capability. The surgery may in addition require special equipment and expendables. These surgeries represent about 8.6% of all reported additional surgeries across the two years; some programs are more likely than others to have surgeons who are more comfortable or have such cases referred to them, such as the DR Congo, Mercy Ships, and one site in Uganda.
- ***Removal of bladder stones and foreign bodies in viscera.*** This is a routine pre-repair surgery that may improve closure rates, because stones are often associated with infection and bladder irritation. The procedure does not represent a large proportion of all additional surgeries reported (6.9%, over two years), the rates do not vary much across programs or over time, although the numbers are few for comparison. However, it is a reminder of the importance of looking for foreign

bodies in all cases before a repair is attempted; otherwise there is increased risk of a repair breakdown.

- ***Uterine or other pelvic organ prolapse (POP) surgery.*** This is of importance because of the epidemiologic and programmatic link with female genital fistula. Anecdotally high numbers do exist in Ethiopia, Sierra Leone and Nigeria. The numbers reported to the project, however, are not high, and do not clearly show variation across programs. This is because these figures are from a population of women receiving fistula surgery, and they therefore do not give a true picture of the magnitude of the problem.
- ***Colostomies.*** Reported cases of colostomies are 2.8% for two years. Colostomies are almost always temporary as a step in the management of fecal fistula with or without urinary fistula. Colostomy procedures have been collapsed in this data together with 'colostomy reversals' and this may be difficult to tease out; however, it can be assumed that most colostomies will be reversed.
- ***Urinary diversions.*** Urinary diversions are not often recorded in FC supported programs, although DR Congo has recorded a couple of cases which were performed by the Harvard Humanitarian Initiative. It is not clear whether the lack of reporting reflects need, or the fact that the program has some reservations about these procedures and will require much more information with regard to diversion cases. Urinary diversions involve major surgery and there are crucial programmatic and ethical considerations that are needed. Fistula Care will convene a meeting about this issue in FY 10/11.

Training Activities

Sixteen surgeons attended first time training in fistula repair and 47 had continuing training (11 from DRC, 8 from Guinea). FC sponsored advanced training in fistula repair and training techniques on board the *Africa Mercy* hospital ship, under the coaching of Dr. Steve Arrowsmith, for a total of six surgeons: two surgeons from Benin, and one surgeon from Nigeria, Rwanda, Sierra Leone and Uganda; see Table 8. As shown in Table 9, over 6,000 persons attended training in a range of topics about fistula treatment and prevention. Sixty-four (64) providers from four countries were trained in pre- and postoperative care management. Other training in support of fistula treatment included infection prevention (137 providers trained), quality assurance/improvement (183 providers) and fistula counseling (177 providers). Training in prevention related activities included FP counseling, FP methods provision, OC management, and community outreach.

**Table 8. Training in Surgical Repair by Country
October 2009 thru September 2010**

Country	Oct-Dec	Jan-March	Apr-Jun	Jul-Sept	FY Total
Number Surgeons Trained for First Time in Fistula Repair					
Bangladesh	0	0	1	0	1
DR Congo	0	0	0	1	1
Niger	3	0	0	0	3
Nigeria	3	0	1	0	4
Rwanda	0	4	0	0	4
Uganda	1	2	0	0	3
Total	7	6	2	1	16

Country	Oct-Dec	Jan-March	Apr-Jun	Jul-Sept	FY Total
Number Surgeons Continuing Training in Fistula Repair					
Bangladesh	0	0	2	0	2
Benin ²⁵	0	0	2	0	2
DR Congo	0	5	1	7	11*
Guinea	0	5	0	6	8*
Mali	0	2	0	0	2
Niger	0	0	3	0	3
Nigeria	0	5	2	0	6*
Rwanda	0	4	1	0	5
Sierra Leone	1	0	0	1	2
Uganda	3	3*	0	2	6*
Total	4	24	11	16	47*

*When trainees receive more than one continuing training, they are only counted once, in order to have accurate numbers of individuals trained.

**Table 9. Training for fistula treatment and prevention, by country:
Number of persons trained by topic, October 2009 thru September 2010**

	Bangladesh	Benin	DR Congo	Ethiopia	Guinea	Mali	Niger	Nigeria	Rwanda	Sierra Leone	Uganda	Total
First fistula repair & care training for surgeons	1	0	1	0	0	0	3	4	4	0	3	16
Follow up fistula repair & care training for surgeons	2	2	11*	0	8	2	3*	6*	5*	2	6	47
Fistula nursing care /pre post op care	9	0	0	0	0	0	0	9	26	0	20	64
Infection Prevention	77	0	0	0	0	0	60	0	0	0	0	137
Quality Assurance	23	0	0	0	16	0	19	0	0	0	125	183
Fistula Counseling	75	0	48	0	0	18	0	0	15	0	21	177
FP Counseling	20	0	0	0	0	0	0	30	0	0	0	50
FP methods/LAPM methods	42	0	0	0	61	0	30	31	0	0	72	236
Obstetric care	94	0	167	79	67	31	0	24	0	20 ²⁶	43	525
Fistula Screening and /Prevention for Health workers	0	0	0	3210	0	0	0	0	0	0	0	3210
Community Outreach & Advocacy	18	0	0	2066	0	0	0	73	0	0	0	2157
Data Management	47	0	0	0	4	2	0	18	0	0	20	91
Other ²⁷	16	0	0	0	0	0	0	20	0	0	0	36
Total	424	2	227	5355	156	53	112*	215	46*	22	310	6922*

*Four Rwandan surgeons received both first and continuing training, and are therefore only counted once as persons trained during this time period. One surgeon in DR Congo has received multiple continuing trainings during the FY and is only counted once as a person trained in this table. One Nigeria surgeon received both first and continuing training during the year and is only counted once in this table. The same three surgeons in Niger received both first and continuing trainings.

²⁵ On board the Africa Mercy when it was docked in Togo.

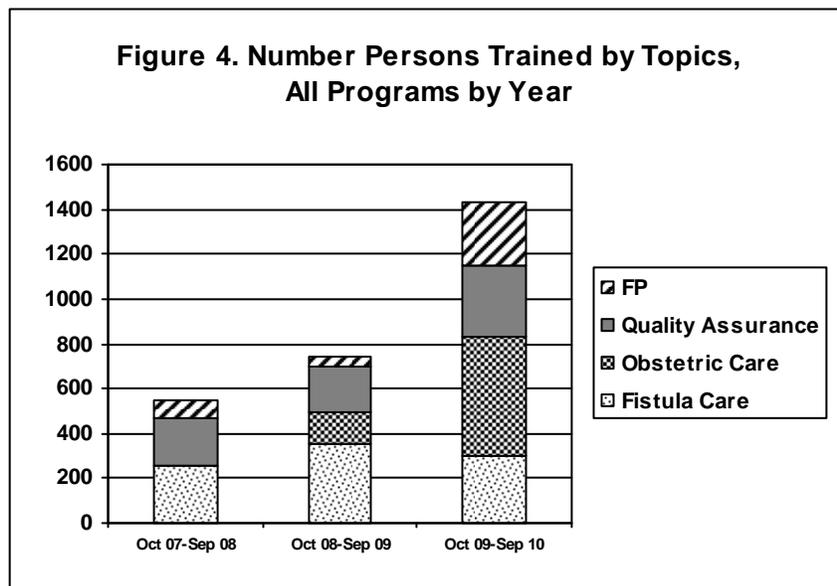
²⁶ 20 nurses in Sierra Leone received continuing obstetric on-the-job training throughout the year

²⁷ Bangladesh: Site orientation for Ad-din Dhaka. Nigeria: Map and community engagement.

Since FY 07/08 the total number of providers attending training in fistula care management (surgical skills, pre and post operative care, fistula counseling), quality assurance (infection prevention, quality improvement), family planning (counseling, contraceptive updates, skills for FP method provision) and obstetric care (emergency obstetric care, partograph, cesareans, AMSTL) has increased; see Table 10 and Figure 4 below.

Table 10. Number of Health Providers Attending Training By Selected Subject, All Countries By Year

	Oct 2007- Sep 2008	Oct 2008- Sep 2009	Oct 2009- Sep 2010	Total
Fistula care management	255	358	304	917
Quality assurance	211	140	320	671
Family Planning	82	45	286	413
Obstetric Care	0	197	525	722
Total	548	740	1435	2723



Fistula Surgeon Training Follow-up Review. The Fistula Care Project has been training surgeons to perform fistula repairs since the inception of the project. In April of 2010, we conducted a systematic review to track the current status of all surgeons who had attended training in fistula surgery with support from USAID since 2005²⁸²⁹. Country programs were contacted and asked to provide detailed information on the surgeons trained in that country: trainee's current workplace, the highest level of training attained (simple, medium/intermediate or complex repairs), whether or not the trainee is currently providing fistula repairs, and if not currently providing repairs, why not. We also asked, if possible, for trainees to estimate the number of repairs performed since training and to report details on any training follow up that had been conducted to assess the trainee's skills post-training. Surgeon training has continued since we completed the review in April 2010, and another systematic follow-up will take place in year five of the project. Information was successfully collected from Bangladesh, Guinea, Mali, Niger, Nigeria, Rwanda, Sierra Leone and Uganda. Data for the Democratic Republic of Congo was collected but remains incomplete and is excluded from this analysis and we did not attempt to collect information from Ethiopia.³⁰

Summary of Findings. The review included a total of 143 surgeons who have attended at least one training between 2005 and April 2010. Of that total, 82 (57%) trainees have attended only one training and 60 (42%) trainees have attended more than one training (1 case missing); see Table 11.

The length of each training event reported varied across programs and for some individual trainees. For example, six trainees from Bangladesh attended only one training event, but that event was reported as lasting more than one month; this group of trainees are likely to have acquired the necessary skills for simple repairs whereas in other countries such as Nigeria and Uganda a trainee who attended a one time event which lasted one or two weeks, was more likely to have left the training with some orientation but not the requisite skills.

In total, among all the surgeons for whom we have data, 76 surgeons have been trained in simple surgery; 25 have been trained in medium/intermediate surgery; and 11 have been trained in complex surgery (information is missing for 31 trainees). The missing data is mostly from Sierra Leone and Uganda; in both instances Fistula Care had no input into trainee selection when these training events were organized and follow up has therefore been a challenge. In Sierra Leone, our partner Mercy Ships, used the fistula repair center in Freetown to orient/train surgeons from Europe, the UK or US in fistula surgery who then in turn would commit their time to volunteering on the hospital ship. We do not have information on whether those individuals did return to volunteer or worked

²⁸ We did not contact Project AXxes in the DR Congo, nor AAFH in Ethiopia about any USAID funded training in fistula repair.

²⁹ Some of this training was supported under the ACQUIRE Project prior to October 2007 (e.g., in Bangladesh, Rwanda, Uganda) or through the AWARE Project (e.g. Niger and through Mercy Ships in Ghana)

³⁰ Much of the USAID funded training information we have from DR Congo was conducted through Panzi Hospital under a bilateral agreement with the International Rescue Committee which ended in 2008; funding from Fistula Care to Panzi and HEAL began in February 2009.

Table 11. Follow up Review of Fistula Repair Trainees by Country (updated by KL 17 Nov)

	Bangladesh	Guinea	Mali	MS	Niger	Nigeria	Rwanda	Sierra Leone	Uganda	Total
No. of Trainees	10	16	3	5	31	26	19	10	23	143
<i>No. trained prior to 10/2007</i>	<i>4³¹</i>	<i>0</i>	<i>0</i>	<i>2</i>	<i>13</i>	<i>2</i>	<i>12³²</i>	<i>3</i>	<i>14³³</i>	38
No. Attending 1 training	9	0	0	5	22	17	6	9	14	82
<i>Of those attending 1 training, # from non-FC supported sites</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>5</i>	<i>7</i>	<i>9</i>	<i>3</i>	<i>9</i>	<i>11</i>	44
No. attending >1 training	1	16	3	0	8	9	13	1	9	60
Highest Level of Training										
Simple	7	10	1	2	21	13	16	NA	6	76
Medium	1	2	2	3	6	6	2	NA	3	25
Complex	1	0	0	0	4	4	0	1	1	11
Data unavailable	1	4	0	0	0	3	1	9	13	31
No. Currently Providing repairs	7	12	0	0	16	10	8	1	10	64
No. Not providing repairs	3	4	3	5	15	13	10	NA	10	63
No. trained providing repairs at FC supported sites	6	16	3	0	12	6	11		2	56
No. repairs performed by trainees since training	33	533	0	45	NA	NA	204	NA	868	1683
Follow up Visit										
No. reporting Follow-up visit	0	0	0	0	8	2	4	1	2	16
No. reporting no follow-up visit	7	0	3	5	0	1	4	1	0	17
Data unavailable	3	0	0	0	0	1	4	9	0	17

³¹ Of the four surgeons trained prior, none are currently providing repairs.

³² Of the 12 surgeons trained prior, 5 continued to receive training after 10/2007.

³³ Of the 14 surgeons trained prior, 3 continued to receive training after 10/2007.

elsewhere. In Nigeria many “one time” trainees were from non-supported sites . .In Uganda, the MOH makes the determination about who should attend fistula training and therefore there is not necessarily any connection to the ability to provide services. In addition, early on in the Uganda program the orientation was to train as many individuals as possible. More recently, we are working more closely with the MOH both in Uganda and in other countries to identify persons for training who will be able to return to their home institution to provide services. There are facilities in most countries where fistula services are provided that are not supported by the project itself but have the capacity to ensure fistula service provision and if we can include them in training events, we do so, These ‘one time’ trainees were often selected without consulting the Fistula Care country staff. We are working to improve collaboration with the our partners in these countries in the trainee selection process.

We were able to gather information about the current status (providing fistula surgery or not) of 88% of the trainees we have listed in our database (n=127). Among those 127 surgeon trainees, about half (64) are currently providing repair services; and 87% of these active surgeons (n=56) are posted at Fistula Care supported sites. All these trainees (regardless of current status, active/non-active) reported they had provided an estimated 1,683 repairs since their training. We know in some countries (e.g. Nigeria, Uganda) the MOH practice of rotating staff oftentimes makes it difficult for surgeons to continue to provide the services for which they have been trained. We have discussed this issue with UNFPA and they also report similar challenges in identifying trainees who will continue to develop their expertise and remain working on fistula.

Part of this wider review of surgical trainees included gathering information about the frequency of follow up visits by a master trainer to assess progress in skills development. While the majority of trainees (77%) reported no follow up visit,³⁴ in fact all of the trainees who have attended more than one training are being followed up and mentored at the subsequent training events Follow-up of trainees by project staff or consultants is generally for those who come from FC supported sites. Follow-up consists of one or more activities: continued participation in training events by master trainers (e.g. Guinea); visits from master trainers to follow up on training of trainers (e.g. Nigeria, Uganda); or visits from Fistula Care clinical staff.

Fistula Care is committed to ensuring that trainee follow-up is a routine part of the training process, however allocation of resources and time have been constraints, as well as trainee availability and case load at trainee home facilities. In addition, we have not always been successful in securing the time of the ‘master’ trainers to conduct the training follow up visits in the desired timeframe. Ideally we would like to have the original trainer conduct the follow- up training visit, however this is not always possible and we sometimes ask other trainers to carry out the follow-up. While not all trainees may have had formal follow-up/mentorship visits by a trainer, any surgeon who has been trained and is working at a Fistula Care supported site has been followed up through our

³⁴ The high number reporting no follow up visit may be a result of poor wording of our question. We know surgeons who have attended training from a FC supported site have had some follow up, perhaps not from the trainer.

routine programmatic monitoring of programs by our Fistula Care country medical associates and /or our global team of senior medical associates. There is frequent programmatic monitoring of supported sites to ensure that the work environment that the trainee is in continues to be supportive of their delivering quality fistula repair services.

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 FY 08/09. The system includes tools—medical monitoring checklist, medical waste management monitoring, protocol for investigating and reporting mortality related to fistula surgery—which are designed to facilitate the standardization of services, not only clinical services but also counseling, clinical training, quality improvement approaches and training site follow-up. In February 2010, we held a medical monitoring meeting with FC project staff to assess the challenges, opportunities and lessons learned in the use of these tools in the last year. During this meeting, participants developed action plans for institutionalizing these tools in programs. We have started to follow up on these plans and will be capturing the data in quarterly reports as well as during medical monitoring visits. In Mali, for example, the Project will conduct a medical monitoring orientation workshop in collaboration with the Ministry of Health in the first quarter of FY 10/11. Use of the FC medical monitoring tools in programs increase this year (see Table 18, Result 4, Use of Technical Products at Supported Sites).

International Training Curricula for Fistula. During FY 08/09 Fistula Care was 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. In FY 09/10 Dr. Ruminjo attended meetings with FIGO and other stakeholders involved in the development of the curriculum to review drafts and feedback from trainers who were involved in the field test (one Fistula Care supported site in Rwanda was included in the field test). Fistula Care project staff met with FIGO in September 2010 to plan for finalization of the curriculum. The curriculum will be finalized in October 2010 at a meeting in Marrakech, organized by FC and attended by representatives from FIGO, PAUSA, Addis Hospital, ISOFS, and other key players. The next steps will be translation of the curriculum into French, and presentation of the curriculum at the ISOFS meeting in Dakar, Senegal in December 2010. At the December meeting there will be discussions about organizing a training of trainers (TOT) and orientation in the use of the document, as well as site selection for the initial training.

Counseling Curriculum for Fistula Clients. This 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. A draft of this document has been available for some time and has been used in programs. In May 2010, Levent Cagatay, Senior Technical Adviser/EngenderHealth and Sita Millimono, Senior Medical Associate, Guinea program conducted training for those involved in fistula services in Rwanda.

In FY 08/09, Fistula Care engaged the services of consultant and collaborated with the Quality of Care Project at Mulago Hospital in Uganda, as well as stakeholders from other programs to prepare a separate module on counseling women who have experienced traumatic gynecologic fistula due to sexual violence. This module will be a supplement to the larger fistula counseling curriculum. The counseling curriculum content will be finalized in the second quarter of FY 10/11 and the supplement ready for piloting by March 2011 in the DR Congo .

Fistula Counseling Follow up Evaluation. Levent Cagatay, Senior Technical Adviser/EngenderHealth and Mieke McKay, Senior Program Associate/Fistula Care visited Bamako and Mopti, Mali in March 2010 to introduce standardized follow-up activities to evaluate the knowledge and skill of trainees in fistula counseling following the fistula counseling training held in August 2009. The service providers from Mopti Regional Hospital who were trained to provide fistula counseling were observed providing counseling to fistula clients and received mentoring and coaching on ways to improve their skills. Those trained as trainers were observed in their capacity to observe and provided mentoring and coaching on fistula counseling. Three follow up tools to assist with assessing trainee skills were pre tested. Two of the three trainees demonstrated markedly improved skills during the visit. It was suggested that the trainee who did not improve work more closely with another trainee based at Mopti Hospital to improve her skills.

Feedback was given to the national trainers on using a follow-up checklist, using facilitative techniques during coaching and improving interaction during debriefs, thereby reinforcing their capacity to provide fistula counseling training and to provide standardized training follow-up. The training and follow-up has been replicated in Gao Hospital.

Curriculum on Prevention and Management of Obstetric Fistula for Nurses and Midwives. With funds from USAID East Africa, the East, Central and Southern Africa Congress of Nurses (ECSACON) has developed this curriculum in collaboration with the Fistula Care team. The development of the curriculum began in FY 07/08. The purpose of the curriculum is to impart knowledge, attitudes and skills in nursing and midwifery tasks in prevention of fistula, as well as pre-, intra-, and postoperative care for women who receive fistula treatment. The training package includes a facilitator's guide and participant handbook. A draft of the training materials was completed in September 2009. Throughout FY 09/10 the Fistula Care Global team has been reviewing the material. We had expected to publish the materials by April 2010, however after reviews were completed by trainers it was decided that there were issues to do with the organization of

the training material that needed resolution before moving forward with publication. In order to expedite the finalization of the materials ECSA and FC decided it would be more efficient and effective to have a consultation meeting to discuss outstanding issues. A three day meeting is planned for December 2010 in New York City with two representatives from ECSACON, selected FC global team members, an EngenderHealth editor and an Instructional Design consultant. The outcomes of this meeting will be discussed in the October-December 2010 Quarterly Report.

Job Aids for Providers. The program in Ethiopia developed fistula screening job aids (poster and brochure) to assist providers in screening women presenting with incontinence. These materials are available on the Fistula Care web site:
http://www.fistulacare.org/pages/pdf/FC_Tools/Handout_IH_logo.pdf
http://www.fistulacare.org/pages/pdf/FC_Tools/Poster_IH_logo.pdf

Hard copies of these English-language materials were distributed in Ethiopia, Sierra Leone, Bangladesh, and Rwanda. French-language materials will be finalized and distributed in the next fiscal year.

A provider brochure on informed consent for fistula services was developed. The booklet entitled “Informed Consent in Fistula Care” (adapted from EngenderHealth’s work on informed choice for sterilization) was designed primarily for services providers at the facility level, but can also be used to inform and support the work of a variety of audiences responsible for policy, management, and supervision of services. This material offers detailed information about the process for obtaining informed consent as well as the information that should be given to the client. This material is being incorporated into the Fistula Counseling Curriculum (see below for an update). Graphic design has been completed. Country programs are sharing feedback on how they would use the materials in their setting and the quantities that they would anticipate needing. Distribution of materials and translation into French will happen in the next FY.

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

Levels of Care Framework for Fistula Services. This framework is intended to capitalize on public interest in increasing access to fistula services, using a strategic approach to link a network of sites to facilitate prevention, diagnosis, limited treatment and referral, treatment of simple cases, treatment of complex cases and the establishment of one or more sites capable of providing training in fistula. The Guinea program has embraced this framework and now supports six level one facilities and three sites which are considered level two/three where fistula surgery is available. A comprehensive evaluation of implementation of this framework in Guinea is under development and will be conducted in FY 10/11. In Uganda work began in the latter half of the year to build a network of level one sites linking them to Kagando and Kitovu Hospitals where fistula repair services are provided. In addition, the National Fistula Technical Working Group is currently reviewing this approach and considering how to harmonize it with the National Policy Guidelines on Sexual and Reproductive Health and Rights. The approach has also been included in strategy recommendations developed for the Nigerian and D.R. Congo programs.

Strengthening fistula prevention services is a key component addressing fistula. Fistula Care is focusing on four key prevention measures: family planning, consistent and correct use of the partograph, immediate catheterization for women who experience obstructed labor, and strengthening cesarean delivery services. Summarize below are key activities undertaken in FY 09/10 to strengthen these services at supported sites.

Family Planning

Family Planning Counseling and Provision of Methods. The total number of sites supported through the Fistula Care project for provision of family planning counseling and/or method provision has tripled since the first year of the project; see Table 12. A total of 64 supported sites reported on provision of FP counseling and/or FP methods this FY, nearly double the number from FY 08/09. The majority of facilities reporting on FP services are located in Nigeria (42%); the Nigeria program tripled the number of supported sites providing FP services between FY 08/09 and FY 09/10; 26 of these sites are solely supported for family planning services. All of the Fistula Care supported sites which provide fistula repair services also provide FP counseling; only three repair sites do not provide FP methods (Kitovu in Uganda, Ebonyi and Laure Fistula Center in Nigeria). As shown below, in FY 09/10 FC supported facilities reported more than 40,000 persons counseled for FP and accepting a FP method during FY 09/10.

Table 12 Number of Persons Counseled for Family Planning and Accepting a Method, by Country and Year, Fistula Care Supported sites

	FY 07-08	FY 08-09	FY 09-10	Total
Bangladesh				
Number of Supported Sites Reporting	3	3	4	
Number Counseled for FP	5635	3234	16970	25839

	FY 07-08	FY 08-09	FY 09-10	Total
Number of FP acceptors	3722	2959	16970	23651
DR Congo³⁵				
Number of Supported Sites Reporting	NA	1	2	
Number Counseled for FP	NA	1	2954	2955
Number of FP acceptors	NA	59	1633	1692
Ethiopia³⁶				
Number of Supported Sites Reporting	NA	3	3	
Number counseled for FP	NA	101	156	257
Guinea				
Number of Supported Sites Reporting	2	7 ³⁷	9	
Number Counseled for FP	147	1175	3458	4780
Number of FP acceptors	214	912	1967	3093
Mali				
Number of Supported Sites Reporting	0	1	1	
Number Counseled for FP	0	444	220	664
Number of FP acceptors	0	2054	220	2274
Niger				
Number of Supported Sites Reporting	4	4	4	
Number Counseled for FP	2998	3115	3083	9196
Number of FP acceptors	1952	3546	3080	8578
Nigeria³⁸				
Number of Supported Sites Reporting	5	9	28	
Number counseled for FP	8165	11959	13269	33393
Number FP acceptors	NA	NA	10249	10249
Rwanda				
Number of Supported Sites Reporting	2	2	3	
Number counseled for FP ³⁹	NA	2	NA	2
Number FP acceptor	131	180	1183	1494
Sierra Leone⁴⁰				
Number of Supported Sites Reporting	1	1	1	
Number Counseled for FP	25	130	51	206
Number of FP acceptors	6	47	27	80
Uganda				
Number of Supported Sites Reporting	2	2	9	
Number Counseled for FP	379	805	1017	2201
Number of FP acceptors	89	267	4,209	4,565
Total All Countries				
Number sites reporting FP services	22	33	64	
Number Counseled for FP	17,349	20,966	41,178	79,493
Number of FP acceptors	6,114	10,024	39,538	55,676

NA: not available

³⁵ In FY 09/10 in DR Congo one site did not report on numbers counseled.

³⁶ Pre Repair centers in Ethiopia do not provide FP. They counsel and refer fistula patients for FP to the nearby health center. In FY 07/08 data fistula patients no reported; in FY 08/09 data were reported for three quarters. AAFH supported sites do not report on FP services.

³⁷ In FY 08/09 one site in Guinea did not report on counseling.

³⁸ Nigeria did not report on number of acceptors of methods in FY 07/08 and FY 08/09. In FY 09/10 26 of the 28 sites provided FP supplies; 2 sites only counseled and referred for FP.

³⁹ In Rwanda the site record keeping systems are not set up to report on number counseled.

⁴⁰ Between September 2008 and January 2010 Marie Stopes provided these services at the center. The center now has trained staff and supplies to provide FP services.

Job Aids for Providers and Patient FP Materials Finalized. During this FY USAID approved three products for prevention:

- Two job aid posters for providers: *FP Methods Quick Reference chart* and *FP-Integrated Counseling Pathway*;
- Client brochure on FP methods

These documents are the products of work done to effectively integrate family planning into fistula and other maternal health services. They give providers memory triggers, reference on newly learned content in FP, and guidance on tailoring counseling to help clients meet their fertility intentions. The client brochure on FP methods was designed in a concise and simple format to encourage couples to make informed decisions.

Partograph

The partograph is a labor monitoring tool that, if used consistently and correctly, alerts health care providers of the need to intervene (or refer) in an emergency and facilitates clear communication between staff. It is also used in training and serves as a checklist of all the elements for labor monitoring. The Fistula Care Project, with its aim of reducing fistula, supports fistula repair but also key interventions to prevent obstructed labor, the primary cause of obstetric fistula. Strengthening partograph use in facilities at different levels of the health systems is one of these key prevention interventions

As discussed above in section 1 about benchmarks, in FY 09/10 the Fistula Care team developed a tool to monitor use of the partograph in supported sites. After agreement on the content for the tool and the objectives of data collection, a methodology for simple sampling was suggested and the team proposed it to some sites in Uganda as a test. The report on Uganda sites was encouraging and suggestions for refinements were given

A final document was shared with Fistula Care programs in five countries for use in reporting for this annual report. Data were collected by Fistula Care staff and whenever possible with country partners. The results of each site review were communicated to the sites and program action plans are under development where needed to improve the use of the partograph

Shown in Table 13 are the findings from 24 sites in 5 countries.

- ***Number of files examined.*** According to the protocol, the number of files examined was dependent on the number of the deliveries in the facility. Busy hospitals, with more than 25 deliveries in the review period (60 days prior to the review) selected between 23 and 25 cases. Some health centers with fewer than 25 deliveries consulted all files for all deliveries in the review period.
- ***Number of partograph found.*** Of 522 files examined, 63.3% included a partograph. Only 5 facilities had 100% of partograph in all mother's files: LAMB and Ad-din Dhaka Hospitals in Bangladesh; Kasese Town counsel and Karambi III in Uganda; and Ruhengeri Hospital in Rwanda. In Labé Hospital (Guinea) and in health center Kiyumba level IV and Kasambya level III (Uganda) no

partograph was found but incomplete follow up notes are written in the patient file.

- ***Number of partographs 100% correctly filled.*** Where partographs were found, 38.6% were 100% correctly filled.
- ***Number of partographs partially correctly filled.*** Of the 329 partographs found, 35.5% were partially filled but some data were missing. Monitoring of the labor was not completely done.
- ***Number of partographs not filled in correctly at all or blank.*** Twenty-six percent (26%) of partographs found were blank or not filled in correctly at all. Nyabugando Health Center III in Uganda and Ad-din/Jessore in Bangladesh had the highest percentage of incorrectly filled partographs.

In summary, further enquiry is needed into why partographs were not found; it could be a supply issue or a matter of staff not understanding the tool's purpose and use. In the case of partially filled partographs, it is unclear if labor monitoring was well done and providers were simply unable to fill the partograph or if procedures were not done. In some countries there is evidence that the partograph is filled in after the delivery as a formality.

The findings of this first round of using the assessment tool show clearly where some of the needs are in terms of strengthening the monitoring of labor and the results will help refine programming support. The tool will be further refined based on feedback from this first round. Conducting the review annually will generate trends illustrating changes in detecting possible complications and timely, appropriate management of labor.

In FY 09/ 10 a partograph literature review was conducted and the Project participated in international fora that covered partograph use to better understand the value the partograph has for the providers, its use, and in what conditions it works best. The literature review summarizes the available literature in scientific and programmatic publications on: use and efficacy of the partograph; training strategies for introduction and effective implementation of the partograph; and barriers to partograph use. The review is being finalized and will be available in the beginning of the next fiscal year. We expect this report will help frame future discussions about strategies to strengthen its use.

Table 13. Summary of Partograph Use Review Results by Country and Facility, FY 09/10

Country/Facility	Number of patient records examined/sampled	Number of partographs found	Number of partographs 100% correctly filled	Number of partographs partially correctly filled	Number of partographs not filled in correctly at all or blank
Bangladesh					
LAMB Hospital	25	25	20	2	3
Ad-din Hospital, Dhaka	25	25	2	2	21
Ad-din Hospital, Jessore	25	19	5	14	0
Kumudini Hospital	25	10	10	0	0
Guinea					
Labe	18	0	NA	NA	NA
Mali					
Gao Hospital	27	15	8	6	1
CS Ref Gao	31	28	20	8	0
CS Ref Ansongo	29	19	12	7	0
CS Ref Menaka	12	2	1	1	0
CS Ref Bourem	32	25	18	7	0
Uganda					
Nyanbugando Health Center III	15	14	0	0	14
Kitovu Hospital	26	6	1	4	1
Masaka Regional Hospital	25	7	0	3	4
Kalungu Health Center III	19	5	0	5	0
Kiyumba Health Center IV	22	0	NA	NA	NA
Kasambya Helath Center III	24	0	NA	NA	NA
Lwengo Health Center	11	11	6	5	0
Kagando Hospital	26	21	1	10	10
Bwera Hospital	22	21	0	10	11
Rwesande HCIV	27	23	0	5	18
Kasese Town Counsel	5	5	0	3	2
Karambi III	3	3	2	1	0
Rwanda					
Kanombe Hospital	24	21	1	20	0
Ruhengeri Hospital	24	24	20	4	0
TOTAL	522	329 (63%)	127 (38.6%)	117 (35.5%)	85 (25.8%)

In addition, we organized a panel on the use of partograph at the August 2010 Maternal Health Task Force (MHTF) meeting in Delhi (and presented the findings from the literature review). We are reviewing the WHO proposed Safe Birth Checklist to determine if and how it might be used in supported sites. We have had discussions with the Gates Funded MHTF and will be organizing a jointly-sponsored meeting on the partograph in FY10/11, with issues framed by the literature review.

Promoting the Use of the Catheter to Prevent or Treat Fistula Associated with Prolonged or Obstructed Labor

Immediate catheterization can be used both as a prophylaxis and as primary or principle treatment. In the case of prophylactic use, it may require a period of 7-14 days in-hospital stay. For primary treatment, it may require 3-4 weeks in-hospital stay. Training is required to effectively recognize the type of fistula that would respond to this kind of treatment. FC has begun to include this intervention as a part of a package of EmOC training in Rwanda and Uganda. The project promoted its inclusion in recommendations for strategies at the national level in both Nigeria and the D.R. Congo. We will be working to prepare evidence-based guidelines in the coming year.

Strengthening Cesarean Delivery Services.

Approximately 10-15% of fistula cases are iatrogenic, although it is not known what percentage of that number are related to cesarean deliveries. Fistula Care will work with sites who have expressed interest in addressing poor cesarean performance as a means of reducing the number of fistula cases. Addressing this issue will require a step-wise approach to determine what policies exist regarding who can do cesarean deliveries, what training or refresher training is required, what reference materials, equipment and supplies are in place or required, the availability of blood, training in life-saving skills, etc. In FY 09/10 a total of 525 persons in 8 countries attended training related to obstetric services which included issues around cesarean section.

Deliveries and Cesareans Sections. During FY 09/10, 23 FC supported sites which provide delivery services reported on the number of deliveries and where available/provided, the number of cesarean sections. As shown in Table 14 the proportion of deliveries which were C-sections ranged from 6% at four general hospitals in Nigeria to more than 60% at two sites in Bangladesh. Many of the institutional rates are high because the facility is a tertiary facility that may often be the only facility in a region /district that can provide cesarean services. As part of our on going work with facilities about cesarean services we will gather more information about the availability of the maternity services in the regions/districts where these facilities are located to better understand the rates.

**Table 14. Number of Deliveries and Cesarean Sections
Selected Fistula Care Supported Sites,
by Country, October 2009 – September 2010**

Country, site	Number Deliveries	Number cesarean deliveries	Cesareans as % of all Deliveries
Bangladesh			
Ad-Din Dhaka	8580	5797	67%
Ad-Din Jessore	3189	1955	61%
Kumundini	1779	777	44%
LAMB	3457	824	24%
DR Congo			
HEAL	1042	133	13%
Panzi	1822	445	24%
Guinea			
Kissidougou	800	407	51%
Ignace Deen	3570	1238	35%
JP II	494	64	13%
Labe	885	281	32%
Kindia	1175	333	28%
Mamou	1268	423	33%
Boke	1448	362	25%
Faranah	600	158	26%
N'Zerekore	996	414	42%
Mali			
Gao	1177	259	22%
Niger			
Dosso	1967	315	16%
Issaka Gazobi	4397	2916	66%
Maradi	2134	955	45%
Nigeria			
Faridat Yak.	745	161	22%
Maryam Abacha	462	43	9%
GH D/D	36	4	11%
GH Kamba	212	14	7%
GH Maiyama	277	17	6%
GH Argungu	331	21	6%
GH Jega	286	22	8%
Rwanda			
CHUK	1974	959	49%
Kanombe	3158	1012	32%
Ruhengeri	4713	1143	24%
Sierra Leone			
Aberdeen	217	35	16%
Uganda			
Kitovu	2284	863	37.8%
Kagando	3455	1238	35.8%
Total	58930	23588	40.0%

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

Completed, Ongoing and Planned Research

Completed Research.

Qualitative Study of Current Practices in Fistula Treatment. This study was completed in FY 08/09. The final report (*Identification of Current Practices In Fistula Treatment: A Qualitative Review*) was published and translated into French and shared on the partners section of the Fistula Care website in FY 09/10. During this FY a journal article was prepared for submission to the BioMed Central Journal of *Pregnancy and Childbirth* (during preparation of this report we learned it was accepted for publication; expected publication date is November 2010).

Ongoing Research.

A Multi-Centre Retrospective Review of Data Collection Procedures and Data Quality of Indications for Cesarean Deliveries. Following review, approval and pilot of this study in Uganda during FY 08/09, data collection for the study was carried out in three additional countries in FY 09/ 10: Bangladesh, Mali and Guinea and one more site in Uganda (Kitovu). The purpose of this study is to assess the availability and quality of data on indications for cesarean delivery. The results from this study will help Fistula Care to:

- Develop indicators to inform Fistula Care's ongoing prevention interventions;
- Identify current practices for how data is collected, reported and maintained concerning cesareans;
- Identify gaps which need to be addressed in order to improve data reporting systems for cesarean services and service delivery; and
- Contribute to the literature about the current trends for clinical indications for cesareans in selected facilities.

The study tools were translated into French during this FY. While the original plan was to conduct the record review study in DR Congo and Rwanda the work plans of the supported sites in those countries were not finalized in time. We therefore included Mali and Niger as there are plans to work on strengthening elements of obstetric care at those supported sites.

Summarized below is the status of data collection and dissemination for each country included in the study.

- **Uganda.** The study pilot, including modification of the data collection tools, was completed in October 2009 at Kagando Hospital. A draft report was prepared for the Kagando study and findings were presented and discussed with the Kagando Hospital staff in February 2010. The Kagando report was finalized in September 2010. The Uganda Country team developed an action plan with the hospital to follow up on recommendations. Data collection at the second Ugandan site (Kitovu Hospital) took place February; a draft report for Kitovu was presented to and discussed with site staff in September 2010. A final report for Kitovu will be disseminated in the next quarter.
- **Bangladesh.** Ms. Evelyn Landry traveled to Bangladesh in March 2010 to train the research teams for the study. Two teams were hired, one each to carry out data collection activities at LAMB and Kumudini Hospitals. Data collection took place March- April

2010. We had hoped to include a third site in Bangladesh (Ad Din in Dhaka), however the record books for 2008 were incomplete. Discussion at study sites of the draft reports and finalizations of reports and recommendations will take place early in the next fiscal year.

- **Mali.** In June/July Ms. Mieke McKay worked with the IntraHealth/Mali team to train two research consultants in data collection methods for cesarean record review study that was eventually carried out in Gao Hospital in July/August 2010. Preliminary results will be shared with the Mali team and Gao Hospital staff in Q1 of FY 2010- 2011.
- **Guinea.** In August 2010, Ms. Renée Fiorentino traveled to Guinea and trained the two consultant teams hired there to carry out the study in Kindia and Kissidougou Hospitals. Data collection was completed in September 2010. Analysis is underway with a goal of sharing preliminary findings with the Guinea FC team and hospital staff in January 2011.
- **Niger.** The final, fifth country, Niger, is on schedule to complete data collection by November 2010 (Ms. Fiorentino will travel to Niger in October 2010 to train the research teams).

We have reviewed a random sample of 3,289 cesarean records from calendar year 2008 in 10 facilities. Information on indications for cesarean are generally available and recorded in records at the facilities included in this study. The most reliable source for these data are the operating theater registers; in some study sites locating patient files was problematic. As shown below in Table 15, a total of 276 of the cesarean records reviewed included either obstructed labor or prolonged labor as the primary indication for the cesarean. We will be reviewing all the recorded indications from the study sites to determine if there are other indications besides obstructed labor/prolonged labor which could be used in determining whether an indicator for ‘fistula averted’ as a result of cesarean is an appropriate reporting indicator. The remaining individual site reports will be completed by April 2011 and a summary analysis by September 2011. We will convene a small working group of experts to review the findings.

Table 15. Cesarean Retrospective Record Review

	Number Records Reviewed	No./% of cesareans for obstructed labor (primary indication)	No./% of cesareans for prolonged labor (primary indication)
Kagando, Uganda	348	20 (11.5%)	43 (12.4%)
Kitovu, Uganda	349	15 (4.3%)	57 (16.3%)
LAMB, Bangladesh	348	15 (4.3%)	5 (1.4%)
Kumudini, Bangladesh	350	6 (1.7%)	14 (4.0%)
Gao, Mali	269	2 (0.7%)	3 (1.1%)
Kindia, Guinea	277	0 (0%)	0 (0%)
Kissidougou, Guinea	376	62 (16.5%)	1 (0.3%)
Dosso, Niger	299	0 (0%)	0 (0%)
Maradi, Niger	349	32 (9.2%)	1 (0.3%)
Tahoua, Niger	324	0 (0%)	0 (0%)
Total	3289	152 (4.6%)	124 (3.8%)

Determinants of Post-Operative Outcomes in Fistula Repair Surgery. Data collection for the study has drawn to a close. The last participants of the study were recruited at Lamordé Hospital in Niger in June 2010. By the end of June 2010 a total of 1499 participants had been enrolled, with 1464 having had fistula repair surgery. Overall we achieved 102% of the total recruitment in terms of surgeries completed relative to the number originally calculated for the study sample size (1436) which accounted for an estimated 30% lost to follow-up. Thirty-five women were determined to be ineligible for the study after enrollment, or were difficult cases that needed to be taken care of by surgeons with advanced expertise not available at the time of enrollment. These women were discontinued from the study, but their care continued according to normal procedures at the sites concerned.

Table 16. Study Progress through September 2010

Country	Site	# enrolled	# having surgery	# completing follow-up
Bangladesh	Kumudini Hospital	103	103	82
	LAMB Hospital	51	50	50
	Memorial Christian Hospital	5	5	5
Guinea	Kissidougou Hospital	265	260	251
Niger	Hôpital Lamorde	118	118	93
	Maradi	82	78	75
Nigeria	Mariam Abacha Hospital	69	64	56
	Faridat Yakubu Hospital	216	216	216
	Specialist Fistula Center Birnin Kebbi	155	155	151
Uganda	Kagando Hospital	180	180	180
	Kitovu Mission Hospital	255	235	211
Totals		1499	1464	1370

At all of the sites, except Lamordé, scheduled follow-up was to be completed by 30 September 2010. By that date, approximately 1370 women had returned for their three month post-surgery follow-up visit and therefore completed the study. Overall this represents nearly 94% follow-up (1370 women who have returned for 3 month follow-up/1464 women having surgery).

Data entry is now complete for 6 of the 11 sites (LAMB, MCH, Kissidougou, Maradi, Gusau, Kagando and Kitovu). A small number of forms from Kumudini, Lamordé, Sokoto, and Kebbi are yet to be received in New York.

Database cleaning continues. Questions, problems and irregularities identified during data entry are recorded on Data Problem Forms and sent to Fistula Care in-country staff or consultants, who then work with site staff to provide responses in an attempt to resolve the problems.

During this quarter, Vera Frajzyngier, who will use data from the study for her PhD dissertation, successfully defended her dissertation proposal at Columbia University. Two abstracts related to the study were submitted for the International Society of Obstetric Fistula Surgeons meeting to be held this December in Dakar, Senegal. Proposed papers from this study include:

- Review: What is known about predictors of successful fistula repair
- Identification of the classification system with the most discriminatory value for predicting fistula closure
- facility-based) predictors of fistula closure
- Predictors of stress incontinence at 3 months post-surgery
- Whether surgical route and duration of catheterization mediate or modify the relationship between fistula complexity and fistula closure at the three month follow-up visit
- Socio-structural factors associated with fistula: cross-country comparisons
- Clinical ramifications of the data

Planned Research

Randomized Clinical Trial for Short Term Catheterization. Little is known about current treatment practices for women suffering from fistula. In 2009, Fistula Care conducted an email and mail survey with fistula surgeons who perform surgery in Sub-Saharan Africa and South Asia to gather objective data about current practices in the care and treatment of fistula. Based on the findings from that study USAID and Fistula Care agreed to develop a clinical trial on the role of short term catheterization following fistula repair surgery. USAID invited WHO to review the concept note about the study and to participate in discussions about collaboration. In June 2010 Karen Beattie, Project Director, met with WHO staff in Geneva to discuss collaboration. In September, Fistula Care, WHO and USAID met to review a draft protocol prepared by the global team and to develop plan to move forward with the study. The study will be a joint venture between EngenderHealth and WHO with USAID funding; a memorandum of understanding is under development between the organizations. Fistula Care will convene a meeting with potential study site investigators and experts in fistula repair in December to review the draft protocol. Implementation will begin mid 2011.

Other Monitoring, Evaluation and Research Activities

Data for Decision Making Module Adapted for Fistula Care Programs. As part of FC's on going quality improvement technical assistance, Fistula Care adapted a module on use of data from EngenderHealth's *Facilitative Supervision for Quality Improvement* curriculum which was produced under the ACQUIRE project. The Fistula Care module was piloted in FY 08/09 as part of larger quality improvement exercises in two countries. The module was presented at the Medial Meeting in Uganda in February 2010 and was further piloted in Uganda and Ethiopia in FY 09/10. The material from the EngenderHealth curriculum has been adapted and designed with a specific focus on the Fistula Care clinical indicators for orientating three groups of health professionals:

1. Supervisors, either on-site or external, who attend facilitative supervision training: to orient them to their role in the process of assuring data quality in reporting and to improve their capacity to analyze, interpret, and use data for decision making and actions in the implementation of fistula programs
2. Facility-Level Providers: to improve the quality of data reporting and use of data at a facility level to improve services (The proposed exercises in this module can be carried out with facility staff by on-site or external supervisors.)
3. National-Level Stakeholders: to strengthen their ability to analyze, interpret, and use data for decision making (This module can be implemented by external supervisors or by key program advisors.)

While the modules include examples of data using the Fistula Care Project’s Clinical Monitoring Tool (Form 1A), trainers/facilitators are encouraged to adapt and use other data as necessary (e.g., family planning service statistics). The primary objectives of the modules and key concepts remain the same, regardless of what data are used. The modules were finalized in September and will be shared with USAID/W in the first quarter of FY 10/11 for review and approval. “Version 1.0” will be shared with country programs to support on going work in use of data (see below). Once the English version is approved and finalized it will be translated into French.

Estimating the Incidence of Fistula. It is commonly quoted that there are 2 million cases of fistula globally, and that the number of incident cases ranges from 50,000 to 100,000 cases annually, however the methods and assumptions used to create these estimates are not well documented. The true global prevalence of vaginal fistula (the number of women currently living with the condition) and incidence of vaginal fistula (the number of new cases over a defined time period) are unknown, and even estimates of obstetric fistula prevalence at the national-level, where they exist, must be interpreted with caution. During this year, Fistula Care worked with programs in Nigeria and DR Congo to estimate incidence as part of national strategy meetings, using assumptions about the proportion of prolonged obstructed labor and the proportion of those labors which develop into fistula. In the next quarter we will continue to provide technical assistance to countries to generate these estimates for planning purposes. We will produce a technical paper describing these methods.

Supported Sites Routine Review of Data. During this year 28 of 29 (97%) Fistula Care supported repair sites (including three pre repair sites in Ethiopia) held at least one meeting to review data. (Excluded from this analysis is the *Africa Mercy* and sites supported by USAID bilateral agreements in DR Congo and Ethiopia and one site in Niger which came on board in the last quarter of the FY). Four sites (14%) met at least once per quarter; one repair site in Guinea never met; see Table 17 Seven sites met more than 4 times (some sites met more than once in a quarter).

Table 17 Number of Meetings held to review data by Country and Site, October 2009 – September 2010

Country	Oct-Dec	Jan-March	Apr-Jun	Jul-Sept	FY Total
Bangladesh					
Kumudini	7	1	1	1	10
LAMB	0	1	0	2	3
Ad-Din Dhaka Hospital	0	0	3	3	6
Ad-Din Jessore Hospital	0	0	0	1	1
DR Congo					
HEAL Africa	n/a	n/a	n/a	n/a	n/a
Panzi	n/a	n/a	n/a	n/a	n/a
Guinea					
Jean Paul II	1	1	1	1	4
Ignace Deen	0	0	0	0	0
Kissidougou	1	1	0	1	3
Labé	1	1	0	0	2
Ethiopia					
Adet HC (pre-repair site)	2	0	2	3	7
Dangla HC (pre-repair site)	5	0	5	5	15
Woreta HC (pre-repair site)	3	0	6	5	14

Country	Oct-Dec	Jan-March	Apr-Jun	Jul-Sept	FY Total
Mali					
Gao	0	1	0	1	2
Niger					
Dosso	0	1	1	0	2
Lamordé	0	0	1	0	1
Maradi	0	1	0	1	2
Nigeria⁴¹					
Babbar Rugar	0	1	0	0	1
Ebonyi Center	0	1	0	0	1
Faridat	0	1	0	0	1
Kebbi	0	1	0	0	1
Laure Fistula Center	0	1	0	0	1
Maryam Abacha	0	1	0	0	1
Rwanda					
CHUK	0	1	0	1	2
Kanombe	0	1	0	1	2
Ruhengeri	0	0	0	1	1
Sierra Leone					
Aberdeen	1	1	1	2	5
Uganda					
Kagando	1	0	1	1	3
Kitovu	1	2	1	1	5
Total Number of Meetings	23	19	23	31	96
Total Number of Sites reporting	10	18	11	17	26

n/a: Data not available

⁴¹ In Nigeria there were no site specific meetings however fistula surgeons and nursing staff from each site reviewed data during a two-day fistula network meeting with the FC team.

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

Activities reported under this result include Fistula Care's work on policy-related issues, international collaborative partnerships, raising the visibility of fistula, and use of FC-produced products.

Policy and Advocacy

During FY 09/10, Fistula Care was actively engaged at the international, regional and country level to improve support for the institutionalization of fistula treatment and prevention services. These accomplishments included:

Briefing for United States Congress on Obstetric Fistula. In June 2010 Dr. Joseph Ruminjo and Ms. Josephine Elechi, the First Lady of Ebonyi State in southeastern Nigeria and the founder of the Mother and Child Care Initiative, were among a group who briefed members of Congress on obstetric fistula in Washington DC.

East, Central and Southern Africa Health Community (ECSA-HC) "Experts Meeting on Model Fistula Policy". In September 2010 Dr. Isaac Achwal participated in a four-day experts meeting in Nairobi to review and validate a regional Model Fistula Policy; work on this policy began in FY 08/09 with supported from USAID/East Africa and with technical assistance from Fistula Care. During this meeting the model policy was shared and reviewed with experts from the member states and partners in order to build consensus for ownership by member states of the ECSA Health Community. During the meeting advocacy and dissemination plans were drafted as well as an M&E framework. The policy will be presented at the East African Ministers' Conference to be held in Zimbabwe in October 2010.

Regional Centre for Quality of Health Care (RCQHC). In the second quarter of the FY Dr. Isaac Achwal, with support from USAID/East Africa, participated in a stakeholders meeting in Kampala, Uganda to review a female genital fistula care quality improvement training curriculum. The curriculum is an initiative of the RCQHC, directly funded by USAID/East Africa. Dr. Achwal chaired this meeting and contributed towards the completion of the curriculum. The curriculum is expected to be completed in 2011 and disseminated across the region.

In **Bangladesh** Fistula Care is the Secretariat of the National Task Force on Obstetric Fistula, which received official recognition from the Ministry of Health and Family Welfare in July 2010. During FY09/10, Bangladesh moved forward with the development of a National Strategic Vision on Obstetric Fistula. National advocacy meetings were organized in Dhaka during December 2009 and August and September 2010, jointly with the government and UNFPA, on the 'Campaign to End Obstetric Fistula in Bangladesh'. These meetings included stakeholders from the public and private sectors, providers, managers and development partners. Their work focused on identifying and developing the terms of reference for the national consultants to develop the strategic vision. In addition, the meetings facilitated the establishment of referral linkages between the National Fistula Center/DMCH and other fistula treatment sites located in Dhaka.

In **DR Congo**, at the request of the USAID Mission, Fistula Care collaborated with Project AXxes to bring together fistula surgeons for a meeting in Goma in November 2009 to discuss providers' perspectives on opportunities and needs to strengthen fistula services. A follow up meeting was held in Kinshasa in April 2010 for further discussion and to lay the foundation for a fistula provider network and Community of Practice. Participants included fistula surgeons from sites who are providing or are interested in doing fistula repairs. Other participants included a urologist from the Kinshasa Teaching Hospital, a uro-gynecologist from Harvard Humanitarian Initiative, representatives from the Ministry of Health, UNFPA, and NGOs with related health activities.

The need to review, update, and put into place a national strategy on fistula prevention, care, and treatment is a shared objective for the FC Project, the USAID Mission, and the fistula working group. UNFPA supported development of a first draft in 2006, but this document was never approved by the MOH and wasn't distributed. In the upcoming fiscal year, the DRC Community of Practice will meet again to update the strategy and further develop plans to form a national fistula service providers' network.

In **Guinea**, Fistula Care staff briefed the newly appointed Minister of Women and National Solidarity, Ms. Nanfadima Magassouba, on the activities of the Fistula Care Project. The 3rd Annual Fistula Day took place on May 28th, 2010, under the auspices of Guinea's First Lady. More than 200 people attended the ceremony, including several Ministers and other key officials and partners, community leaders, representatives from international NGOs, and public and private media. Karen Beattie's visit to Guinea included this ceremony as well as visits to partner sites and meetings with high profile Guinean government officials including the Minister of Health and the Minister of National Solidarity and the Promotion of Women and Children.

In **Nigeria** there were many policy-related activities carried out during the fiscal year. These included media events, and collaborations at both the national/federal and state level. A summary of these activities are as follows:

- *Senate Health Committee on Health.* Fistula Care/Nigeria organized a trip for representatives from this committee to visit five FC supported fistula repair in Sokoto, Kebbi, Zamfara and Ebonyi states in October 2009. A major outcome of this activity was the pledge made by the Senate chair to create a budget line specifically for Fistula intervention in the budget in 2010. The budget now awaits approval by the President. In May 2010 FC, along with other international and national NGOs, partnered with the Chairperson of the Senate Committee on Health to organize the second annual Mother's Night event. The highlight of this occasion was the recognition of persons who have played major roles in the improvement in the health of women in rural communities. Among the recipients this year, were two persons working in the area of fistula, - Mrs. Josephine Elechi, the Wife of the Governor of Ebonyi State and founder of the South East Regional Center, for her role in addressing fistula challenges in Ebonyi State, and Dr. Abba Wali for his untiring efforts at providing succor to women in Sokoto state through fistula repairs.

- *Ebonyi State.* The Mother and Child Care Initiative, in collaboration with FC, UNICEF and UNFPA, organized a two-day dissemination and tool development workshop for 102 members of the Ebonyi state level multi-sector Maternal Mortality and Morbidity Monitoring committee. This included representatives of religious and traditional institutions as well as civil society organizations, the legislature and line ministries in Health and Development. FC/Nigeria is working towards finalizing data capturing tools and training in their use, as well as printing and disseminating a reader friendly version of the Mother and Child Care Law currently in place.
- *Sokoto State Commissioner for Women Affairs.* The Nigeria Fistula Care Project held a policy dialogue with the commission to further discuss the need to establish a state level taskforce on fistula. As part of its advocacy activities, the project worked with the Honorable Commissioner to develop an initial list of possible members from different sectors of the government and civil society organizations (CSOs).
- *National Reproductive Health Working Group (NRHWG).* In June 2010 Fistula Care participated, along with more than 60 other representatives from federal ministries, departments, agencies, USAID implementing partners, NGOs, universities and health professional groups in this two-day meeting to review the final draft of the National Reproductive Health policy, and disseminate the Report on Key Interventions Promoting Maternal Health. The NRHWG is a national forum with representation from key stakeholders working in the area of reproductive health including public health regulatory bodies. At this meeting the Fistula desk officer from the Federal Ministry of Health made presentations on fistula activities throughout the country and highlighted the need to reconstitute the National Fistula Taskforce and well as the need to increase budgetary allocation for fistula interventions at the national level. The National Taskforce on Fistula, when reconstituted, will be an affiliate of the National RH Working Group
- *National Stakeholder Meeting Convened by Fistula Care.* At the request of USAID/Nigeria, the Fistula Care project organized a Stakeholder Meeting in April 2010 to review progress on implementation of the National Plan for VVF – 2005-2010, to discuss accomplishments and progress made, to identify gaps and to discuss strategies to address identified gaps. The Federal Ministry of Health, Family Health Department and UNFPA were invited to collaborate in this activity. This meeting was one component of an environmental scan of fistula prevention, treatment and reintegration services in Nigeria. A report has been prepared with recommendations and is under review by USAID/Nigeria.

In December 2009 Fistula Care collaborated with the Ministry of Health, and Rwanda Medical Association in **Rwanda** to hold a two-day meeting on fistula prevention through the integration of family planning with fistula and other maternal health services. The goal of the meeting was to engage policymakers, health care officials and leaders at the district and national levels in the issue of fistula in Rwanda and to stimulate thinking among stakeholders of the value of family planning in fistula prevention as well as the role that they can play in facilitating integrated fistula services. Meeting participants generated a list of achievable recommendations to the MOH to be taken into consideration for developing a strategic plan to operationalize FP-integration with fistula and other maternal health services. Following this meeting Fistula Care staff participated in meetings of the Family Planning Technical Working Groups which is drafting a family planning strategy. Throughout the year the Fistula Care team in Rwanda

participated in meetings with the Safe Motherhood Technical Working Group to discuss the development of fistula strategy. Both strategies are expected to be finalized in the next FY.

In **Sierra Leone** the Ministry of Health and Sanitation held a series of meetings with national NGOs, including the Aberdeen Women's Centre (AWC), and UNFPA to discuss the government strategy "Agenda for Change". The government wants to promote multi-agency collaboration on fistula prevention and treatment; AWC has been identified as the leading facility in-country for effective care. The strategy includes developing a wider screening program to sensitize patients and to increase awareness of fistula, its prevention and thus increasing access for patients to the availability of treatment services.

The Fistula Care team in **Uganda** has been involved in several national level activities this year.

- *National Fistula Strategy*. With support from UNFPA, the Ministry of Health is developing this strategy. A situational assessment and a draft National Strategy have been prepared and are under review; Dr. Isaac Achwal, Senior Medical Associate for FC, served as a resource person for UNFPA's writing of Uganda's National Fistula Strategy.
- *Fistula Technical Working Group (FTWG)*. The FTWG is a group convened by the Ministry of Health of all partners working on fistula. The Fistula Partnership Forum is a group of NGOs that are supporting fistula activities in the country. Fistula Care supported several meetings of this group as well as participated in the Fistula Partnership Forum meetings. The Levels of Care Framework was introduced and was well received by the FTWG; recommendations were made to adopt the framework for inclusion in the National Guidelines for Sexual and Reproductive Health as well as the National Fistula Strategy currently under development. Other policy related issues discussed by the working group included adoption of an essential drugs, equipment and consumables list for fistula, a formal system of certification for surgeons and other service providers and standardization of partograph usage in Uganda.
- *DHS Module on Fistula*. FC has been working with UNFPA, USAID/Uganda, and Ugandan Bureau of Statistics on the inclusion of questions on fistula in Uganda's upcoming DHS.

Collaborations

In addition to partnering with USAID/W, USAID Missions and our in-country counterparts which include governments, private and missionary hospitals, the project has been managing an impressive array of partnerships and collaborations. IntraHealth International, a partner on the project, in consultation with EngenderHealth, has taken the lead on fistula activities in two countries: Ethiopia and Mali. The project continues to collaborate with UNFPA Campaign to end Obstetric Fistula and the International Obstetric Fistula Working Group (IOFWG). This collaboration covers the full range of fistula activities and issues – prevention, treatment, classification, research, indicators, etc. Although there have been no formal meetings of the IOFWG since June 2009 in Tanzania, we have continued to communicate with UNFPA both at the central and at the country levels. UNFPA was invited to participate in both strategy exercises organized by the project in Nigeria and in the D.R. Congo. In addition, the project is participating in international initiatives of the International Society of Obstetric Fistula Surgeons, the Pan-African Urological Surgeons Association, the International Federation of Obstetricians and Gynecologists, especially in support of the development of training curricula for surgeons

Other important and strategic alliances described earlier in this report are with FIGO and WHO.

Fistula Care collaborated with **UNFPA and Silence Speaks** to develop an article about the DVD “Learn From My Story: Women Confront Fistula in Rural Uganda” and its accompanying Facilitator’s Guide. The article is available at http://www.endfistula.org/news_features_digital_stories_4oct10.htm.

Fistula Care was invited to provide a technical and programmatic voice in a coalition of policy-focused groups (including the Goodworks Group, UNFPA, UN Foundation, Fistula Foundation, CARE, Human Rights Watch, White Ribbon Alliance, Guttmacher Institute, United Methodists, and the National Council of Churches). This group has discussed putting forward a series of articles about fistula programming and needs to be published in an online magazine.

Raising the Visibility of Fistula with External Audiences

During FY 09/10 the issues of fistula and prevention were highlighted in several different ways: presentations at professional conferences, dissemination of lessons learned through the technical brief series, the project newsletter and web site, and the media. A summary of each of these categories is listed below.

Presentations at Professional Conferences. During FY 09/10 Fistula Care staff and partners made a total of 20 presentations at eight international meetings about Fistula Care research and project activities; a full list of presentations for this FY and the previous two FY are included in Annex 4. Presentations at international meetings in FY -9/10 included:

- FIGO World Congress of Gynecology and Obstetrics, Cape Town (October 4th-October 9th, 2009; 4 presentation/posters)
- Ninth Annual Global Health Mini University, Washington D.C. (October 9th, 2009; 1 presentation)
- APHA 137th Annual Meeting, Philadelphia (November 7th-11th, 2009; 1 poster, 1 presentation)
- ISOFS Third Annual Meeting (Nairobi November 25th-November 27th, 2009; 1 paper)
- Unite for Sight 7th Annual Global Health & Innovation Conference, Yale University, (April 17th-April 18th, 2010; 1 poster)
- Women Deliver Conference, Washington D.C. (June 7th-June 9th, 2010; panel)
- 37th Annual International Conference on Global Health, Washington, D.C. (June 15th, 2010; 1 poster)
- Maternal Health Taskforce Global Maternal Health Conference, New Delhi, India (August 30th-September 1st, 2010; 7 papers, 2 posters)

Fistula Care Technical Briefs. During this FY two technical briefs were completed: *A Collaborative Network to Improve Access to Fistula Treatment in Nigeria* and *Beyond Repair: Involving Communities in Fistula Prevention and Social Reintegration—Experience from Kissidougou, Guinea*. The Nigeria brief is posted on the Fistula Care web site (http://fistulacare.org/pages/pdf/technical-briefs/Nigeria_pooled%20effort_brief_.pdf) and was disseminated by the project newsletter; hard copies were sent to Nigeria for distribution.

The English version of the Guinea brief was finalized in September 2010; the French version will be finalized in October 2010; both versions will disseminated via the quarterly newsletter as well in Guinea by project staff. As this report went to press both versions were posted to the Fistula Care Web site: <http://www.fistulacare.org/pages/resources/publications/technical-briefs.php> (English) and <http://www.fistulacare.org/pages/fr/resources/publications/technical-briefs.php> (French)

Outlines for three additional briefs were prepared in the final quarter of the FY: levels of care framework, mobile phone programs to reach women with fistula in Kenya and Tanzania, and the Sierra Leone Aberdeen Women's Centre's transformation from a stand-alone fistula repair center to one which now encompasses fistula prevention and obstetric care. We expect to publish these briefs by September 2011.

Fistula Care Newsletters and Web Site. The first issue of the Fistula Care Newsletter was launched in March 2010. Newsletters are issued quarterly and back issues are available at <http://www.fistulacare.org/pages/resources/newsletters.php>. Three issues were disseminated during the FY. Each issue highlights Fistula Care products and publications, newly available web content, and updates from country programs. In addition, newsletters list forthcoming meetings, highlight champions for fistula programming, and let subscribers know how many repairs have been made possible at USAID-supported sites to date. A total of 149 people have subscribed to receive Fistula Care updates.

The Fistula Care website continues to be updated with project highlights, stories from the field, and program statistics. During the period of October 2009 to September 2010 there were 10,692 visits from 2,475 cities; see Figure 5. At the end of September 2010, there were a total of 15,222 visits since the website's launch in March 2009.

Media. During the July to September 2010 period EngenderHealth board member Belle Taylor-McGhee wrote "The Right of Every Woman," published in the [Summer 2010 Issue of Ms. Magazine](#). The article discusses maternal mortality and morbidity in Uganda, mentioning Fistula Care and EngenderHealth and quoting Dr. Peter Mukasa, Fistula Care Senior Medical Associate in Uganda.

During the FY we tracked 10 articles about work related to fistula were produced in the press in the United States and two articles in Nigeria which featured the visit of EngenderHealth's president; see Annex 5. In addition to these articles about fistula, articles also appeared in other news media in Nigeria, see country report below.

**Figure 5: Geographic Distribution of Fistula Care website visitors
October 2009- September 2010 (Google Analytics).**



Other activities. In addition to the presentations at professional meetings, Fistula Care global team members also attended other meetings representing EngenderHealth/Fistula Care:

- Karen Beattie participated in a two day meeting hosted by Health Development International at the Carter Center in Atlanta (March 2010) to review an approach to community and facility based prevention of obstructed labor and obstructed labor.
- Carrie Ngongo was a guest speaker on a panel presentation at Advent Lutheran Church: “Maternal Health – The Issues, The Challenges, The Opportunities” in April 2010 in New York City.
- Carrie Ngongo participated in two UN related events. In February she attended a day long meeting with the UN Foundation along with representatives from nine other organizations working on fistula treatment and prevention or involved in advocacy for fistula to discuss mechanisms for improving collaboration. In June she was an EngenderHealth representative to a meeting at the UN-- “Informal Interactive Hearings of the General Assembly with Non-governmental organizations, Civil society organizations and the Private sector.

Use of Fistula Care Technical Products at Supported Sites

During this FY a total of 60 supported sites (71 % of all supported sites), including 3 sites supported by USAID/Ethiopia reported using at least one FC tool; see Table 18. Besides the quarterly reporting forms, the most widely used tool reported was the Monitoring and Supervision for Delivery Check list (used at 39 facilities) followed by medical waste monitoring, tool and the surgeon training knowledge assessment tool. Use of these three tools increased over use in the last year.

Table 18. Use of Fistula Care Technical Tools by Country and Site, October 2009- September 2010

Country/Site	Quarterly Reporting Tools	Monitoring/Supervision for Service Delivery Check list	Medical Waste Management ⁴²	Training Strategy	Training Knowledge Assessment Tool	Monitoring/Supervision for Training Site	Fistula Site Assessment Tool	Fistula Standard Equipment List	Fistula Counseling Curriculum
Africa Mercy									
Benin	X			X	X				
Togo	X			X	X				
Bangladesh									
Kumudini	X	X	X						
LAMB	X	X	X						
Ad-Din Dhaka	X	X	X						
Ad-Din Jessore	X	X	X						
DR Congo									
HEAL Africa	X	X	X						
Panzi	X	X	X						
Ethiopia									
Bahir Dar Ctr	X								
Mekelle Ctr	X								
Adet HCtr	X		X						
Dangla HC	X		X						
Woret HC	X		X						
Guinea									
Ignace Deen	X		X						
Jean Paul II	X		X	X					
Kissidougou	X	X	X						
Labé	X		X	X					
Mamou	X								
Kindia	X								
Boke	X								
Faranah	X								
N'Zerekore	X								
Mali									
Gao	X		X	X	X	X			X
Niger									
Dosso	X		X						
Issaka Gazobi	-		X						

⁴² A section in the Monitoring /Supervision for Service Delivery Check List.

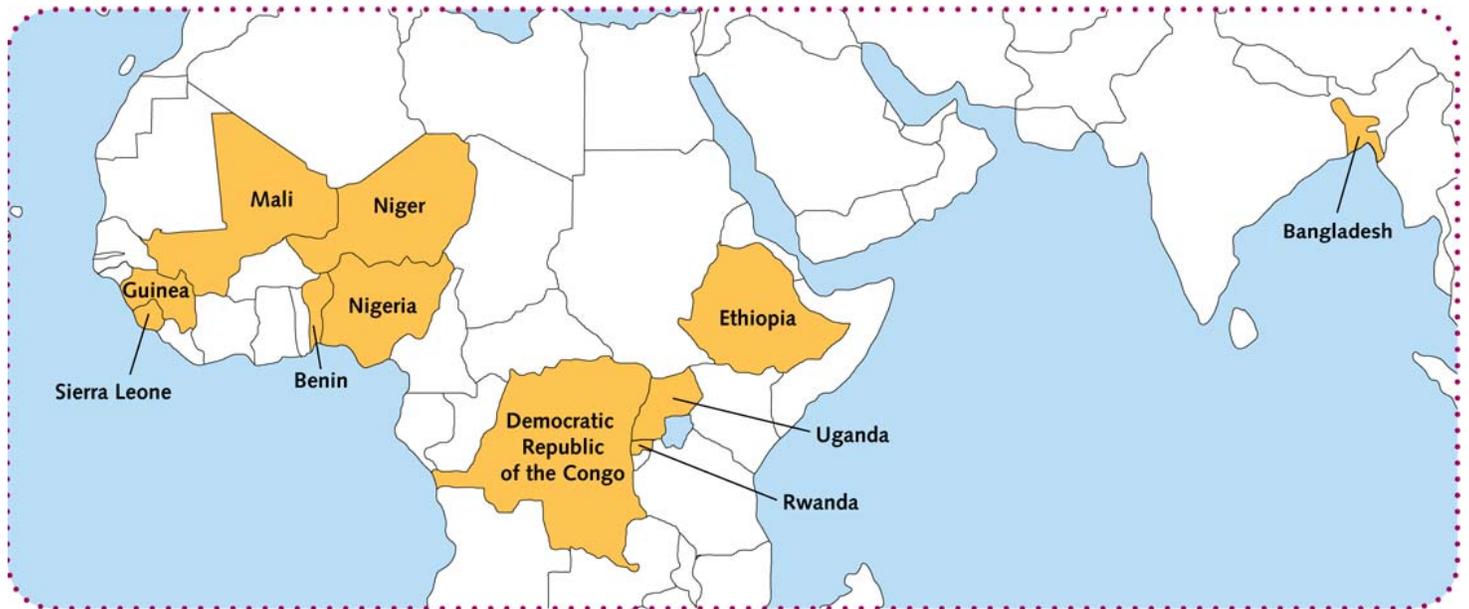
Country/Site	Quarterly Reporting Tools	Monitoring/ Supervision for Service Delivery Check list	Medical Waste Management ⁴²	Training Strategy	Training Knowledge Assessment Tool	Monitoring/ Supervision for Training Site	Fistula Site Assessment Tool	Fistula Standard Equipment List	Fistula Counseling Curriculum
Lamordé	X		X						
Maradi	X		X						
Nigeria									
Babbar R.	X	X	X		X				
Ebonyi Center	X	X	X		X				
Faridat Yak.	X	X	X						
Kebbi	X	X	X		X				
Laure Fist. C	X	X							
Maryam Abacha	X	X							
<i>Prevention only sites :</i>									
Bakura General Hospital, Zamfara	X	X							
Takai Community HC, Kano	X	X							
Comp. HC, Kano	X	X							
Tarauni MCH , Kano	X	X							
Unguku MCH, Kano	X	X							
Muhammadu A. Wase Specialist Hosp. Kano	X	X							
General Hospital, Arungu	X	X							
General Hospital Dakingari	X	X							
General Hospital Maiyama	X	X							
General Hospital Kamba	X	X							
Bungudu General Hospital, Zamfara	X	X							
MCCI FP Clinic	X	X							
Ezangbo Maternity Hospital	X	X							
Mgbo PHC	X	X							
Owutu Edda General Hospital	X	X							

Country/Site	Quarterly Reporting Tools	Monitoring/ Supervision for Service Delivery Check list	Medical Waste Management ⁴²	Training Strategy	Training Knowledge Assessment Tool	Monitoring/ Supervision for Training Site	Fistula Site Assessment Tool	Fistula Standard Equipment List	Fistula Counseling Curriculum
Cottage Hospital	X	X							
General Hospital,, D/D	X	X							
Ebonyi State University Teaching Hospital	X	X							
Iss General Hospital	X	X							
Jabo PHC	X	X							
General Hospital, Jega	X	X							
General Hospital, Rabah	X	X							
Rwanda									
CHUK	X	X	X		X				X
Ruhengeri	X	X	X						X
Kanombe	X		X		X			X	
Kibogora*							X		
Nyamata*							X		
Butare*							X		
Sierra Leone									
Aberdeen	X								
Uganda									
Kagando	X	X	X		X			X	X
Kitovu	X	X	X	X	X	X		X	X
Total sites using tools	60	39	27	6	10	2	3	3	5

*Sites involved in site assessment, but not currently supported by Fistula Care.

IV: Country Reports

Summarized below are key achievements for October 2009 through September 2010 period for each country. These reports highlight major accomplishments for the last year.



BANGLADESH



Program Background

Service start date: July 2005

Sites: Four private hospitals:

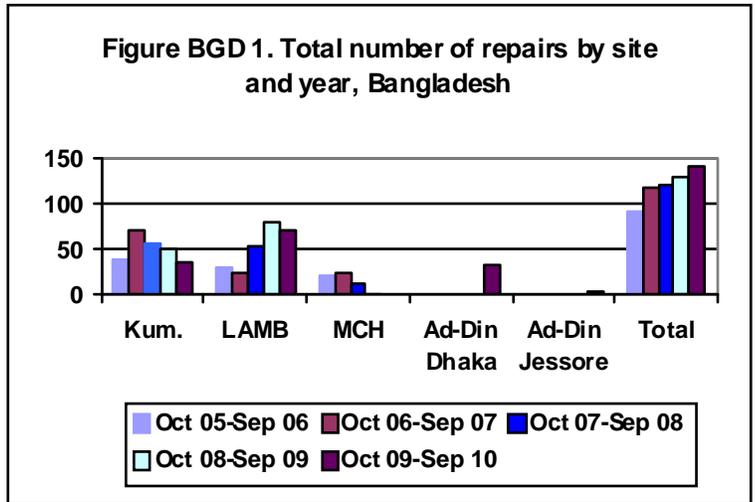
- Kumudini Hospital, Mirzapur, Tangail
- LAMB Hospital, Parbatipur, Dinajpur
- Ad-din Hospital, Dhaka
- Ad-din Hospital, Jessore

In November 2009, a subaward was approved providing support to the Ad-Din Hospitals in Dhaka and Jessore. Ad-Din/Dhaka is now providing routine services while Ad-Din/Jessore provides periodic outreach repair services. As of the end of December 2008, Memorial Christian Hospital is no longer participating in the project.

The Fistula Care Bangladesh office has continued efforts to raise private funds locally from corporations and individuals to support the treatment expenses for fistula patients. Major contributors included HSBC, UK and NuVista Pharma Ltd., with the remaining donations coming from individual donors.

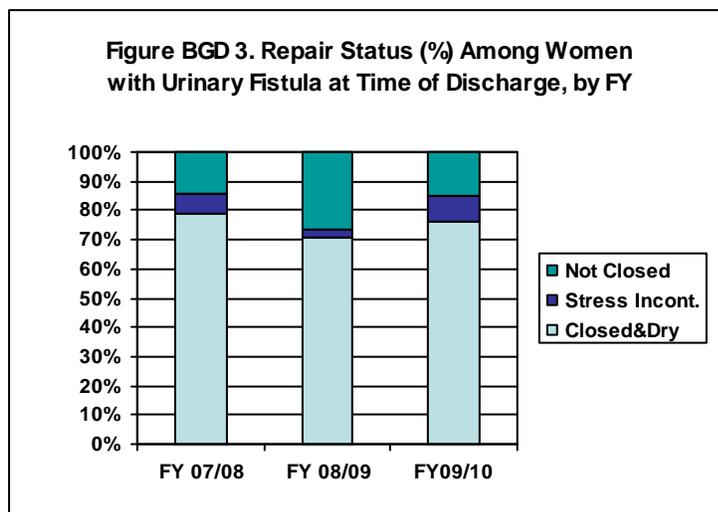
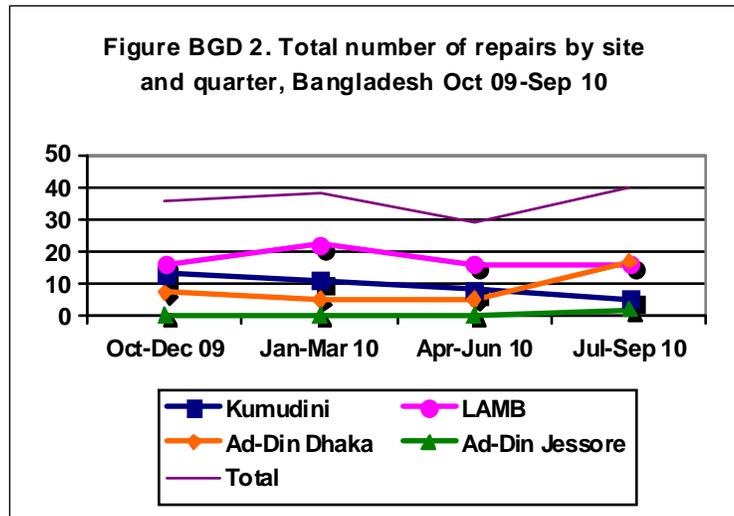
Key Accomplishments October 2009-September 2010

Fistula Repairs. A total of 143 repairs were performed in Bangladesh during the fiscal year. Overall, Bangladesh had a 9% increase in number of repairs when compared with FY 08/09 (See Figure BGD 1). While Kumudini and LAMB carried out fewer repairs in FY 09/10, the addition of Ad-din Dhaka raised the capacity for repairs and helped raise the overall numbers. The compiled percentage of women receiving their first repair rose slightly when compared to FY 08/09 (67% to 73%). The percentage of women closed and dry at discharge increased as well (71% to 76%), with Ad-Din Dhaka reporting particularly high rates for the year (90%). Reported complication rates decreased significantly in comparison to FY 08/09 (31 to 11%).



The number of repairs carried out remained consistent overall between quarters, with only the third quarter showing a decline in number of repairs. Ad-din Jessore carried out its first repairs in the fourth quarter of the fiscal year. The vast majority of repairs were first repairs and were urinary-only or urinary/RVF cases.

Reported complication rates were generally low. Table BGD1 provides full details on clinical indicators for all the sites, and Figure BGD2 shows the repair totals for FY 09/10, by site and quarter.



Overall, 76% of women with a urinary fistula were closed and dry upon discharge for FY 09/10 (see Figure BGD3). Most cases that were not closed were first attempts at surgery and were believed to be good candidates for closure at future repair attempts. Many patients at Kumudini had very complicated fistula cases; a special repair session was organized in the second quarter to bring a more experienced surgeon from Dhaka who was able to operate on the most complicated cases. LAMB

reported seeing many women with extensive scar tissue, resulting in higher rates of women discharged with remaining incontinence.

Ad-din Hospital subaward was in place as of November 2009. One of their fistula surgeons was injured in the beginning of the fiscal year but is now recovered and providing repairs.

The number of repairs carried out at Kumudini Hospital decreased with each subsequent quarter during FY 09/10. This was attributed to the lack of a dedicated community health program and workers, compared to LAMB and Ad-Din Jessore. Kumudini conducts limited outreach in the immediate area. Discussions have taken place regarding how Kumudini staff can expand their community awareness raising activities outside their current catchment area to improve identification and referral of fistula patients.

In the third quarter of the fiscal year, two concentrated repair efforts were organized – one at Kumudini and one at LAMB. Surgeries were down by 24% compared to the second quarter. The reasons for this included the surgeon from LAMB hospital being out on leave and the harvesting season impacting the number of women willing to come to the facility for surgery.

Ad-din Hospital carried out a fistula orientation in their catchment area in the third quarter and patients began to present for surgery at both Dhaka and Jessore. An expat surgeon visited LAMB for 15 days, and performed surgery on the most complicated cases. Both Kumudini and LAMB do not have the institutionalized capability to operate on the complicated cases and rely on visiting surgeons (from Dhaka or outside of Bangladesh) to perform those surgeries. In the third quarter, 40% of patients at LAMB were discharged with remaining incontinence, most of whom will be scheduled for further surgery.

In the fourth quarter, Ad-Din Jessore finished preparing its operating theater and training staff in order to begin repairs. There was an overall upward trend in repairs at the sites due to increased patient flow at Ad-Din Dhaka and LAMB Hospitals, attributed to community outreach efforts in the previous quarter, as well as referrals from other hospitals and cured patients. During this quarter, two concentrated repair efforts were organized at LAMB and Ad-Din Jessore Hospital. The regular surgeon at LAMB remained on leave during this quarter and an outside surgeon was brought in to conduct the repairs at the aforementioned organized session.

A total of 32 additional surgeries were performed at all the sites during FY 09/10. LAMB performed the most additional surgeries. Overall, 3rd and 4th degree perineal tear repairs were the most frequently occurring surgery, followed by examination under anesthesia and ureteric reimplantation. Table BGD2 provides more information on additional surgeries performed during the year.

**Table BGD1. Clinical Indicators by Site,
October 2009 - September 2010, Bangladesh**

	Ad-Din Dhaka					Ad-Din Jessore					Kumudini				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	10	7	10	23	50	0	0	0	6	6	16	16	10	6	48
No. requiring FRS	8	6	8	19	41	0	0	0	3	3	13	11	8	6	38
No. receiving FRS	7	5	5	17	34	0	0	0	2	2	13	11	8	5	37
% receiving FRS	88%	83%	63%	89%	83%	0%	0%	0%	67%	67%	100%	100%	100%	83%	97%
Type of FRS performed															
----- urinary only	7	5	5	17	34	0	0	0	2	2	13	11	8	5	37
----- urinary & RVF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-----RVF only	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
For 'Urinary only' or 'Urinary and RVF' repairs															
----- first repair	6	3	3	13	25	0	0	0	2	2	7	10	5	4	26
----- second repair	1	2	2	4	9	0	0	0	0	0	2	0	3	1	6
----- >2	0	0	0	0	0	0	0	0	0	0	4	1	0	0	5
% women with first repair (urinary only)	86%	60%	60%	76%	74%	0%	0%	0%	100%	100%	54%	91%	63%	80%	70%
No. discharged after FRS (urinary only)	7	5	3	14	29	0	0	0	0	0	11	10	8	5	34
No. discharged after FRS (urinary & RVF)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. discharged after FRS (RVF only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total no. discharged after FRS	7	5	3	14	29	0	0	0	0	0	11	10	8	5	34

	Ad-Din Dhaka					Ad-Din Jessore					Kumudini				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. not discharged after FRS	0	0	2	3	5	0	0	0	2	2	2	1	0	0	3
Outcome of FRS (urinary only & urinary/RVF)															
----No. with closed fistula who are dry	7	4	3	12	26	0	0	0	0	0	6	10	6	3	25
----No. with closed fistula & stress incontinence	0	1	0	2	3	0	0	0	0	0	0	0	0	0	0
-----No. whose fistula was not closed	0	0	0	0	0	0	0	0	0	0	5	0	2	2	9
% with closed fistula who are dry (urinary only & urinary/RVF)	100%	80%	100%	86%	90%	0%	0%	0%	0%	0%	55%	100%	75%	60%	74%
Outcome of FRS (RVF only)															
-----closed and dry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-----incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
----incontinent with firm stool	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% with closed and dry fistula (RVF only)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No. with complications after FRS	0	1	1	0	2	0	0	0	0	0	0	0	0	0	0
-----Major surgical complications	0	1	1	0	2	0	0	0	0	0	0	0	0	0	0
---- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Fistula Treatment Indicators	Ad-Din Dhaka					Ad-Din Jessore					Kumudini				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
-----Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent with complications after FRS	0%	20%	33%	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

**Table BGD1. Clinical Indicators by Site,
October 2009 - September 2010, Bangladesh (Continued)**

Fistula Treatment Indicators	LAMB					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	17	24	11	24	76	43	47	31	59	180
No. requiring FRS	16	22	10	21	69	37	39	26	49	151
No. receiving FRS	16	22	16	16	70	36	38	29	40	143
% receiving FRS	100%	100%	160%	76%	101%	97%	97%	112%	82%	95%
Type of FRS performed										
---- urinary only	15	22	16	13	66	35	38	29	37	139
--- urinary & RVF	0	0	0	0	0	0	0	0	0	0
---- RVF only	1	0	0	3	4	1	0	0	3	4
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	12	15	11	10	48	25	28	19	29	101
----- second repair	2	6	4	1	13	5	8	9	6	28
----- >2	1	1	1	2	5	5	2	1	2	10
% women with first repair (urinary only)	80%	68%	69%	77%	73%	71%	74%	66%	78%	73%
No. discharged after FRS (urinary only)	15	22	16	13	66	33	37	27	32	129
No. discharged after FRS (urinary & RVF)	0	0	0	0	0	0	0	0	0	0
No. discharged after FRS (RVF only)	1	0	0	3	4	1	0	0	3	4

Fistula Treatment Indicators	LAMB					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
Total no. discharged after FRS	16	22	16	16	70	34	37	27	35	133
No. not discharged after FRS	0	0	0	0	0	2	1	2	5	10
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	12	15	9	11	47	25	29	18	26	98
----- No. with closed fistula & stress incontinence	2	5	2	0	9	2	6	2	2	12
----- No. whose fistula was not closed	1	2	5	2	10	6	2	7	4	19
% with closed fistula who are dry (urinary only & urinary/RVF)	80%	68%	56%	85%	71%	76%	78%	67%	81%	76%
Outcome of FRS (RVF only)										
--- closed and dry	1	0	0	3	4	1	0	0	3	4
---- incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
---- incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
% with closed and dry fistula (RVF only)	100%	0%	0%	100%	100%	100%	0%	0%	100%	100%
No. with complications after FRS	6	5	1	1	13	6	6	2	1	15
-----Major surgical complications	0	0	0	1	1	0	1	1	1	3
----- Anesthesia-related complication	0	0	1	0	1	0	0	1	0	1
----- Post-operative complication related to perceived success of surgery	6	5	0	0	11	6	5	0	0	11
% with complications after FRS	38%	23%	6%	6%	19%	18%	16%	7%	3%	11%

**Table BGD 2. Number of Additional Surgeries for Fistula Patients,
October 2009 – September 2010, Bangladesh**

	Oct- Dec	Jan – March	Apr- June	Jul- Sep	FY Total
Type of Surgery by Site					
LAMB					
Ureteric reimplantation	2	1	0	2	5
Examination under anesthesia	0	3	1	2	6
Removal of bladder stones or foreign bodies in the viscera	0	1	0	1	2
Urethral lengthening or other operations for concomitant stress incontinence	0	1	0	0	1
3 rd /4 th degree perineal tears	0	0	1	2	3
Colostomy and reversal colostomy	0	0	0	1	1
Other	1	0	1	2	4
Kumudini					
3 rd /4 th degree perineal tear	2	0	2	4	8
Ad-Din Hospital					
Ureteroneocystostomy	1	0	1	0	2
Total	6	6	6	14	32

Training. During FY 09/10, a total of 424 individuals were trained through Fistula Care. One surgeon received first training in fistula repair, and two surgeons received continuing training. Nine nurses received training in pre- and post-operative fistula care. Ninety-four people were trained in emergency obstetric related topics, which included basic counseling, partograph use, AMSTL, management of pre-eclampsia and eclampsia and referral and training of trainers. Ninety-five counselors were trained in topics including orientation to fistula, fistula counseling and family planning counseling. Infection prevention and waste management training was carried out for 77 individuals. Training in quality assurance, including facilitative supervision and medical monitoring was provided to 23 supervisors and managers. Table BGD3 provides additional information on all trainings.

**Table BGD 3. Number of Persons Trained by Topic,
October 2009 – September 2010, Bangladesh**

Training Topic	Oct- Dec	Jan- Mar	Apr – Jun	Jul- Sep	FY Total
EmOC services (nurses/midwives)	30	0	0	28	58
Fistula surgery and management (nurses)	4	0	0	5	9
Orientation on fistula prevention and treatment for counselors	75	0	0	0	75
Orientation on project proposal and implementation	16	0	0	32	48
FP refresher training	4	0	0	0	4
MIS training	0	12	0	3	15
TOT on community orientation	0	0	18	0	18
TOT on EmOC	0	0	0	10	10

Training Topic	Oct-Dec	Jan-Mar	Apr – Jun	Jul-Sep	FY Total
EmOC referral training (counselors)	0	0	0	26	26
Training and refresher training on IP and waste management	0	0	77	0	77
Obstetric fistula and family planning counseling	0	0	20	0	20
FP and LAPM orientation	0	0	38	0	38
Facilitative supervision and medical monitoring	0	0	0	23	23
Continuing surgical training in fistula repair	0	0	2	0	2
First surgical training in fistula repair	0	0	1	0	1
Total	129	12	156	127	424

Quality Improvement. Bi-annual visits for facilitative supervision and medical monitoring took place at Kumudini and LAMB. Waste management reviews were conducted at the sites, as well as partograph monitoring. All four sites met at least once to review data during the fiscal year. Additionally, monthly status reports on the recruitment of study participants were gathered and feedback was provided accordingly.

Community Outreach. A total of 135 community outreach events were organized during FY 09/10, reaching an estimated 6,697 individuals. Outreach activities focused on reaching adolescent peer leaders and married couples to raise awareness and support for fistula prevention and repair. Meetings were organized with government officials, local NGO leaders, and local medical practitioners in several catchment areas to provide orientations to the prevention of fistula, identification of probable fistula cases, information on availability of treatment, family planning services and reintegration efforts. Religious leaders were also targeted through outreach efforts. Kumudini Hospital catchment also raised awareness on blood donation Table BGD4 provides more information on specific community outreach activities.

Table BGD 4. Number of Community Outreach Events and Persons Reached, October 2009 - September 2010, Bangladesh

Event Type	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached						
Advocacy and Planning Meeting	1	24	6	184	0	0	0	0	7	208
Awareness Raising	25	811	6	220	0	0	2	110	33	1141
Community leaders and NGO workers orientation	24	1588	2	76	14	657	3	148	43	2469
Orientation for health and family planning officials	2	156	0	0	0	0	0	0	2	156
Rehabilitation training	0	0	1	20	0	0	0	0	1	20
Community Orientation	0	0	0	0	15	916	0	0	15	916
Orientation for adolescent peer leaders	0	0	0	0	6	286	4	210	10	496
Orientation for rural medical practitioners	0	0	0	0	3	196	2	118	5	314
Awareness raising among married couples and	0	0	0	0	4	227	8	468	12	695

Event Type	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
religious leaders										
Orientation of village health volunteers on EMOC and FP	0	0	0	0	7	282	0	0	7	282
Total	52	2579	15	500	49	2564	19	1054	135	6697

Prevention. During FY 09/10, a pictorial partograph was developed at LAMB hospital, in collaboration with Emory University, and is being pilot tested. Additionally, a poster and banner promoting fistula awareness was produced for Ad-din Hospital. Referral linkages were established between the National Fistula Center at DMCH, Rehabilitation Center, and other local hospitals providing fistula repair, including Ad-din/Dhaka.

Family Planning. Nearly 17,000 people received family planning through FC supported sites during FY 09/10. The most popular methods were oral pills and injectables. Table BGD5 provides more detailed information, by site, on family planning counseling and distribution.

Table BGD 5. Number of FP Clients by Method and Number Counseled about FP, by site. October 2009 – September 2010, Bangladesh

	Ad-Din Dhaka	Ad-Din Jessore	Kumudini	LAMB	Country Total
Fistula FP Methods	FY Total	FY Total	FY Total	FY Total	FY Total
Oral Pill	2825	941	387	1090	5243
IUCD	56	150	0	0	206
Condom (male)	1385	136	244	0	1765
Condom (female)	0	0	0	0	0
Injectable	5673	2086	193	1167	9119
Implant	0	0	0	0	0
Tubal Ligation	229	135	98	160	622
Vasectomy	0	0	10	5	15
Foaming Tablets	0	0	0	0	0
Total FP acceptors	10168	3448	932	2422	16970
Total Number of clients counseled about FP methods	10168	3448	932	2422	16970

Obstetrics. Table BGD6 presents information on obstetric services, by site, for the first two quarters of the fiscal year. The high C-section rates are attributed in part to the tertiary level of the hospital and the fact that they are receiving predominantly high-risk deliveries.

**Table BGD 6. Obstetric Services, by site.
October 2009 – September 2010, Bangladesh.**

	Ad-Din Dhaka	Ad-Din Jessore	Kumudini	LAMB
	Total	Total	Total	Total
Vaginal deliveries	2783	1234	1002	2633
C-sections	5797	1955	777	824
Total number of deliveries	8580	3189	1779	3457
Percent deliveries by C-section	67%	61%	44%	24%

Policy. Fistula Care Bangladesh is the Secretariat of the National Task Force on Obstetric Fistula, which received official recognition from the Ministry of Health and Family Welfare in July 2010. During FY 09/10, Bangladesh moved forward with the development of a National Strategic Vision on Obstetric Fistula. National advocacy meetings were organized in Dhaka during December 2009 and August and September 2010, jointly with the government and UNFPA, on the ‘Campaign to End Obstetric Fistula in Bangladesh’. These meetings included stakeholders in both the public and private sectors, providers, managers and development partners. Their work focused on identifying and developing the terms of reference for the national consultants to develop the strategic vision. In addition, the meetings facilitated the establishment of referral linkages between the Dhaka facilities offering fistula repair.

A poster was presented at the FIGO meeting in South Africa in October 2009 on the prevention and treatment of obstetric fistula, entitled “Community work makes a difference.” The authors of the presentation were Dr. Apurba Chakraborty, Dr. S. M. Shahidullah, and Dr. Abu Jamil Faisal. Dr. Kristine Prenger of LAMB Hospital made two presentations at the Global Maternal Health Conference in India in August/September 2010 entitled, “Improving the use of the partograph – a case study from a rural integrated health and development project” and “Strengthening c-section services: a case study from a rural integrated health and development project in Bangladesh.”

DEMOCRATIC REPUBLIC OF CONGO (DRC)



Program Background

USAID Support Start Date: July 2005

Service Sites: Two private hospitals in Eastern DRC to prevent and repair fistula.

- HEAL Africa Hospital
- Panzi Hospital

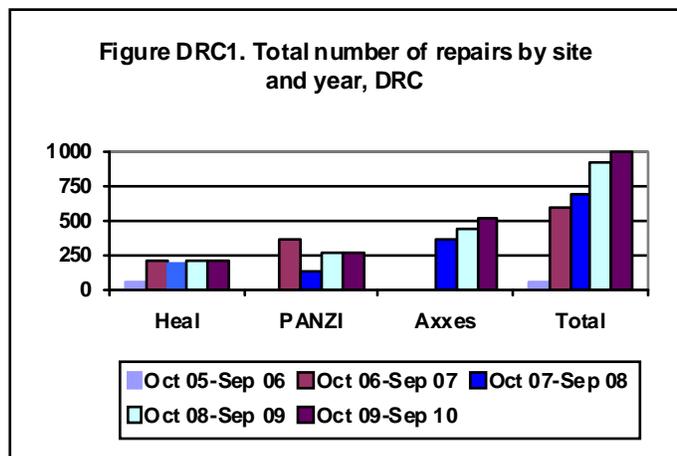
Between July 2005 and April 2008, USAID-funded fistula activities were managed through a bilateral agreement with the International Rescue Committee (IRC). This relationship ended in October 2008, at which time funding began through the Fistula Care Project. Funding began at HEAL Africa and Panzi in February 2009.

We include repair data reported by Project AXxes, a non-Fistula Care, USAID-supported project to increase access to integrated primary health care, increase capacity of health zones and the referral system and reinforce national programs and provincial/district offices in DRC. Project AXxes supports 60 hospitals, over 900 clinics, and over 4,000 providers.

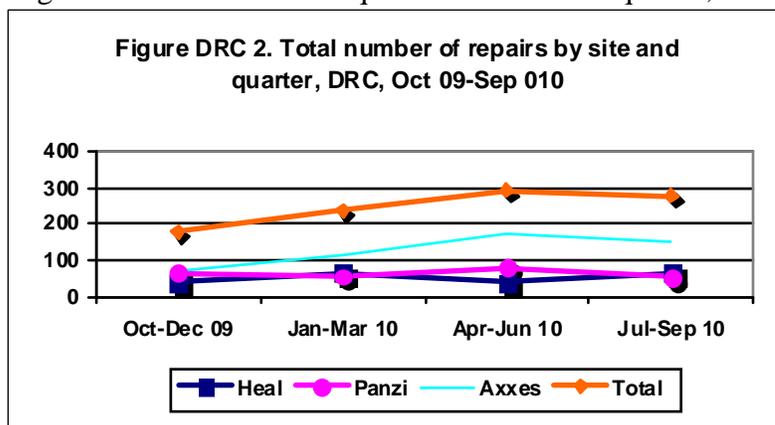
Fistula care is a small part of their work and is generally provided by one private surgeon. It is a four year project (Sept. 2006 – Sept. 2010) and they began supporting and collecting fistula data in year two of the project. Year 2 data (FY 07/08) came from regional hospitals, in Years 3 and 4 (FY 08/09 and FY 09/10), the project transitioned to a mobile service model with fistula surgeons visiting facilities to perform surgery. In FY 09/10 fistula repairs were carried out in five facilities using this model: in the second quarter: – Ldoja, Kole and Kaziba Hospitals, in third quarter: – Kaziba, Kabondo and Kolwezi Hospitals, and fourth quarter: – Kabondo and Kaziba Hospitals.

Key Accomplishments October 2009-September 2010

Fistula Repairs. A total of 986 fistula repairs were carried out in the DRC in the October 2009-September 2010 period. HEAL Africa performed 210 repairs, Panzi performed 262 repairs and Project AXxes carried out 514 repairs. This represents a 7% increase in repairs when compared to FY 08/09 (See Fig. DRC1). The majority of women were receiving their first repairs (76%); however there was a wide range between sites with 55% of women at HEAL and 89% of Project AXxes repairs being first repairs.



The number of repairs conducted increased for the first three quarters (see Fig DRC2) with a slight decline in the fourth quarter. In the third quarter, HEAL experienced a downward trend in fistula repairs because there were no outreach activities in the zones surrounding Goma. Panzi reports most of their cases are obstetric fistula, but during the third quarter there were two women with traumatic fistula due to sexual violence.



Reported complication rates were very low at all sites. Success rates were generally high, with the percentage of fistula cases closed and dry at discharge ranging from 78% to 89% at the sites. For more detailed information on repairs, see Table DRC1. Please note, data for repair outcomes were unavailable for Project AXxes for the third quarter, which artificially deflates the success rates in the table below. When accounting for the unavailable data, the overall success rate was 83% (see Fig DRC3).

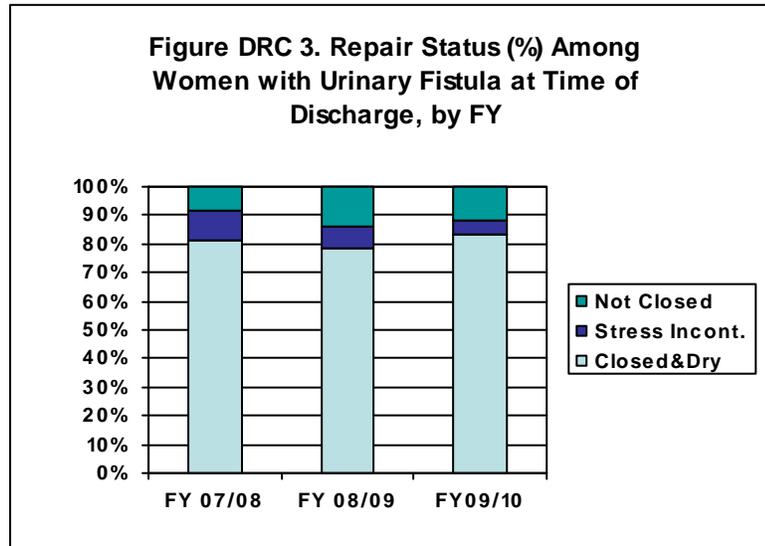


Table DRC I. Clinical Indicators by Site, October 2009 – September 2010, DRC

Fistula Treatment Indicators	HEAL Africa					Panzi				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	42	85	42	80	249	53	68	129	60	310
No. requiring FRS	40	65	40	65	210	49	56	45	56	206
No. receiving FRS	40	65	40	65	210	67	57	82	56	262
Percent receiving FRS	100%	100%	100%	100%	100%	137%	102%	182%	100%	127%
Type of FRS performed										
--- urinary only	40	61	34	62	197	63	44	73	48	228
--- urinary & RVF	0	3	1	2	6	0	0	3	2	5
---RVF only	0	1	5	1	7	4	13	6	6	29
For 'Urinary only' or 'Urinary and RVF' repairs										
--- first repair	28	22	22	40	112	48	34	48	33	163
--- second repair	2	17	2	9	30	10	7	14	7	38
--- >2	10	25	11	15	61	5	3	14	10	32
Percent women with first repair (urinary only)	70%	34%	63%	63%	55%	76%	77%	63%	66%	70%
No. discharged after FRS (urinary only)	38	51	28	60	177	63	37	68	47	215
No. discharged after FRS (urinary & RVF)	0	1	1	2	4	0	0	3	2	5
No. discharged after FRS (RVF only)	0	0	3	1	4	4	13	6	5	28
Total no. discharged after FRS	38	52	32	63	185	67	50	77	54	248
No. not discharged after FRS	2	13	8	2	25	0	7	5	2	14
Outcome of FRS (urinary only & urinary/RVF)										
---No. with closed fistula who are dry	31	48	23	55	157	51	26	57	37	171
--- No. with closed fistula & stress incontinence	2	3	2	1	8	4	1	8	5	18
--- No. whose fistula was not closed	5	1	4	6	16	8	10	6	7	31
Percent with closed fistula who are dry (urinary only & urinary/RVF)	82%	92%	79%	89%	87%	81%	70%	80%	76%	78%
Outcome of FRS (RVF only)										
----closed and dry	0	0	3	1	4	4	13	6	5	28
---- incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
---- incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	0%	100%							

Fistula Treatment Indicators	HEAL Africa					Panzi				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. with complications after FRS	2	3	2	1	8	1	0	0	0	1
---Major surgical complications	0	0	0	0	0	1	0	0	0	1
---Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
---Post-operative complication related to perceived success of surgery	2	3	2	1	8	0	0	0	0	0
Percent with complications after FRS	5%	6%	6%	2%	4%	1%	0%	0%	0%	0%

Table DRC I. Clinical Indicators by Site, October 2009 – September 2010, DRC (continued)

Fistula Treatment Indicators	Project AXxes					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	n/a	189	230	173	592	95	342	401	313	1151
No. requiring FRS	n/a	116	169	156	441	89	237	254	277	857
No. receiving FRS	71	116	171	156	514	178	238	293	277	986
Percent receiving FRS	n/a	100%	101%	100%	117%	200%	100%	115%	100%	115%
Type of FRS performed										
----urinary only	n/a	106	127	74	307	103	211	234	184	732
----urinary & RVF	n/a	6	35	77	118	0	9	39	81	129
----RVF only	n/a	4	7	4	15	4	18	18	11	51
For 'Urinary only' or 'Urinary and RVF' repairs										
----first repair	n/a	104	146	129	379	76	160	216	202	654
----second repair	n/a	6	17	21	44	12	30	33	37	112
---->2	n/a	2	0	2	4	15	30	25	27	97
Percent women with first repair (urinary only)	n/a	93%	90%	85%	89%	74%	73%	79%	76%	76%
No. discharged after FRS (urinary only)	n/a	106	130	74	310	101	194	226	181	702
No. discharged after FRS (urinary & RVF)	n/a	6	26	66	98	0	7	30	70	107
No. discharged after FRS (RVF only)	n/a	4	9	3	16	4	17	18	9	48
Total no. discharged after FRS	n/a	116	165	143	424	105	218	274	260	857
No. not discharged after FRS	n/a	0	15	13	28	2	20	28	17	67

Fistula Treatment Indicators	Project AXxes					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
Outcome of FRS (urinary only & urinary/RVF)										
----No. with closed fistula who are dry	n/a	97	n/a	121	218	82	171	80	213	546
----No. with closed fistula & stress incontinence	n/a	3	n/a	2	5	6	7	10	8	31
----No. whose fistula was not closed	n/a	12	n/a	17	29	13	23	10	30	76
Percent with closed fistula who are dry (urinary only & urinary/RVF)	n/a	87%	n/a	86%	53%	81%	85%	31%	85%	67%
Outcome of FRS (RVF only)										
----closed and dry	n/a	4	7	3	14	4	17	16	9	46
----incontinent with water stool and /or flatus (gas)	n/a	0	0	0	0	0	0	0	0	0
----incontinent with firm stool	n/a	0	2	0	2	0	0	2	0	2
Percent with closed and dry fistula (RVF only)	n/a	100%	78%	100%	88%	100%	100%	89%	100%	96%
No. with complications after FRS	n/a	4	0	1	5	3	7	2	2	14
----Major surgical complications	n/a	3	0	0	3	1	3	0	0	4
----Anesthesia-related complication	n/a	1	0	0	1	0	1	0	0	1
---- Post-operative complication related to perceived success of surgery	n/a	0	0	0	0	2	3	2	1	8
Percent with complications after FRS	n/a	3%	0%	1%	1%	3%	3%	1%	1%	2%

One hundred and forty-nine additional surgeries were performed during the fiscal year at Panzi and HEAL Africa. The majority of these surgeries were examinations performed under anesthesia and urethral lengthening and other operations for concomitant stress incontinence. Table DRC2 provides information on all additional surgeries performed during the quarters.

**Table DRC 2. Number of Additional Surgeries for Fistula Patients,
October 2009 – September 2010, DRC**

	Oct- Dec	Jan – March	Apr- June	Jul- Sep	FY Total
Type of Surgery by Site					
HEAL Africa					
Examination under anesthesia	n/a	14	1	10	25
Removal of bladder stones or foreign bodies in viscera	n/a	1	3	2	6
Colostomy and reversal colostomy	n/a	1	2	1	4
Ureteric reimplantation	n/a	2	1	5	8
Urethral lengthening and other operations for concomitant stress incontinence	n/a	4	3	2	9
Wound resuture	n/a	1	0	0	1
Uterine prolapse associated with fistula	n/a	1	0	0	1
Repair of 3 rd and 4 th degree perineal tears	n/a	4	1	1	6
Other	n/a	0	1	0	1
Panzi					
Examination under anesthesia	22	15	6	3	46
Removal of bladder stones or foreign bodies in viscera	0	0	2	1	3
Urethral lengthening and other operations for concomitant stress incontinence	17	1	0	2	20
Urethral reimplantation	0	2	2	3	7
Uterine prolapse associated with fistula	0	1	1	0	2
Repair of 3 rd and 4 th degree perineal tears	0	1	0	3	4
Other	1	0	5	0	6
Total	40	48	28	33	149

Training. During the fiscal year, a total of 227 individuals received training in DRC. One surgeon at HEAL received continuing training over the course of the year, and a total of ten surgeons received continuing training at Panzi. One surgeon received first training in repair at Panzi in the fourth quarter of the year. Both sites have conducted several trainings on fistula prevention for birth attendants, including use of the partograph and indications for c-section delivery. One hundred and sixty seven individuals were trained in emergency obstetric care, including the aforementioned topics. HEAL Africa conducted trainings on counseling for traumatic fistula during the first and third quarters of the year. More detailed information on trainings and numbers of trainees can be found in table DRC3.

**Table DRC 3. Number of Persons Trained by Topic,
October 2009 – September 2010, DRC**

Training Topic	Oct- Dec	Jan- Mar	Apr - Jun	Jul- Sep	FY Total
HEAL Africa					
Continuing surgical training in fistula repair	0	1	1	1	1*
Traumatic fistula counseling	16	0	32	0	48
Fistula prevention for birth attendants, including partograph, AMSTL and indications for c-section	20	0	20	20	60
C-section training	48	0	10	10	68
Partograph training	0	0	15	0	15
Panzi					
Continuing surgical training in fistula repair	0	4	0	6	10
Fistula prevention for birth attendants including use of the partograph	10	0	0	14	24
First surgical training	0	0	0	1	1
Total	94	5	78	52	227*

*The same surgeon received training in the second, third and fourth quarters and is only counted once in the total.

Quality Improvement. During the second quarter, medical monitoring and waste disposal management monitoring was carried out at both sites.

Community Outreach. Due to insecurity in the area, there were no outreach activities conducted during the first two quarters of the year. Additionally, UNICEF had been paying for outreach and transportation for women in the HEAL catchment area, and this support ended in 2009. During the second quarter, a radio program was aired on fistula awareness, and efforts were made to reach out to rural churches. During the third quarter of the year, community agents employed radio messages and posters as part of a ground campaign to inform women about maternal mortality.

Family Planning. The most common family planning methods dispensed at the sites included male condoms, oral pills and injectables. The low number of male condoms distributed at HEAL in the fourth quarter is attributable to stock outages of condoms at the site. Over 1,633 individuals received family planning but the data on numbers of clients counseled about family planning are incomplete. Table DRC4 provides all the available family planning method information by site.

Table DRC 5. Number of FP Clients by Method and Number Counseled about FP, by site. October 2009 – September 2010, DRC

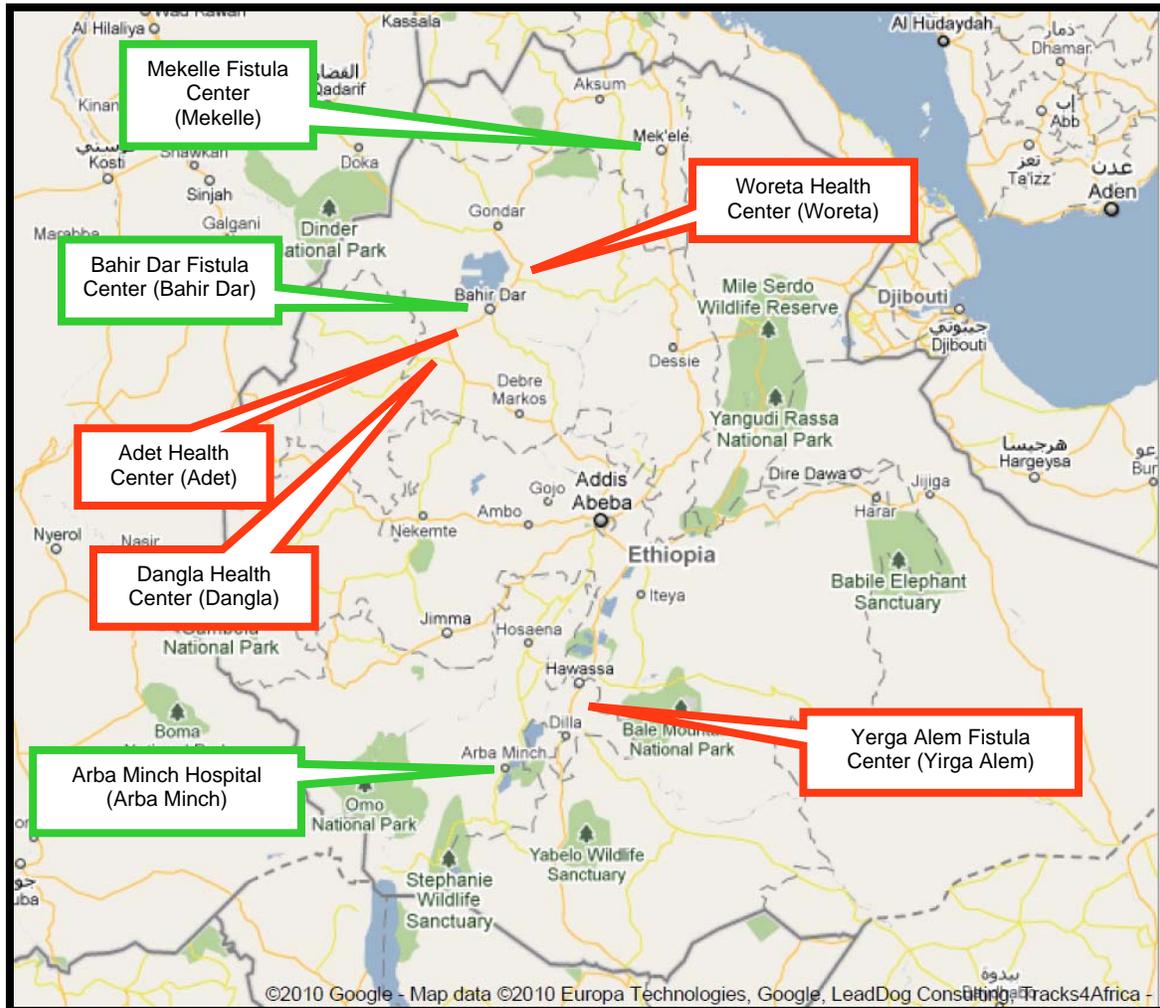
Fistula FP Methods	HEAL Africa					Panzi					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
Oral Pill	n/a	n/a	304	338	642	n/a	0	38	28	66	n/a	0	342	366	708
IUCD	n/a	n/a	6	2	8	n/a	2	13	8	23	n/a	2	19	10	31
Condom (male)	n/a	n/a	227	80	307	n/a	0	2	22	24	n/a	0	229	102	331
Condom (female)	n/a	n/a	3	0	3	n/a	0	0	0	0	n/a	0	3	0	3
Injectable	n/a	n/a	215	171	386	n/a	0	0	21	21	n/a	0	215	192	407
Implant	n/a	n/a	9	12	21	n/a	6	23	29	58	n/a	6	32	41	79
Tubal Ligation	n/a	n/a	6	4	10	n/a	19	27	18	64	n/a	19	33	22	74
Vasectomy	n/a	n/a	0	0	0	n/a	0	0	0	0	n/a	0	0	0	0
Foaming Tablets	n/a	n/a	0	0	0	n/a	0	0	0	0	n/a	0	0	0	0
Total FP acceptors	n/a	n/a	770	607	1377	n/a	27	103	126	256	n/a	27	873	733	1633
Total Number of clients counseled about FP methods	n/a	n/a	1500	1454	2954	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1500	1454	2954

Obstetrics. Of the 2,864 deliveries that occurred at HEAL and Panzi during the fiscal year, just over 20% were C-sections. Table DRC5 provides site specific numbers on obstetric services.

Table DRC 6. Obstetric Services, by site. October 2009 – September 2010, DRC.

	HEAL					Panzi					TOTAL				
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Total
Number of vaginal deliveries	233	201	224	251	909	n/a	496	448	433	1377	233	697	672	684	2286
Number of C-sections	30	36	32	35	133	n/a	122	162	161	445	30	158	194	196	578
Total number of deliveries	263	237	256	286	1042	n/a	618	610	594	1822	263	855	866	880	2864
Percent deliveries by C-section	11%	15%	13%	12%	13%	n/a	20%	27%	27%	24%	11%	19%	22%	22%	20%

ETHIOPIA



Program Background

Service Start Date: 2006

USAID support to Ethiopia began in 2006, with funds provided through the ACQUIRE project to support activities implemented by ACQUIRE partner, IntraHealth International, to directly support the work of the Addis Ababa Fistula Hospital (AAFH) in selected facilities outside of Addis Ababa. In April 2007, the USAID Mission directed funds to IntraHealth International through the Expanding Service Delivery (ESD) Project and continued direct funding to the Addis Ababa Fistula Foundation. ESD funding ended in 2008 and Fistula Care funds now support the pre-repair center work implemented by IntraHealth. Program activities in Ethiopia consist of the following:

- Through the Addis Ababa Fistula Hospital, repairs and prevention are carried out at the Bahir Dar Fistula Center in Amhara Region and the Mekelle Fistula Center in Tigray Region. During this fiscal year, USAID/Ethiopia also provided support to a third facility, Arba Minch located in Southern Nations, Nationalities, and People's

Region (SNNPR); USAID/Ethiopia will provide support to this facility for repairs for one year. The facility is run by the Norwegian Lutheran Mission and is expected to receive support for fistula repairs from the government. In addition, activities are supported at the Yirga Alem Center in the Southern Nations, Nationalities, and People's Region (SNNPR) for communication about prevention and treatment.

- Fistula Care supports and strengthens three referral/pre-repair units (PRU), located within existing health centers in the Amhara region, referring repair cases to the Bahir Dar fistula center. These centers ---Adet Health Center, Dangla Health Center and Woreta Health Center – also focus on fistula prevention activities in their surrounding communities.

Key Accomplishments October 2009-September 2010



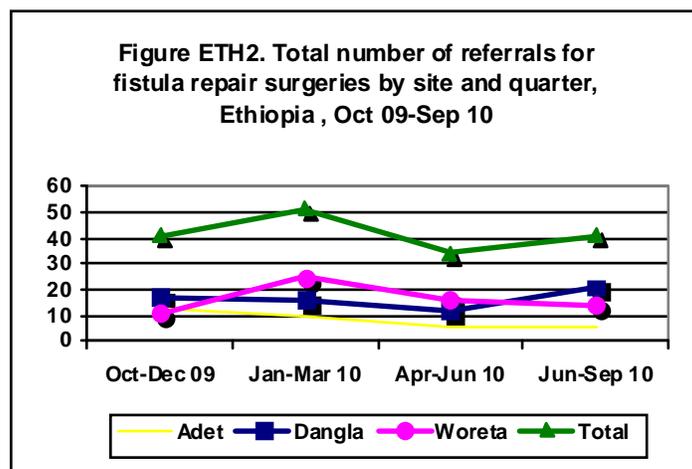
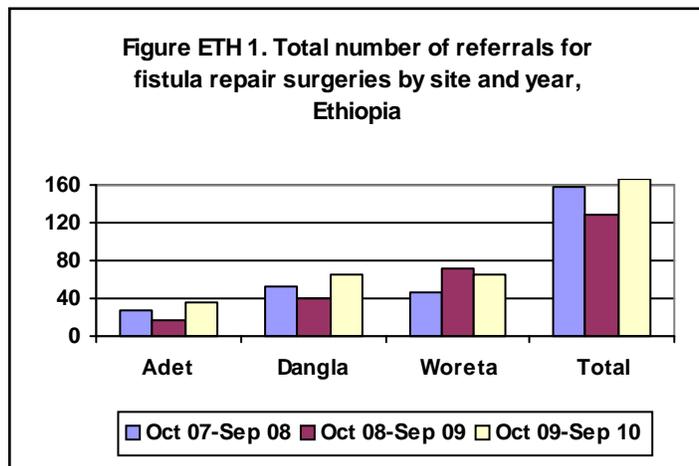
Above: Woreta Fistula pre-repair patients.

Expansion of Pre Repair Model. A team of Fistula Care project staff from EngenderHealth and IntraHealth and representatives from two zones, the regional health bureau, and the Mekelle Hamlin Fistula Center conducted an assessment 15-20 March of health centers in Eastern Amhara that might serve as fistula pre-repair unit sites. The assessment team recommended moving forward with two sites: a zonal hospital and a health center. Discussions with the USAID/Ethiopia mission about the recommendations have taken place and a plan and timeline have been developed for establishing PRU services at Tefera Hailu Memorial Hospital in Sekota. A memorandum of understanding (MOU) has been drafted between IntraHealth and the hospital in Sekota; this MOU is under review and will be finalized in the first quarter of FY 10/11. This pre-repair unit will be integrated into the hospital's services as much as possible through joint trainings, joint supportive supervision and joint PRU support in terms of staffing, space, food, laundry and laboratory support. The project will develop an outreach strategy to include training community groups (represented from kebeles) as well as health extension workers attached to the health centers within the hospital's catchment woreda.

Screening for Fistula and other Services at Pre repair Centers. In total, 257 women were referred from the community for urinary incontinence to the pre repair units during the fiscal year; 181 of these women (70%) were diagnosed with fistula and 167 women were referred to Bahir Dar for fistula repair surgery; see Fig. ETH1 and Table ETH1. Seventy-seven women were referred for follow-up care or surgery. The number of women screened increased when compared to FY 08/09, while the percentage of women diagnosed with fistula remained steady. The mentors continue to strengthen their community mobilization and awareness creation activities and their efforts to train more health

providers at the health centers has resulted in increased referrals and accurate fistula diagnoses.

When looking at referrals by quarter, the second quarter had the highest overall rates of



referral (See Fig. ETH2), due to the end of the rainy season and mentors concentrating their activities in adjacent

Woredas not previously reached by the project. Work in the adjacent woredas includes identification of new community volunteers and training of health workers from health centers not previously reached. The first and fourth quarters had similar numbers of referrals. In the third quarter, the number of women reporting to the fistula pre-repair centers with urinary incontinence issues dropped, while the percentage screened and diagnosed with fistula increased.

Table ETH1. Number of Women seeking, requiring and referred for fistula repair October 2009 - September 2010, by Pre Repair Centers, Ethiopia

Fistula Screening	Adet					Dangla					Woreta					Country Total				
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	FY Total
No. referred with incontinence	23	17	15	18	73	19	19	16	27	81	21	25	21	25	92	74	61	52	70	257
No. diagnosed with fistula	11	10	9	6	36	19	14	12	21	66	21	19	18	21	79	51	43	39	48	181
No. referred for 1st FRS	13	10	6	6	35	17	16	12	21	66	11	25	16	14	66	41	51	34	41	167
No. Referred for continuing FRS care ⁴³	4	2	8	2	16	9	0	14	0	23	18	0	18	2	38	31	2	40	4	77
Total No. Referred	17	12	14	8	51	26	16	26	21	89	29	25	34	16	104	72	53	74	45	244

⁴³ Oct-Dec period includes women who were referred and transported back to Bahir Dar for post surgery follow up. Subsequent quarters only include women referred back for a second follow up surgery.

HIV Counseling and Testing. All women referred to the pre-repair units are to be provided with HIV pre- and post-counseling by the fistula mentors and offered HIV testing by the health center. During the fiscal year, 236 women were counseled and 177 consented to testing. One woman tested positive in the fourth quarter and was referred to the health center for pre-ART. Some of the women who declined testing reported that they already knew their HIV status.

Family Planning Counseling. A total of 156 post-repair women were counseled about family planning and referred to the health center’s family planning services for a family planning method.

Fistula Repairs. USAID/Ethiopia-supported repairs began at Arba Minch Hospital during this fiscal year. Data on repairs performed were available for the first and third quarters and are reported in table ETH2, along with all clinical data from Bahir Dar and Mekelle. During the FY 09/10, a total of 587 repairs were conducted at the three fistula repair sites. This represents a 27% increase in repairs compared to FY 08/09 (see Fig. ETH3). Bahir Dar had a significant increase compared to the previous year, while Mekelle’s repair numbers remained steady. When comparing repairs by quarter, the fourth quarter had the lowest number of repairs (see Fig. ETH4).

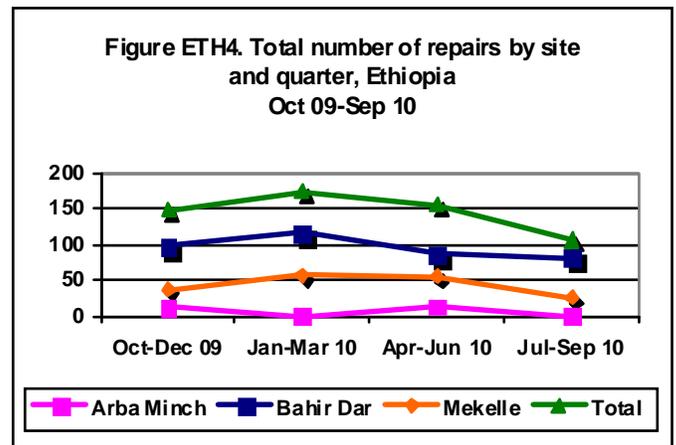
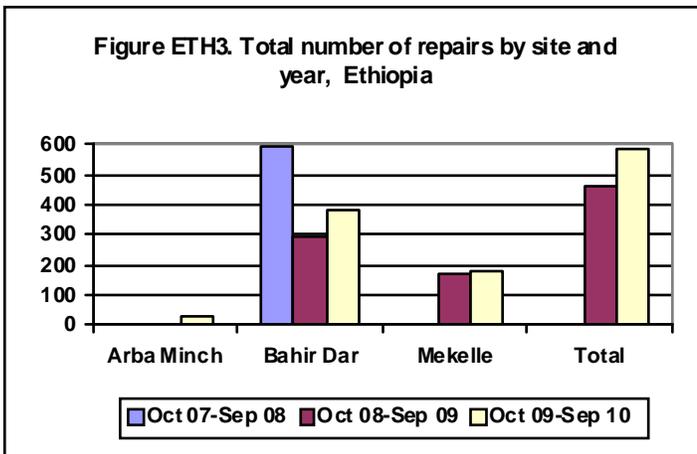


Table ETH2. Clinical Indicators by Site, October 2009 - September 2010, Ethiopia

Fistula Treatment Indicators	Arba Minch					Bahir Dar Ctr				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	n/a	n/a	15	n/a	15	293	263	264	179	999
No. requiring FRS	n/a	n/a	14	n/a	14	194	181	168	131	674
No. receiving FRS	13	n/a	14	n/a	27	98	117	87	81	383
Percent receiving FRS	n/a	n/a	100%	n/a	193%	51%	65%	52%	62%	57%
Type of FRS performed										
----- urinary only	13	n/a	14	n/a	27	86	106	80	71	343
----- urinary & RVF	0	n/a	0	n/a	0	4	2	3	4	13
----- RVF only	0	n/a	0	n/a	0	8	9	4	6	27
For 'Urinary only' or 'Urinary and RVF' repairs							n/a			
----- first repair	13	n/a	14	n/a	27	78	101	73	63	315
----- second repair	0	n/a	0	n/a	0	12	7	8	8	35
----- >2	0	n/a	0	n/a	0	0	0	2	4	6
Percent women with first repair (urinary only)	100%	n/a	100%	n/a	100%	87%	94%	88%	84%	88%
No. discharged after FRS (urinary only)	11	n/a	14	n/a	25	66	106	75	83	330
No. discharged after FRS (urinary & RVF)	0	n/a	0	n/a	0	3	4	6	3	16
No. discharged after FRS (RVF only)	0	n/a	0	n/a	0	4	4	2	2	12
Total no. discharged after FRS	11	n/a	14	n/a	25	73	114	83	88	358
No. not discharged after FRS	2	n/a	0	n/a	2	27	21	19	16	83
Outcome of FRS (urinary only & urinary/RVF)										
---- No. with closed fistula who are dry	8	n/a	8	n/a	16	51	88	53	69	261
---- No. with closed fistula & stress incontinence	1	n/a	3	n/a	4	13	19	22	13	67
---- No. whose fistula was not closed	2	n/a	3	n/a	5	5	3	6	4	18
Percent with closed fistula who are dry (urinary only & urinary/RVF)	73%	n/a	57%	n/a	64%	74%	80%	65%	80%	75%
Outcome of FRS (RVF only)										
---- closed and dry	0	n/a	0	n/a	0	4	4	2	2	12

	Arba Minch					Bahir Dar Ctr				
---- incontinent with water stool and /or flatus (gas)	0	n/a	0	n/a	0	0	0	0	0	0
----- incontinent with firm stool	0	n/a	0	n/a	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	n/a	0%	n/a	0%	100%	100%	100%	100%	100%
No. with complications after FRS	0	n/a	0	n/a	0	0	12	8	12	32
----Major surgical complications	0	n/a	0	n/a	0	0	0	0	2	2
----Anesthesia-related complication	0	n/a	0	n/a	0	0	0	4	9	13
-----Post-operative complication related to perceived success of surgery	0	n/a	0	n/a	0	0	12	4	1	17
Percent with complications after FRS	0%	n/a	0%	n/a	0%	0%	11%	10%	14%	9%

Table ETH2. Clinical Indicators by Site, October 2009 - September 2010, Ethiopia (Continued)

	Mekelle Ctr					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	124	150	129	95	498	417	413	408	274	1512
No. requiring FRS	66	105	81	58	310	260	286	263	189	998
No. receiving FRS	38	57	56	26	177	149	174	157	107	587
Percent receiving FRS	58%	54%	69%	45%	57%	57%	61%	60%	57%	59%
Type of FRS performed										
----- urinary only	31	55	54	24	164	130	161	148	95	534
----- urinary & RVF	3	1	0	0	4	7	3	3	4	17
----- RVF only	4	1	2	2	9	12	10	6	8	36
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	34	50	47	22	153	125	151	134	85	495
----- second repair	0	4	7	1	12	12	11	15	9	47
----- >2	0	2	0	1	3	0	2	2	5	9
Percent women with first repair (urinary only)	100%	89%	87%	92%	91%	91%	92%	89%	86%	90%
No. discharged after FRS (urinary only)	32	57	61	14	164	109	163	150	97	519
No. discharged after FRS (urinary & RVF)	0	4	0	2	6	3	8	6	5	22

	Mekelle Ctr					Country Total				
No. discharged after FRS (RVF only)	2	3	0	1	6	6	7	2	3	18
Total no. discharged after FRS	34	64	61	17	176	118	178	158	105	559
No. not discharged after FRS	18	6	3	9	36	47	27	22	25	121
Outcome of FRS (urinary only & urinary/RVF)										
-----No. with closed fistula who are dry	27	47	50	11	135	86	135	111	80	412
-----No. with closed fistula & stress incontinence	0	0	4	2	6	14	19	29	15	77
-----No. whose fistula was not closed	5	14	7	3	29	12	17	16	7	52
Percent with closed fistula who are dry (urinary only & urinary/RVF)	84%	77%	82%	69%	79%	77%	79%	71%	78%	76%
Outcome of FRS (RVF only)										
-----closed and dry	2	3	0	1	6	6	7	2	3	18
-----incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
-----incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%
No. with complications after FRS	0	0	0	1	1	0	12	8	13	33
-----Major surgical complications	0	0	0	0	0	0	0	0	2	2
-----Anesthesia-related complication	0	0	0	0	0	0	0	4	9	13
-----Post-operative complication related to perceived success of surgery	0	0	0	1	1	0	12	4	2	18
Percent with complications after FRS	0%	0%	0%	6%	1%	0%	7%	5%	12%	6%

In addition to fistula repairs, some women required additional surgeries. Table ETH3 lists the 355 additional surgeries carried out during the fiscal year. Just over half of all the additional surgeries were urethral lengthening and other operations for concomitant stress incontinence.

Table ETH 3. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Ethiopia

	Oct- Dec	Jan – March	Apr- June	Jul- Sept	FY Total
Type of Surgery by Site					
Bahir Dar					
Urethral lengthening and other operations for concomitant stress incontinence	41	32	30	39	142
Examination under anesthesia	4	6	9	6	25
Removal of bladder stones or foreign bodies in the viscera	1	3	4	1	9
3 rd /4 th degree perineal tears	10	14	9	2	35
Other	13	11	12	0	36
Total Bahir Dar	69	66	64	48	247
Mekelle					
Examination under anesthesia	9	6	9	3	27
Urethral lengthening and other operations for concomitant stress incontinence	13	13	9	8	43
3 rd /4 th degree perineal tears	5	4	8	3	20
Prolapse associated with fistula	0	1	2	0	3
Removal of bladder stones or foreign bodies in viscera	0	0	3	2	5
Other	2	0	2	6	10
Total Mekelle	29	24	33	22	108
Total	98	90	97	70	355

Training for Prevention. The Pre Repair Center fistula mentors and the AAFH continue to provide new and refresher trainings at the facility level on obstetric fistula prevention and referral. Fistula mentors focused their training activities on health extension workers, CBRHAs, staff of women’s affairs and women’s associations and community leaders who were successful at mobilizing the community in identifying and referring women with incontinence to the pre-repair centers. During the fiscal year the fistula mentors trained a total of 758 new health workers and conducted refresher training for 294 providers; see Table ETH4. On the job training on use of the partograph was carried out for 79 health center staff members.

In addition to training of health workers, the mentors also conducted refresher training for 579 community volunteers and trained 1,487 new community volunteers. Community volunteers are educated on factors that contribute to fistula including the importance of encouraging women to seek ANC services and deliver at the health facility. They also receive education on HIV prevention and family planning. These volunteers included women’s associations, community based regional health workers, and other health facility and community members.

AAFH trained a total of 2,158 providers – health extension workers (HEWs), health officers, nurses and midwives – during FY 09/10. The focus of the training is on safe motherhood delivery, fistula identification, care, referral and treatment from six selected woredas in the Amhara Tigray and SNNP regions. Following the training, the health extension workers and the traditional birth attendants were given birth delivery kits to assist them for safe motherhood delivery. A total of 11,033 safe delivery kits were distributed in the fiscal year.

**Table ETH4.Number Persons Trained by Topic
October 2009 – September 2010, Ethiopia**

Training Topic	Oct-Dec	Jan-Mar	Apr-June	Jul-Sep	FY Total
Pre Repair Centers Supported Training					
New training for health workers and management	281	213	217	47	758
Refresher training for health workers and management	184	0	107	3	294
New community volunteer training	150	315	277	745	1487
Refresher community volunteer training	501	0	11	67	579
OJT in partograph for health center staff	0	0	79	0	79
Total Pre Repair Centers Supported Training	1116	528	691	862	3197
AAFH Supported Training					
Training of Health Workers in referral and prevention	527	629	301	701	2158
Total AAFH Supported Training	527	629	301	701	2158
Total Trained	1643	1157	992	1563	5355

Supportive Supervision. One component of capacity building at the health center level is joint supportive supervision collaboration by the fistula mentors with woreda health officers. During the fiscal year, thirteen facilities received supportive supervision visits, which showed the following trends: poor infection prevention, poor use of the partograph, weak levels of record keeping, lack of oxytocin to assist with AMSTL, and limitations in focused ANC. Action plans were developed to address the identified gaps, including initiation of a pilot referral card system for pregnant women.



Left: Collated data posted on the walls of the center at Woreta.

Reintegration. In addition to prevention and care, reintegration is an important focus of the work of the fistula mentors at the pre repair centers. The fistula mentors perform post-repair visits to a patient's homes to provide counseling to the patient and her family on nutrition, family planning, personal hygiene, and social reintegration in the community normally within a few months after surgery. During the fiscal year, they visited a total of 195 women who have undergone fistula repair surgery. Additionally, community core team members are performing post-repair visits with similar messages and made a total of 168 visits to post-repaired women in their homes during the six month reporting period.

Community Outreach. The three pre-repair centers and AAFH-supported hospitals continued to provide outreach activities in selected woredas to educate communities about fistula prevention and care. During the FY 09/10 period, more than 3,800 events took place reaching 535,982 people; see Table ETH5.

During the fourth quarter, Fistula Care project staff organized a series of workshops and events for community officials and community members to highlight fistula awareness including prevention, screening and identification of fistula cases, and pre-repair care and repair services. During this fistula awareness creation week campaign, workshops were held at woreda and regional level and community mobilization activities were conducted in villages surrounding the project sites.

Table ETH5. Number of Community Outreach Events and Persons Reached by Health Center Catchment Areas, October 2009 – September 2010, Ethiopia

*number of events for AAFH supported sites is not available (n/a)

Catchment Areas	Oct-Dec		Jan – Mar		Apr-Jun		Jul-Sept		FY Total	
	Events*	Persons Reached	Events*	Persons Reached	Events*	Persons Reached	Events*	Persons Reached	Events*	Persons Reached
Pre Repair Centers										
Adet	274	33,329	246	33,742	331	57,715	255	36,399	1,106	161,185
Dangla	339	55,802	394	63,391	556	79,178	539	64,478	1,828	262,849
Woreta	123	10,848	232	22,888	220	23,680	369	47,429	944	104,845
Fistula Awareness week outreach	0	0	0	0	0	0	4	412	4	412
Total Pre Repair Centers	736	99,979	872	120,021	1,107	160,573	1,167	148,718	3,882	529,291
AAFH										
Bahir Dar	n/a	1,555	n/a	679	n/a	964	n/a	281	n/a	3,479
Tigray	n/a	400	n/a	332	n/a	219	n/a	253	n/a	1,204
Yirga Alem	n/a	1,400	n/a	226	n/a	125	n/a	257	n/a	2,008
Total AAFH	n/a	3,355	n/a	1,237	n/a	1,308	n/a	791	n/a	6,691
Total	736	103,334	872	121,258	1,107	161,881	1,167	149,509	3,882	535,982

Obstetrics. *Dangla Emergency Obstetric Care Center.* In October 2009, the Dangla Center was finally equipped by the Addis Ababa Fistula Hospital. The final opening of the center was delayed until September 21, 2010 at which time an OB/Gyn mentor was finally recruited. By the end of September, two C-sections and a forceps delivery had already been performed. Emergency obstetric care services are being offered 24 hours a day, seven days a week.

Monitoring Labors at Health Centers with the Partograph. Fistula mentors have been providing on the job training to staff in the health center maternity units in the use of the partograph. The fistula mentors routinely review the partographs at the health centers to assess their completeness and accuracy. Deliveries at the health post are not monitored with partograph due to the lack of skilled birth attendants at these facilities. Additionally, health workers at the newly upgraded health centers (formerly health posts) have not yet been trained in use of the partograph. They are also reporting a heavy workload and lack of skilled nurses and midwives. The mentors have begun conducting on-the-job training for all technical staff and conduct continuous monitoring of these health facilities on using partograph.

Deliveries at the health facilities have steadily increased, with a total of 989 health post deliveries and 1,153 health center deliveries during the fiscal year. Among these deliveries a total of 464 labors were monitored using the partograph; a total of 689 labors were not monitored with the partograph (461 women arrived fully dilated; the remaining 228 were not monitored with a partograph). Among the 464 labors which were monitored with the partograph, the proportion completed correctly ranged from 77 % (Adet) to 93% (Dangla) with overall rates of 86% completed correctly for all sites during the fiscal year. (See Table ETH6).

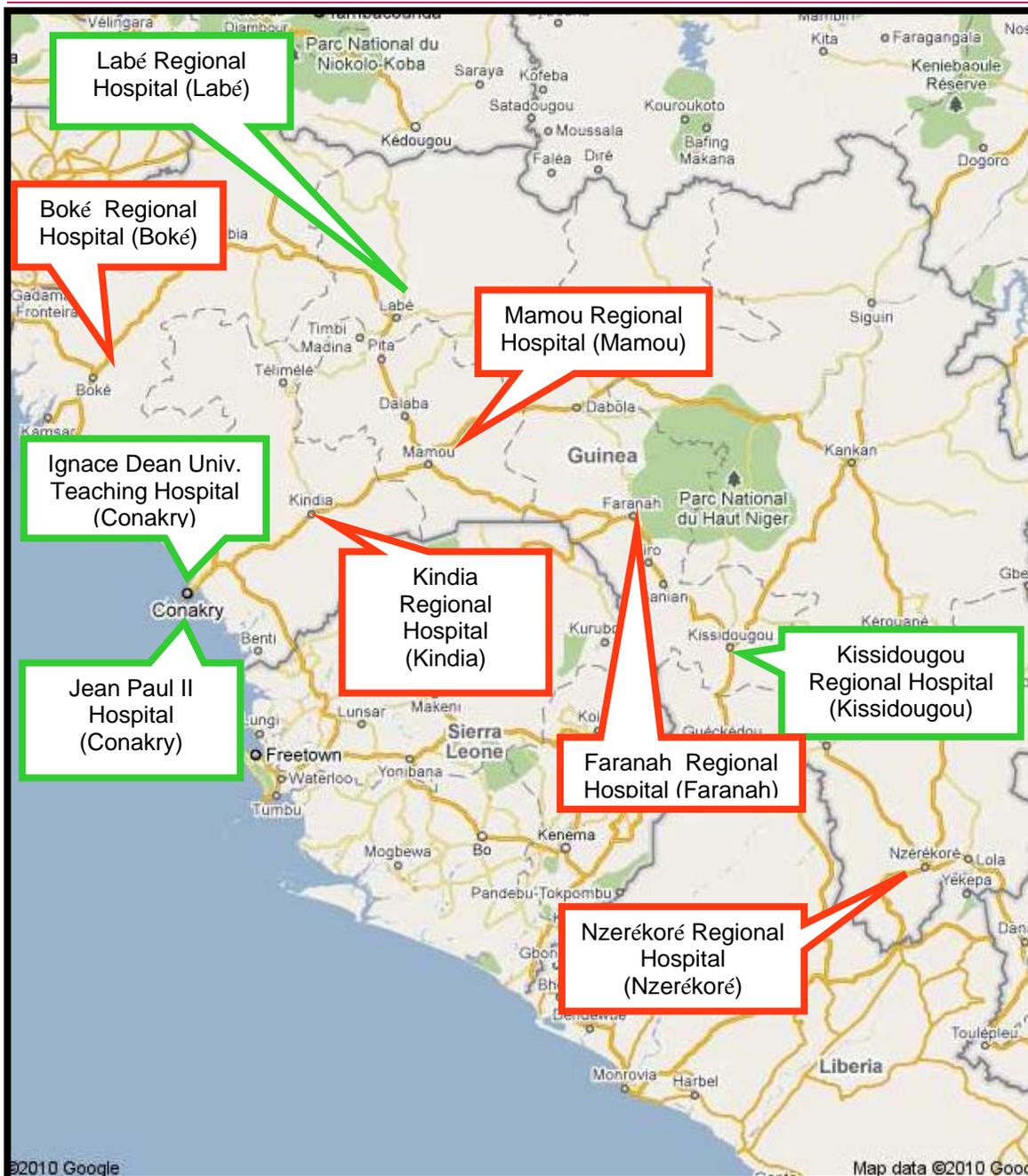
Although the project staff have trained staff at all the health centers, reasons for non-compliance, beside chronic issues of staff shortages and turnover, is an overall lack of commitment to use partographs and a lack of supervision. The team continues to work with the health center department heads to monitor this issue during supportive supervision visits and emphasize the importance of its use. Fistula Care is working on a simple monitoring checklist tool that the mentors can utilize in order to standardize the review process.

**Table ETH6. Deliveries and Use of the Partograph
at Pre Repair Health Centers,
October 2009 to September 2010, Ethiopia**

Fistula Screening	Adet					Dangla					Woreta					Country Total				
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total
Number women delivered at health center, by facility																				
Health post	47	37	26	14	124	83	151	166	158	558	76	120	75	36	307	206	308	267	208	989
Upgraded health center	0	8	13	21	42	0	0	67	75	142	35	27	8	20	90	35	35	88	116	274
Health center	51	65	67	61	244	59	68	75	101	303	70	85	77	100	332	180	218	219	262	879
Number women arriving at HC fully dilated (partograph not used)																				
Number women arriving at HC fully dilated (partograph not used)	21	34	42	42	139	19	33	26	56	134	40	46	44	58	188	80	113	112	156	461
Number labors monitored with partograph	30	25	24	28	107	40	34	63	90	227	28	38	27	37	130	98	97	114	155	464
Number/percent of labors monitored with partograph which were done correctly ⁴⁴	29/ 96%	9/ 36%	18 / 75%	26/ 93%	82/ 77%	40/ 100%	25/ 73%	61 / 97%	86/ 96%	212/ 93%	21/ 75%	28/ 74%	22/ 81%	34/ 92%	105/ 81%	90/ 92%	62/ 64%	101/ 89%	146/ 94%	399/ 86%
Number women with obstructed labor referred from HC to regional hospital	14	17	18	9	58	10	7	4	5	26	10	10	17	17	54	34	34	39	31	138

⁴⁴ Based on the number of women who delivered at a health center and who arrived NOT fully dilated and for whom the partograph was used to monitor labor.

GUINEA



Program Background

Service start up: January 2006.

Service sites: Four public hospitals for fistula repair and five prevention sites:

- The National University Teaching hospital Ignace Deen, Conakry (through June 2010; effective July 2010 it is a level 1 facility; see below)
- The District Hospital of Kissidougou, Forest Region of Guinea
- Jean Paul II Maternity Hospital, Conakry

- Labé Regional Hospital, Central Region
- Level 1 fistula care (prevention): Regional hospitals of Boke, Kindia, Mamou, Faranah, N'Zerekore

Labé Regional Hospital was added in FY 08/09 as were the three Level 1 sites of Boke, Kindia, and Mamou. Faranah and N'Zerekore Regional Hospitals have been added as Level 1 (prevention) sites in 2010. Ignace Deen has a total of 13 surgeons on site who are trained in fistula repair: eight for medium-complex repairs and five for simple repairs. Ignace Deen only has four pre- and post-operative beds for fistula patients. Due to the limited number of beds available to fistula clients and for cost-effectiveness, Fistula Care has decided to cease support of repairs at this site; beginning in July 2010 support will only be provided for prevention activities. Jean Paul II and Kissidougou both have two surgeons able to perform simple repairs, and Kissidougou has one surgeon for medium-complex repairs. Jean Paul II has 31 pre- and post-operative beds available for fistula patients, while Kissidougou has 22 and 13 beds respectively. Labé currently has 16 pre- and post-operative beds available. Three surgeons are being trained to provide simple repairs during surgical repair sessions. Repairs are conducted twice per quarter at Labé: one session conducted by a team of local experts and one conducted by GFMER experts. Each site has at least one theater available for fistula surgery, with two theaters available at Jean Paul II.

Private funds from EngenderHealth are used in support of the community outreach activities.

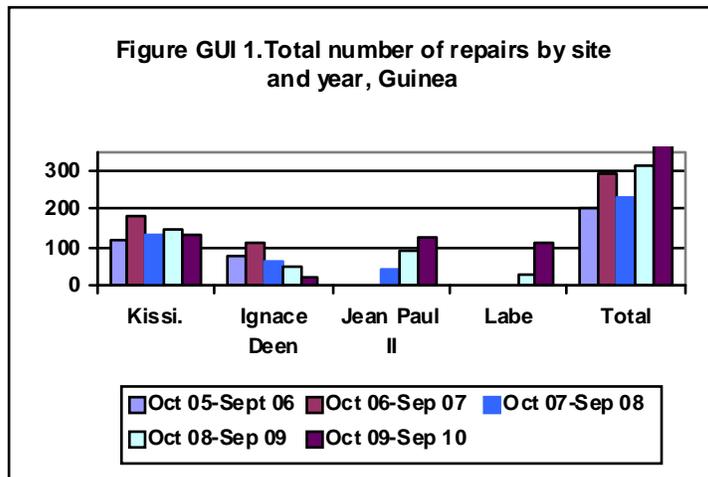
Key Accomplishments October 2009-September 2010

During the first quarter, Guinea experienced several political upheavals which culminated into extreme violence. The ensuing security situation impeded the ability of the Guinea office to carry out many of their planned activities, particularly in the capital of Conakry.

In the first quarter, the Fistula Care Project in Guinea signed a memorandum of understanding (MOU) with the USAID bilateral project Extending Service Delivery (ESD) to ensure the availability and accessibility of family planning services in FC supported sites. ESD will ensure the availability of contraceptive methods at Ignace Deen, Jean Paul II, the regional hospitals of Faranah and N'Zerekore and the Kissidougou District hospital and they will also provide training in distribution of FP as well as oral contraceptives, condoms and natural FP methods to Village Safe Motherhood committee members in Kissidougou. FC project will support training and provide the same methods for Safe Motherhood committee members outside of the ESD intervention zones (regional hospitals of Kindia, Labe, Mamou and Boke). ESD will also provide tools to the FC sites to support contraceptive logistical management, FP consultations and FP activity reports. Fistula Care will further integrate FP and FC services by reinforcing family planning units and training health providers in family planning at all supported sites and integrating FP in the training modules for the Village Safe Motherhood committees. The FC project will also revitalize long actng/permanent methods by increasing the availability and demand for the IUCD in all of the project sites.

As described above, Fistula Care has decided to suspend support for repairs at Ignace Deen due to limited bed capacity to improve cost effectiveness. The trained surgeons from this site will continue to be trained at the Jean Paul II site and those trained to do medium/complex repairs will be deployed as necessary to sites that need these skills. Fistula Care will continue to support prevention activities, including family planning and emergency obstetric services at Ignace Deen.

Fistula Repairs. During the fiscal year, a total of 392 repairs were carried out at four supported sites in Guinea. This represents a 24% increase when compared to FY 08/09.



In comparison to FY 08/09, there was a 50% increase at Jean Paul II and an almost 300% increase in repairs at Labe. Ignace Deen, which provided no repairs in the fourth quarter of FY 09/10 had a decrease in numbers, as did Kissidougou. Fig GUI1 provides a comparison of repairs by site, over time.

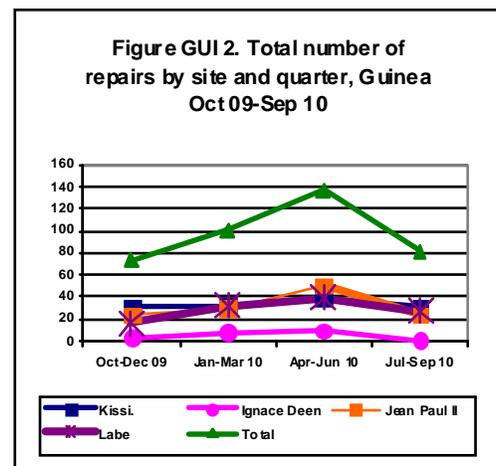
The 24 % increase in the number of repairs performed is mainly due to the following:

1) The Guinea program has developed 3 approaches to train local surgeons and repair obstetric fistula:

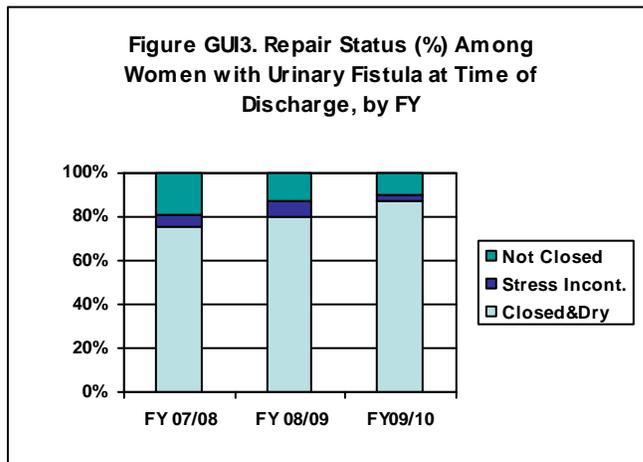
- Routine sessions during which simple surgical repairs are conducted routinely by local surgeons from FC supported sites;
- National sessions during which simple to moderate fistula repairs are performed by a core of national surgeons from the Urology Department of Ignace Deen Hospital;
- International sessions during which simple to complicate fistula repairs are performed by experts from the Geneva Foundation for Medical Education & Research (GFMER)

2) The Levels of Care Framework for fistula implemented by the Guinea program has been instrumental to reinforcing the referral system of fistula clients; level I sites have been identifying and referring an increased number of fistula clients to level II and III sites.

Because of the above approaches, although the maternity of Ignace Deen has been reclassified from level II to level I (no longer providing repairs), fistula repairs are expected to continue to increase in the coming year.



All three sites had their highest number of repairs in the third quarter of the fiscal year (see Fig. GUI2). This was attributed to strong community outreach efforts and the organization of multiple repair sessions during that period. In the fourth quarter, support to Ignace Deen was not provided for repairs. Numbers decreased at Jean Paul II and Labe because the GFMER international session was postponed due to the political situation.



Nearly 70% of all repairs were first repairs, with the range of first repair ranging from 53% at Jean Paul II to 87% at Kissidougou. The vast majority of repairs at all sites were urinary-only repairs. Of the 383 women with urinary-only or urinary/RVF repairs discharged after surgery, 87% were closed and dry (Fig. GUI3). Table GUI1 provides detailed information on the clinical indicators, by site.

Jean Paul II and Labe both are experiencing backlogs of women waiting for repair. With the increased community awareness about the services available, a greater number of clients are seeking care despite limited bed capacity. Actions have been taken to ensure that level I sites will only refer women to repair sites if there is room for them to undergo surgery. Additionally, all women registered at the screenings will be invited for fistula treatment according to a schedule to ensure they all receive repairs.

A total of 17 additional surgeries were reported being performed during the fiscal year. The most common surgeries were urethral lengthening and other operations for concomitant stress incontinence and wound resuture. We are in the process of working with the sites to ensure that data for all additional surgeries performed is being captured appropriately. See Table GUI2 for the surgeries that were reported being performed.

Table GUII. Fistula Repair Clinical Indicators, by Site and Quarter, October 2009 thru September 2010, Guinea

Fistula Treatment Indicators	Ignace Deen					Jean Paul II					Kissidougou				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	3	8	11	NS	22	51	51	74	42	218	32	37	54	72	195
No. requiring FRS	3	8	9	NS	20	45	44	70	28	187	32	37	54	72	195
No. receiving FRS	3	8	9	NS	20	23	29	50	24	126	31	32	39	30	132
Percent receiving FRS	100%	100%	100%	0%	100%	51%	66%	71%	86%	67%	97%	86%	72%	42%	68%
Type of FRS performed															
--- urinary only	2	8	9	NS	19	23	22	46	23	114	29	30	39	27	125
---urinary & RVF	1	0	0	NS	1	0	0	4	0	4	1	1	0	0	2
--- RVF only	0	0	0	NS	0	0	7	0	1	8	1	1	0	3	5
For 'Urinary only' or 'Urinary and RVF' repairs															
----- first repair	0	3	8	NS	11	5	17	27	14	63	26	23	34	27	110
----- second repair	2	4	0	NS	6	12	1	13	7	33	3	5	4	0	12
----- >2	1	1	1	NS	3	6	4	10	2	22	1	3	1	0	5
Percent women with first repair (urinary only)	0%	38%	89%	0%	55%	22%	77%	54%	61%	53%	87%	74%	87%	100%	87%
No. discharged after FRS (urinary only)	2	8	9	NS	19	23	22	46	23	114	45	19	50	27	141
No. discharged after FRS (urinary & RVF)	1	0	0	NS	1	0	0	4	0	4	0	1	0	0	1
No. discharged after FRS (RVF only)	0	0	0	NS	0	0	7	0	1	8	1	1	1	3	6
Total no. discharged after FRS	3	8	9	NS	20	23	29	50	24	126	46	21	51	30	148
No. not discharged after	0	0	0	NS	0	0	0	0	0	0	1	12	0	0	13

	Ignace Deen					Jean Paul II					Kissidougou				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
FRS															
Outcome of FRS (urinary only & urinary/RVF)															
----No. with closed fistula who are dry	2	7	8	NS	17	19	22	42	20	103	36	17	47	25	125
---- No. with closed fistula & stress incontinence	0	0	1	NS	1	1	0	0	1	2	4	1	1	1	7
--- No. whose fistula was not closed	1	1	0	NS	2	3	0	8	2	13	5	2	2	1	10
Percent with closed fistula who are dry (urinary only & urinary/RVF)	67%	88%	89%	0%	85%	83%	100%	84%	87%	87%	80%	85%	94%	93%	88%
Outcome of FRS (RVF only)															
----- closed and dry	0	0	0	NS	0	0	2	0	1	3	1	1	1	3	6
----- incontinent with watery stool and /or flatus (gas)	0	0	0	NS	0	0	0	0	0	0	0	0	0	0	0
----- incontinent with firm stool	0	0	0	NS	0	0	5	0	0	5	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	0%	0%	0%	0%	0%	29%	0%	100%	38%	100%	100%	100%	100%	100%
No. with complications after FRS	0	0	0	NS	0	0	0	1	0	1	1	0	0	0	1
----- Major surgical complications	0	0	0	NS	0	0	0	0	0	0	0	0	0	0	0
-----Anesthesia-related complication	0	0	0	NS	0	0	0	0	0	0	0	0	0	0	0

	Ignace Deen					Jean Paul II					Kissidougou				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
----Post-operative complication related to perceived success of surgery	0	0	0	NS	0	0	0	1	0	1	1	0	0	0	1
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	2%	0%	1%	2%	0%	0%	0%	1%

Table GUII, continued

	Labe					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	23	81	42	80	226	109	177	181	194	661
No. requiring FRS	23	78	42	77	220	103	167	175	177	622
No. receiving FRS	16	32	39	27	114	73	101	137	81	392
Percent receiving FRS	70%	41%	93%	35%	52%	71%	60%	78%	46%	63%
Type of FRS performed										
----- urinary only	15	32	37	27	111	69	92	131	77	369
----- urinary & RVF	1	0	2	0	3	3	1	6	0	10
----- RVF only	0	0	0	0	0	1	8	0	4	13
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	11	22	25	14	72	42	65	94	55	256
----- second repair	5	8	7	8	28	22	18	24	15	79
----- >2	0	2	7	5	14	8	10	19	7	44
Percent women with first repair (urinary only)	69%	69%	64%	52%	63%	58%	70%	69%	71%	68%
No. discharged after FRS (urinary only)	15	16	43	26	100	85	65	148	76	374

	Labe					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. discharged after FRS (urinary & RVF)	0	0	2	0	2	1	1	6	0	8
No. discharged after FRS (RVF only)	1	0	0	0	1	2	8	1	4	15
Total no. discharged after FRS	16	16	45	26	103	88	74	155	80	397
No. not discharged after FRS	0	16	10	11	37	1	28	10	11	50
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	13	13	39	23	88	70	59	136	68	333
----- No. with closed fistula & stress incontinence	0	0	3	0	3	5	1	5	2	13
----- No. whose fistula was not closed	3	3	3	3	12	12	6	13	6	37
Percent with closed fistula who are dry (urinary only & urinary/RVF)	87%	81%	87%	88%	86%	81%	89%	88%	89%	87%
Outcome of FRS (RVF only)										
----- closed and dry	1	0	0	0	1	2	3	1	4	10
----- incontinent with watery stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
----- incontinent with firm stool	0	0	0	0	0	0	5	0	0	5
Percent with closed and dry fistula (RVF only)	100%	0%	0%	0%	100%	100%	38%	100%	100%	67%
No. with complications after FRS	0	0	1	0	1	1	0	2	0	3
-----Major surgical complications	0	0	0	0	0	0	0	0	0	0
---- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
---- Post-operative complication related to perceived success of surgery	0	0	1	0	1	1	0	2	0	3
Percent with complications after FRS	0%	0%	2%	0%	1%	1%	0%	1%	0%	1%

Table GUI 2. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Guinea

	Oct-Dec	Jan – March	Apr-June	Jul-Sep	FY Total
Type of Surgery by Site					
Jean Paul II					
Urethral lengthening and other operations for concomitant stress incontinence	0	1	1	1	3
Removal of bladder stones or foreign bodies in the viscera	0	0	0	3	3
Prolapse, if associated with fistula	0	0	0	1	1
Ignace Deen					
Colostomy and reversal colostomy	1	0	0	0	1
Labé					
Urethral lengthening and other operations for concomitant stress incontinence	0	0	3	0	3
Wound resuture	0	0	4	0	4
Kissidougou					
Other	0	0	0	2	2
Total	1	1	8	7	17

Training During FY 09/10, a total of 156 providers received training in Guinea. Sixty-seven providers received training on EmOC, AMTSL, catheterization and partograph. Quality improvement training in EmOC was conducted in Kissidougou. Training on community based distribution of contraception was provided to selected members of the village committees of Labe and Kissidougou by ESD, as part of their MOU with Fistula Care.

Five surgeons received continuing training in surgical repair in the second quarter, and six surgeons were trained in the fourth quarter. A total of 8 individual surgeons received training, as several of the surgeons were trained more than once during the fiscal year. There was no fistula care sponsored training during the third quarter. Table GUI3 provides information in numbers of persons trained, by topic.

Table GUI 3. Number of Persons Trained by Topic, October 2009 – September 2010, Guinea

Training Topic	Oct-Dec	Jan-Mar	Apr - Jun	Jul-Sep	FY Total
Continuing surgical training for fistula repair	0	5	0	6	8*
Training and supervision in EmOC, AMTSL, catheterization and partograph	11	46	0	10	67
Quality Improvement for EmOC (Kissidougou)	0	16	0	0	16
Training on community based distribution of contraception (Labe and Kissidougou)	0	61	0	0	61
Training in data collection for C-section indication study	0	0	0	4	4
Total	11	128	0	20	156*

*Totals are the number of individuals trained, not the number of training events. Surgeons who receive multiple continuing trainings are only counted once for the fiscal year.

Quality Improvement. The FC steering committee officially established a Quality of Fistula Care team whose role is to conduct field visits to ensure that sites are following the Fundamental's of Care. The team is comprised of Pr Namory Keita, head of the Maternity of the Naional Hospital of Donka, Dr. Mara Mamadou, head of Maternity at JPII and Dr. Sita Millimono, Fistula Care Program Officer. A medical monitoring visit was conducted at Labe and Kissdougou in the second quarter and the Quality of Fistula Care team visited in the fourth quarter.

In the fourth quarter, a joint supervision visit was carried out to look at the family planning services being provided at all the supported sites. Recommendations were made to improve internal facilitative supervision, undertake changing space arrangements to ensure better confidentiality, and improve stock management of contraceptives.

Community Outreach and Prevention. Brochures, IEC/BCC aids and posters for the community were produced during the first quarter.

The Village Committees of Kissidougou and Labe carried out 30 outreach activities during the year, reaching nearly 40,000 people. In the first quarter, 10 religious leaders were oriented to fistula prevention as part of a larger MAP program. These religious leaders went on to hold nearly 70 sensitization sessions at mosques and churches, reaching over 15,000 people. Details on community outreach efforts are presented below in Table GUI 4. The Village Committees in both sites and the religious leaders in Labe held quarterly data review meetings to compile and analyze the most recent data available.



Left: Quarterly Data Review meeting of the Villa Committee of Labe

Table GUI 4. Number of Community Outreach Events and Persons Reached, October 2009 - September 2010, Guinea

Event Type	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached
Kissidougou village committee outreach	3	5685	4	5939	3	3430	5	4878	15	19,932
Labe village committee outreach	3	5243	4	6197	3	4031	5	4425	15	19,896
Orientation of religious leaders	1	10	0	0	17	8188	52	7010	70	15,208
Total	7	10,938	8	12,136	23	15,649	62	16,313	100	55,036

The village safe motherhood committees in Kissidougou and Labe continued their work. During the fiscal year, nearly 20,000 women were reached through sensitization meetings, and 816 women attended their first prenatal visit. Details on the activities of the Safe Motherhood Committees are provided below in Table GUI5.

The village Safe Motherhood Committees in Kissidougou and Labe conducted training sessions for new members that included danger signs of pregnancy and delivery, fistula prevention, use of media supports and management tools, etc.

As part of the social immersion reintegration program, during the fiscal year 68 healed women were hosted by voluntary families in Kissidougou and Labe and conducted sensitization meetings reaching over 2,400 community members.

Table GUI 5. Safe Motherhood Committee Activities, Kissidougou and Labé Regions by Quarter, October 2009 thru September 2010, Guinea

Safe Motherhood Committee Activities	Oct-Dec	Jan - Mar	Apr-Jun	Jul-Sep	FY Total
#women reached at sensitization meetings	5155	6116	3,654	4694	19619
# men reached at sensitization meetings	n/a	n/a	3,807	4609	8416
# women attending prenatal					
1 st visit	360	153	132	171	816
2 nd visit	347	191	174	212	924
3 rd visit	242	156	118	175	691
4 th visit	162	153	108	112	535
# women receiving Tetanus Toxin					
1 st injection	424	288	200	321	1233
2 nd injection	355	350	296	309	1310

Family Planning. In total, 1,967 individuals accepted family planning at the supported sites in Guinea. The most popular methods were the injectable and oral pill, followed by IUCDs and male condoms. Over 3,400 individuals received family planning counseling. Information on family planning methods provided, by site, is provided in Table GUI6. ESD is providing contraceptives to the FC supported sites of JPII and Ignace Deen, while the AGBEF (IPPF affiliate) is providing contraceptives to the Labe site. Implants are not currently available in country.

Table GUI 6. Number of FP Clients by Method and Number Counseled About FP, by Site and Quarter. October 2009 – September 2010, Guinea.

	Boke	Faranah	Ignace Deen	Jean Paul II	Kindia	Kissidougou	Labe	Mamou	N'Zerekore	Country Total
Fistula FP Methods										
Oral Pill	91	39	105	39	14	100	24	39	21	472
IUCD	44	2	196	4	6	22	10	23	15	322
Condom (male)	158	9	0	9	0	0	1	53	14	244
Condom (female)	2	0	0	0	0	0	0	0	0	2
Injectable	107	150	134	121	137	118	40	34	10	851
Implant	0	0	0	0	0	0	0	0	0	0
Tubal Ligation	22	0	0	3	4	17	0	0	0	46
Vasectomy	0	0	0	0	0	0	0	0	0	0
Foaming Tablets	0	0	0	30	0	0	0	0	0	30
Total FP acceptors	424	200	435	206	161	257	75	149	60	1967
Total Number of clients counseled about FP methods	474	453	416	311	604	479	234	204	283	3458

Obstetrics. Information on obstetric services can be found in Table GUI 7. A total of 11,236 deliveries took place in the fiscal year, of which just under 33% were C-sections.

Table GUI 7. Obstetric Services, by site. October 2009 – September 2010, Guinea.

	Kissidougou	Ignace Deen	JPII	Labe	Kindia	Mamou	Boke	Faranah	N'Zerekore	Country Total
Number of vaginal deliveries	393	2332	430	604	842	845	1086	442	582	7556
Number of C-sections	407	1238	64	281	333	423	362	158	414	3680
Total number of deliveries	800	3570	494	885	1175	1268	1448	600	996	11236
Percent deliveries by C-section	60%	35%	13%	32%	28%	33%	25%	26%	42%	33%

Policy. In the second quarter, Fistula Care staff briefed the newly appointed Minister of Women and National Solidarity, Ms. Nanfadima Magassouba, on the activities of the Fistula Care Project.

The 3rd Annual Fistula Day took place on May 28th, 2010, under the auspices of Guinea's First Lady. More than 200 people attended the ceremony, including several Ministers and other key officials and partners, community leaders, representatives from international NGOs, and public and private media. Karen Beattie's visit to Guinea included this ceremony as well as visits to partner sites and meetings with high profile Guinean government officials including the Minister of Health and the Minister of National Solidarity and the Promotion of Women and Children.

Right: Healed fistula women at the Jean Paul II site.



MALI



Program Background

Service start date: October 2008

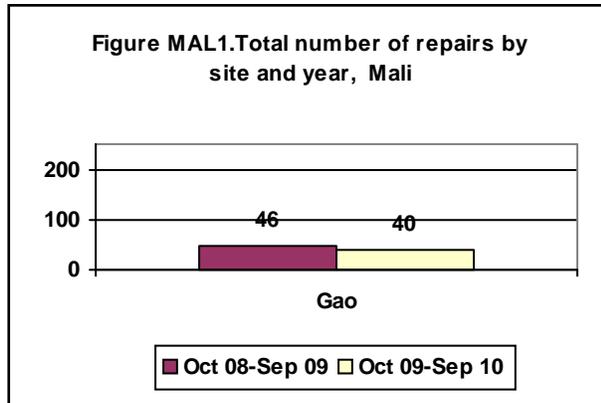
Sites: Gao Regional Hospital

The fistula project in Mali is implemented by IntraHealth, a partner on the Fistula Care Project, with technical support and project oversight led by EngenderHealth. Although Gao Hospital is the principal site supported by Fistula Care, quality of fistula services training has included staff from other facilities providing fistula services in Mopti, Segou and Point G National Hospital in Bamako. Additionally, the Fistula Care Project is supporting the following referral health centers (CSRef) in Gao in EmOC training: Ansongo, Bourem, Menaka and Gao CSREF. The project also partners with GREFFA, a local NGO to support community outreach and recruitment efforts.

Key Accomplishments October 2009-September 2010

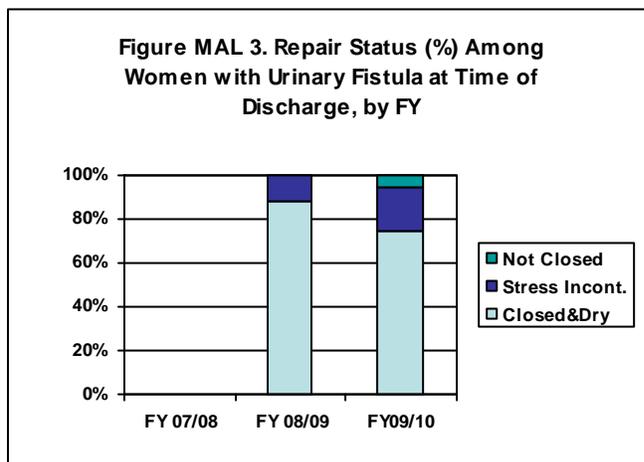
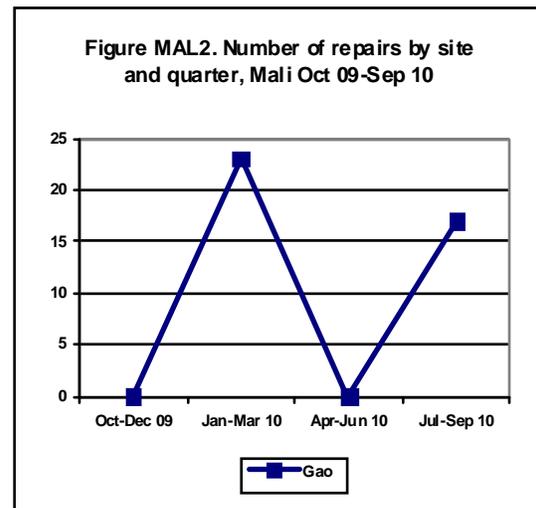
No activities were implemented during the first quarter in Mali because the workplan and budget were not yet finalized for this fiscal year. The Scope of Work was approved by EngenderHealth's Grants and Contracts Unit in February 2010.

Fistula Repairs. During FY 09/10, a total of 40 repairs were carried out in Mali (see Table MAL1). Compared to the number of repairs in FY 08/09, there was a decrease of 13%, which is explained by the delay in subaward approval in addition, one planned fistula repair



campaign was reprogrammed for the following fiscal year due to difficulty recruiting women during the rainy season (see Fig MAL1).

Repair sessions were carried out in the second and fourth quarters. The last organized repair session overlapped the third and fourth quarters of the fiscal year. Women were recruited and screened in the third quarter, and received repairs and were discharged in the fourth quarter (see Fig MAL2). Outcome data is reported for the 14 women who were discharged from the hospital during the first quarter, though no repairs took place during that time.



Nearly all women requiring repairs received them and the majority were urinary repairs. The majority of women had already received one repair prior to their current surgery. There were no complications reported and three quarters of the women discharged were closed and dry (see Fig MAL3). The vast majority of women who were not dry after surgery had undergone more than 2 surgeries and were older, having had fistulas for longer periods of time. Follow-up for these women to provide alternate methods of managing

their injury and income generating opportunities continues.

**Table MAL I. Fistula Repair Clinical Indicators by Site and Quarter,
October 2009 - September 2010, Mali**

Fistula Treatment Indicators	Gao Regional Hospital I				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	0	36	28	0	64
No. requiring FRS	0	23	18	0	41
No. receiving FRS	0	23	0	17	40
Percent receiving FRS	0%	100%	0%	0%	98%
Type of FRS performed					
----urinary only	0	18	0	16	34
---- urinary & RVF	0	3	0	1	4
----RVF only	0	2	0	0	2
For 'Urinary only' or 'Urinary and RVF' repairs					
---- first repair	0	11	0	2	13
---- second repair	0	9	0	3	12
---- >2	0	1	0	12	13
Percent women with first repair (urinary only)	0%	52%	0%	12%	34%
No. discharged after FRS (urinary only)	12	0	18	16	46
No. discharged after FRS (urinary & RVF)	2	0	3	1	6
No. discharged after FRS (RVF only)	0	0	2	0	2
Total no. discharged after FRS	14	0	23	17	54
No. not discharged after FRS	0	23	0	0	23
Outcome of FRS (urinary only & urinary/RVF)					
---No. with closed fistula who are dry	13	0	15	11	39
---No. with closed fistula & stress incontinence	1	0	3	6	10
---No. whose fistula was not closed	0	0	3	0	3
Percent with closed fistula who are dry (urinary only & urinary/RVF)	93%	0%	71%	65%	75%
Outcome of FRS (RVF only)					
-----closed and dry	0	0	2	0	2
--- - incontinent with water stool and /or flatus (gas)	0	0	0	0	0
-----incontinent with firm stool	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	0%	100%	0%	100%
No. with complications after FRS	0	0	0	0	0
---- Major surgical complications	0	0	0	0	0
-----Anesthesia-related complication	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0
Percent with complications after FRS	0%	0%	0%	0%	0%

Seven additional surgeries were performed, which included ureteric reimplantations and urethral lengthening or other operation for concomitant stress incontinence. Table MAL2 presents this information below.

Table MAL 2. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Mali

	Oct-Dec	Jan – March	Apr-June	Jul-Sep	FY Total
Type of Surgery by Site					
GAO Hospital					
Ureteric re-implantation	0	3	0	0	3
Urethral lengthening or other operation for concomitant stress incontinence	0	0	0	3	3
Other	0	0	0	1	1
Total	0	3	0	4	7

Strengthening Capacity. The process for procuring operating theater equipment and fistula repair kits for Gao hospital began in the last quarter.

Training. Two surgeons received continuing training in fistula repair during the second and fourth quarters. During the third and fourth quarters, trainings were conducted at the CSREF level on emergency obstetric care and fistula prevention. Participants included health providers from 4 health districts and from Gao Nursing School. Table MAL3 provides information on persons trained, by topic.

Table MAL 3. Number of Persons Trained by Topic, October 2009 – September 2010, Mali

Training Topic	Oct-Dec	Jan-Mar	Apr – Jun	Jul-Sep	FY Total
Continuing training for fistula surgeons	0	2	0	2	2*
Fistula counseling	0	18	0	0	18
CSREF training of trainers on emergency obstetrics and fistula prevention	0	0	16	15	31
Data management for C-section study	0	0	0	2	2
Total	0	20	16	19	53*

*The same two surgeons received continuing training in Q1 and Q3, and are only counted once as a “person trained”.

Two global Fistula Care colleagues visited Bamako and Mopti, Mali in the second quarter to introduce standardized follow-up tools and approaches for fistula counseling training. The tools and approaches were used to evaluate the knowledge and skill of trainees in fistula counseling following the fistula counseling training held in August 2009. The visit included evaluation and discussion with IntraHealth staff, who participated as trainers during the August training, to orient them to the counseling training follow-up tools and to assess their capacity to observe and provided mentoring and coaching on fistula counseling to trainees. The service providers from Mopti

Regional Hospital who were trained in FY 08/09 to provide fistula counseling were observed providing counseling to fistula clients and received mentoring and coaching on ways to improve their skills. More details about the findings and recommendations from this training are discussed above in Section III, Global Accomplishments, Result 1.

Prevention. In addition to the treatment and prevention activities supported by Fistula Care in the region of Gao, the project also partnered with hospitals and NGOs supporting fistula services in two other regions and Bamako.

Fistula Care Mali has provided training in fistula counseling for services providers from the regional hospitals in Segou and Mopti and the national teaching hospital in Bamako, Point G as well as staff from NGOs Medecine du Monde (MDM) and Delta Survie. MDM is supporting fistula repair services and Delta Survie is supporting patient recruitment and reintegration of fistula patients post repair at Mopti regional hospital. Fistula repair services are supported by an international NGO, Imaneh Suisse, and its local affiliate, Imaneh Mali in Segou. The UNFPA, Imaneh Suisse and other partners support fistula services at Point G Hospital.

In addition to the support in fistula counseling mentioned above, the project is actively seeking to continue to engage service providers and staff supporting fistula services in these regions to support the MOH's aim to establish national coverage of quality fistula services .

During the second and fourth quarters, radio messages were broadcast, in 3 languages, to raise awareness within the community on the causes and the prevention of fistula, in addition to the availability of treatment. During the organized repair sessions, Professor Ouattara, the national trainer, participates in a local radio program to talk about fistula, the availability of treatment, success rates of the surgery and prevention through skilled birth attendance. The hour long programs are designed in a discussion format with a journalist;. During the last repair campaign, the program included messages from local authorities about the importance of delaying marriage and the dangers of fistula related to early marriage/childbirth. Between the campaigns, Fistula Care, through support to GREFFA, supports ongoing radio spots about the campaign primarily for recruitment purposes.

Group and individual awareness raising sessions take place at Gao Hospital for women and their companions covering the causes of fistula, risk factors, prevention strategies and family planning. The group sessions are mostly sensitization/education sessions about the causes of fistula, which includes dispelling myths about witchcraft/fidelity and includes information on prevention and treatment. The one-on-one sessions between the nurse counselors and the woman focus on their specific cases pre and post repair surgery. Patients are able to discuss their experiences that caused the fistula and are given counseling in family planning and the ability to have more children. They are presented with information about the surgery and the healing process and the counselors attempt to prepare them for the surgery and respond to all their questions and concerns

Community Outreach. Partners in Mali report that drought and famine are affecting many areas which in turn impacts women’s willingness to leave their homes to travel for repairs – they do not want to abandon their animals since they often provide womens’ sole source of income. Additionally, political unrest in surrounding areas has lead some ethnic groups to move very far from combat zones. Fistula cases are sought by GREFFA in very remote areas across the districts of Gao and Menaka as community awareness efforts move into more and more distant areas. Although the organization is largely successfully in accessing and recruiting women from the most remote and affected areas of the region, GREFFA faces challenges of reaching nomadic groups on poor roads and paths. Furthermore, increasing security issues in those areas continue to pose challenges to their work.

Despite these challenges, the number of community outreach efforts has dramatically increased in this fiscal year compared to earlier efforts. With the support of Fistula Care, GREFFA has almost doubled the number of facilitators working in the field so they can be active in the 4 districts at the same time. Information on community outreach and awareness raising events is presented in Table MAL4, below.

Table MAL 4. Number of Community Outreach Events and Persons Reached, October 2009 - September 2010, Mali

Event Type	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached
Information and awareness-raising sessions in the Cercles of Gao, Bourem, Ansongo and Menaka	0	0	50	1419	72	1843	357	1902	479	5164
Presentation of annual assessment of the DRS and Hospital, ammendment and validation of the 2011 workplan of these two structures.	0	0	1	200	0	0	0	0	1	200
Development of a 2011 regional fistula action plan, evaluation of 2009 regional fistula activities, and assessment of progress made.	0	0	1	30	0	0	0	0	1	30
Total	0	0	52	1649	72	1843	357	1902	481	5394

Family Planning. A total of 220 people received family planning methods during the fiscal year, with injectables making up the vast majority of methods distributed. Additional information on family planning methods is provided in Table MAL5.

Table MAL 5. Number of FP Clients by Method and Number Counseled about FP, Gao, October 2009 – September 2010, Mali.

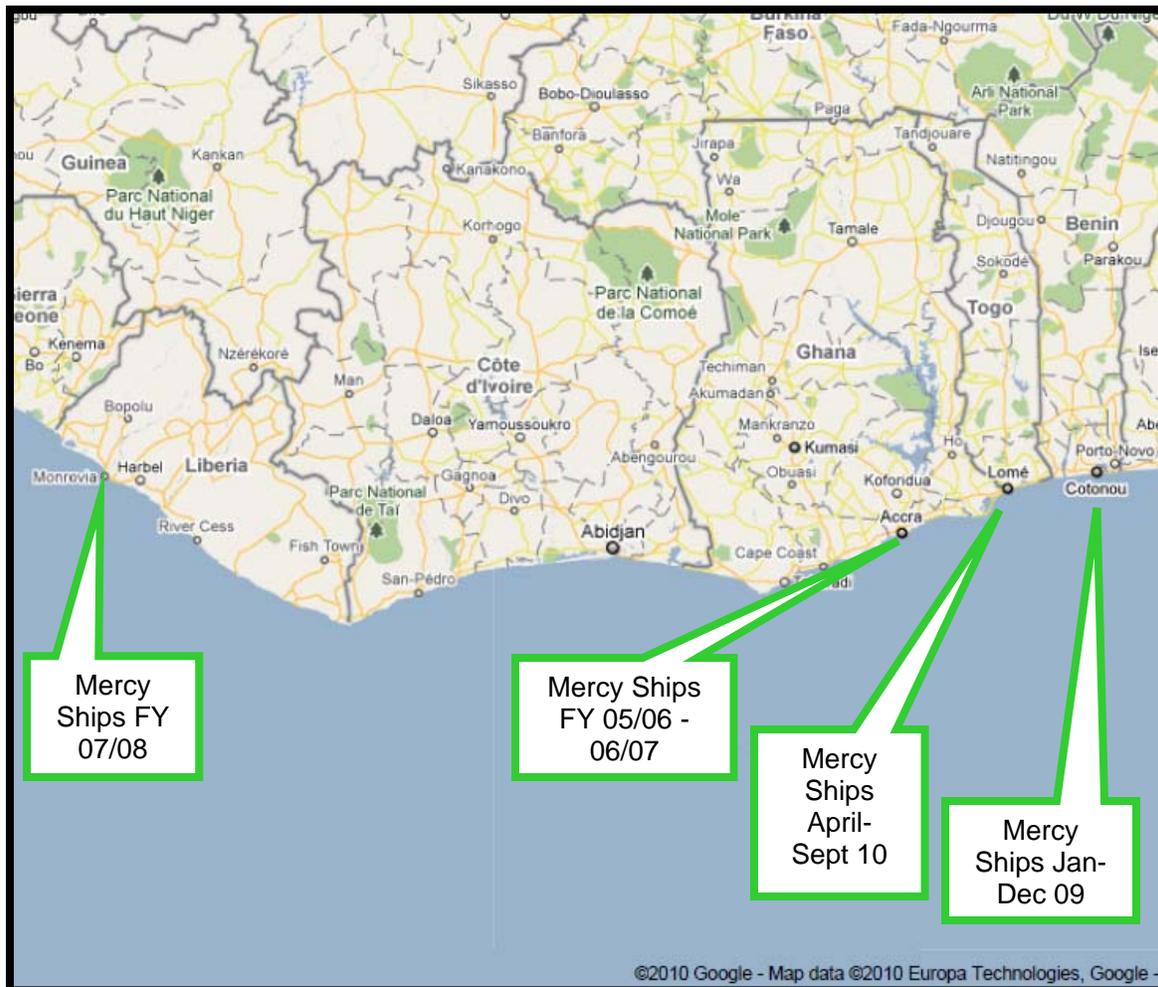
	Gao Regional Hospital				
Fistula FP Methods	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
Oral Pill	5	5	7	4	21
IUCD	2	0	1	0	3
Condom (male)	0	0	0	0	0
Condom (female)	0	0	0	0	0
Injectable	54	48	52	42	196
Implant	0	0	0	0	0
Tubal Ligation	0	0	0	0	0
Vasectomy	0	0	0	0	0
Foaming Tablets	0	0	0	0	0
Total FP acceptors	61	53	60	46	220
Total Number of clients counseled about FP methods	61	53	60	46	220

Obstetrics. Obstetric data for the fiscal year reports a total of 1,177 deliveries at Gao Hospital, with 22% (259 deliveries) being c-sections. Additional detail by quarter is found below in Table MAL6.

Table MAL6. Obstetric Services, by site. October 2009 – September 2010, Mali.

	Gao Hospital				
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Total
Number of vaginal deliveries	188	177	248	305	918
Number of C-sections	60	76	60	63	259
Total number of deliveries	248	253	308	368	1177
Percent deliveries by C-section	24%	30%	20%	17%	22%

MERCY SHIPS: AFRICA MERCY



Program Background

Service start date: First subaward to Mercy Ships granted in FY 05/06 through other EngenderHealth funding mechanisms from USAID

Sites: Mercy Ship's *Africa Mercy* hospital ship, docked in Benin during calendar year 2009, and Togo in 2010.

Mercy Ships had subawards between October and December 2009 (for services and training in Benin) and between April and August 2010 (for services and training in Togo). Therefore there is no data reported from the ship for the second quarter of this fiscal year.

Key Accomplishments October 2009-September 2010

Fistula Repairs. A total of 118 repairs were performed during the fiscal year. No repairs were performed in the second quarter, due to the absence of a subaward. Repairs supported in the third and fourth quarters were part of training sessions while the ship was docked in Togo. Information on repairs can be found in table MS1.

Twenty-seven additional surgeries were performed during the fiscal year, primarily urethral lengthening and ureteric reimplantation. The details for the surgeries can be found below in Table MS2.

Table MS1. Clinical Indicators by Site, October 2009 – September 2010, Mercy Ships

Fistula Treatment Indicators	Benin		Togo			Total				
	Oct-Dec	FY Total	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	37	37	130	n/a	130	37	0	130	0	167
No. requiring FRS	29	29	101	n/a	101	29	0	101	0	130
No. receiving FRS	21	21	94	3	97	21	0	94	3	118
Percent receiving FRS	72%	72%	93%	n/a	96%	72%	0%	93%	0%	91%
Type of FRS performed										
- urinary only	21	21	91	3	94	21	0	91	3	115
--urinary & RVF	0	0	2	0	2	0	0	2	0	2
--RVF only	0	0	1	0	1	0	0	1	0	1
For 'Urinary only' or 'Urinary and RVF' repairs										
--first repair	14	14	55	1	56	14	0	55	1	70
--second repair	1	1	28	2	30	1	0	28	2	31
--->2	6	6	10	0	10	6	0	10	0	16
Percent women with first repair (urinary only)	67%	67%	59%	33%	58%	67%	0%	59%	33%	60%
No. discharged after FRS (urinary only)	21	21	91	3	94	21	0	91	3	115
No. discharged after FRS (urinary & RVF)	0	0	2	0	2	0	0	2	0	2
No. discharged after FRS (RVF only)	0	0	1	0	1	0	0	1	0	1
Total no. discharged after FRS	21	21	94	3	97	21	0	94	3	118
No. not discharged after FRS	0	0	0	0	0	0	0	0	0	0
Outcome of FRS (urinary only & urinary/RVF)										
---No. with closed fistula who are dry	13	13	77	1	78	13	0	77	1	91

Fistula Treatment Indicators	Benin		Togo			Total				
	Oct-Dec	FY Total	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
--No. with closed fistula & stress incontinence	6	6	6	2	8	6	0	6	2	14
--No. whose fistula was not closed	2	2	10	0	10	2	0	10	0	12
Percent with closed fistula who are dry (urinary only & urinary/RVF)	62%	62%	83%	33%	81%	62%	0%	83%	33%	78%
Outcome of FRS (RVF only)										
- closed and dry	0	0	1	0	1	0	0	1	0	1
--incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
--incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	0%	100%	0%	100%	0%	0%	100%	0%	100%
No. with complications after FRS	7	7	3	0	3	7	0	3	0	10
--Major surgical complications	0	0	3	0	3	0	0	3	0	3
--Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
--Post-operative complication related to perceived success of surgery	7	7	0	0	0	7	0	0	0	7
Percent with complications after FRS	33%	33%	3%	0%	3%	33%	0%	3%	0%	8%

**Table MS2. Number of Additional Surgeries for Fistula Patients,
October 2009 – September 2010, Mercy Ships**

	Oct- Dec	Jan – March	Apr- June	Jul- Sep	FY Total
Type of Surgery by Site					
Benin					
Ureteric reimplanataion	2	0	NS	NS	2
Urethral lengthening and other operations for concomitant stress incontinence	4	0	NS	NS	4
Other	1	0	NS	NS	1
Togo					
Examination under anesthesia	NS	NS	4	NS	4
Removal of bladder stones or foreign bodies in the viscera	NS	NS	2	NS	2
Ureteric reimplantation	NS	NS	7	NS	7
Urethral lengthening and other operations for concomitant stress incontinence	NS	NS	7	NS	7
Total	7	0	20	NS	27

One challenge Mercy Ships often faces when providing fistula surgery is the lack of a consistent stock of supplies required for surgery. Supplies come from a variety of donors and locations, creating challenges to pinpointing availability and accessibility of supplies. To help address this issue during the recent fistula repair sessions in West Africa, the fistula surgical team developed a fistula -specific inventory and logistics system. This system tracked the quantity and types of supplies used for each fistula patient, for screening days and for other fistula-related activities. This model will be used in future outreaches, helping identify and eradicate gaps in patient care supplies.

Infection control on the wards was another challenge. The fistula patients present to the ship with multiple drug-resistant strains of bacteria in their urine. After catheters are removed post-operatively, many often have to use the toilet frequently, some as often as every 5-10 minutes, a significant challenge with only two bathrooms for 20 patients. Regarding infection control, there was no reportable incidence of hospital acquired infection requiring antibiotic treatment, which is attributed to the diligence of the nursing staff and the Togolese Day Volunteers (DVs) in their work to maintain a clean environment.

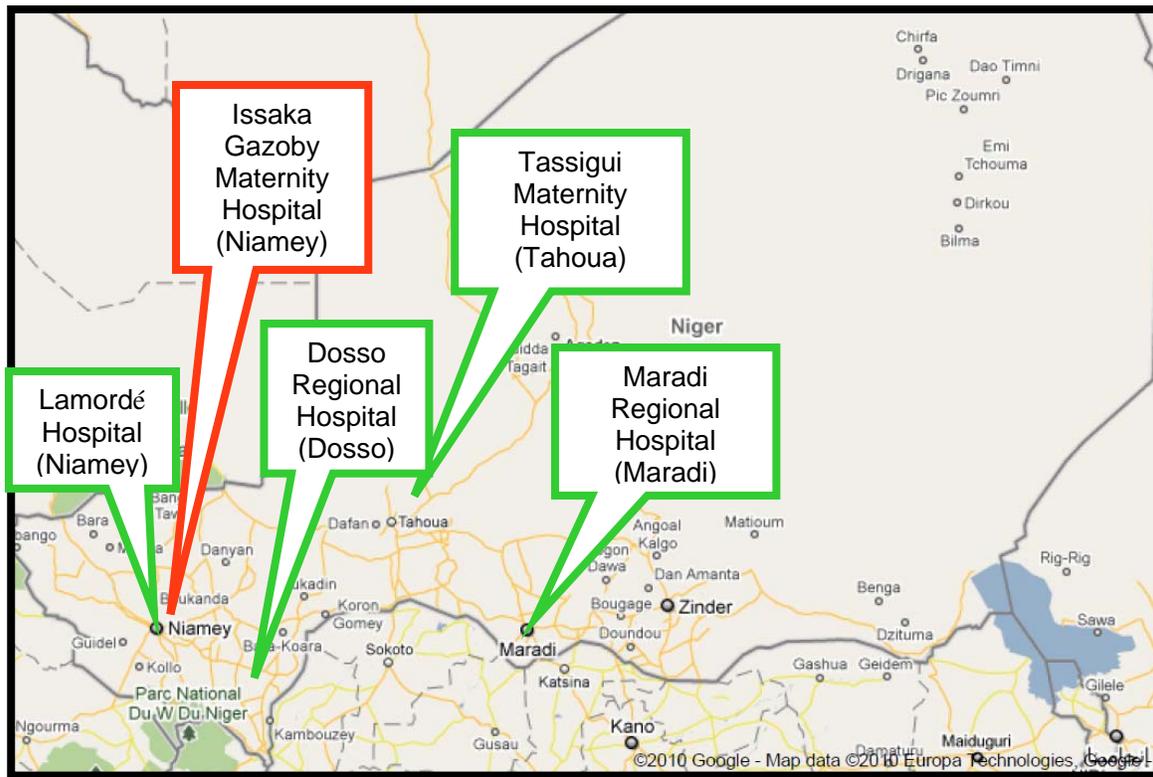
Language barriers are constant challenges for the fistula program. During the Ship's stay in Togo, approximately two-thirds of the patients were from linguistically isolated villages in northern Togo. These women spoke dialects that most of the DVs did not speak, with the result that screening patients for surgery was challenging, as an accurate history is essential for selecting appropriate surgical candidates. Challenges were also encountered on the ward as it is difficult to assess patients for certain post-operative complications without speaking the appropriate language.

The fistula program, having learned from the recommendations from the 2009 outreach in Benin, had great success in employing a prior fistula patient as a DV due to her

knowledge of ten northern Togolese languages. This DV was shared between the ward, admissions, and at times the operating room, since she was essentially the only one who was able to communicate with many patients. As a former patient, this DV had a unique understanding of the psychosocial needs and how best to communicate with the women on the wards.

Training. In the first quarter, one surgeon from Sierra Leone and one surgeon from Uganda received continuing training board the *Africa Mercy*, and both are now competent to perform complex repairs. Details on these trainings are reported in the relevant country sections. During the third quarter, four surgeons received continuing training on board the *Africa Mercy*: 2 from Benin, 1 from Nigeria and 1 from Rwanda. The Nigerian and Rwandan surgeons and their teams are counted in their respective country sections.

NIGER



Program Background

Service start up: July 2007

Sites: Five public hospitals:

- **Fistula Treatment:**
 - Dosso Regional Hospital
 - Lamordé National Hospital, Niamey
 - Maradi Regional Hospital
 - Tassigui Maternity Hospital (Part of Tahoua Regional Hospital)
- **Fistula Prevention:**
 - Issaka Gazoby Maternity Hospital, Niamey

Le Réseau Pour l’Eradication des Fistules (REF) is Fistula Care’s in-country managing partner. A subaward was granted to REF in November 2008⁴⁵ to provide support to four public hospitals. The Issaka Gazoby Maternity Hospital in Niamey continued to serve as a prevention site in this fiscal year. While four surgeons from this site have been trained in fistula repair, the maternity reference hospital is chronically inundated by women requiring emergency cesarean sections and is not sufficiently staffed or organized to provide non-emergency surgeries.

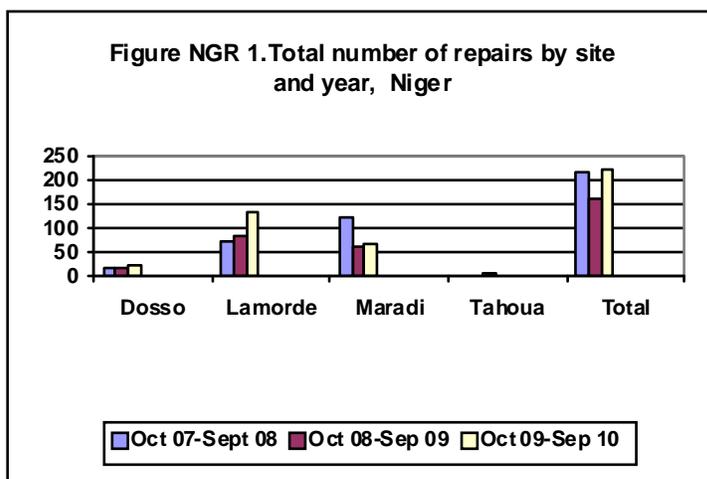
⁴⁵ While the subaward was issued in November, funds were not advanced until January 2009.

Of the four facilities offering fistula repair, Lamordé, Maradi, and Dosso all have at least three trained surgeons on staff. Lamordé and Maradi teams undertake complex repairs, while Dosso provides simple repairs and refers complex cases to Lamordé or holds concentrated efforts when the Lamordé team visits. Dosso and Maradi each have one theater available for fistula surgery while Lamordé has two theaters. All sites strive to offer fistula repair services routinely. Tassigui Maternity Hospital (Tahoua) began providing repairs as a supported site in the fourth quarter of this fiscal year following a site assessment by regional senior medical associate Dr. Jeanne Kabagema.

Key Accomplishments October 2009-September 2010

In January 2009, the Goldman Fund provided EngenderHealth with a pass-through grant which enables REF to subsidize repairs at supported sites in Niger. Between November 2008 and June 2010, 145 fistula repairs were made possible through Goldman Fund support.

Fistula Repairs. A total of 220 women received fistula repairs during the fiscal year. This represents a 35 % increase over FY 08/09 (see Fig NGR1). There were increases at all sites, but primarily at Lamordé which saw over a 50% increase when compared to FY 08/09. The following explanations for increases are provided, by site:

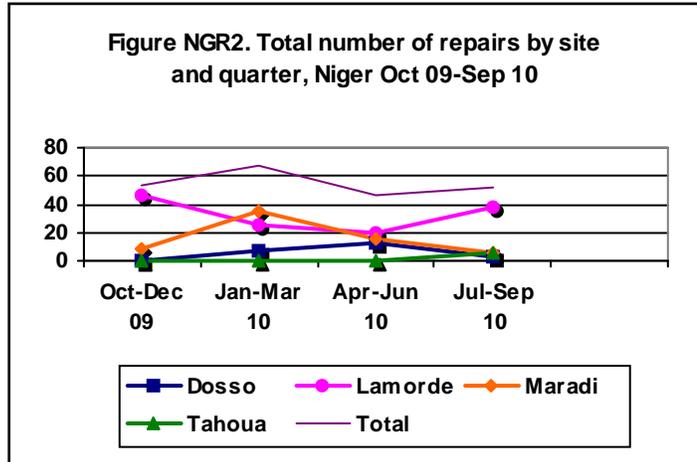


Maradi: During FY 08/09, there was a four month period when no repairs were conducted due to site renovations and the absence of a surgeon capable of complex repairs who had traveled to Mecca. During FY 09/10, Maradi consistently had three surgeons performing repairs, although space constraints continue to limit the number of repairs performed in light of the number of obstetric

emergencies. Dosso: During FY 08/09, Dosso had only one surgeon who was overextended with other responsibilities. Beginning in October 2009, two additional surgeons were trained and available to do simple repairs throughout the fiscal year.

Lamordé: The number of fistula cases has increased steadily at Lamordé due to transfer of fistula cases from the National Hospital of Niamey. Senior urologist Dr. Sanda Ganda has been named to head the newly constructed National Fistula Center, but the center is not yet equipped and functional so in practice this means that its patients are repaired at Lamordé. Only one site, Dosso, is experiencing a significant backlog, due to the level of difficulty of the repairs and the need to wait for a visiting surgeon who is capable of performing the repairs.

In the fourth quarter, an upward trend in the rate of women receiving surgery was noted in Lamordé (see Fig NGR2), as patients identified earlier as having fistulas that were too new to repair were now able to receive surgery. In the third quarter, 62% of women discharged at Maradi had remaining urinary incontinence, possible reasons for this include these women having complicated cases and having had more than 2 repairs already, as well as the quality of postoperative care. In the



fourth quarter, a small number of women were repaired at Maradi that had been identified during earlier quarters. Lamordé saw very low numbers of women presenting due to this being a period of farm work in the region, which prevents women from leaving their villages. There were few cases of fistula identified through community outreach at Dosso during the quarter. Tahoua began providing repairs in the fourth quarter.

Table NGRI. Clinical Indicators by Site, October 2009-September 2010, Niger

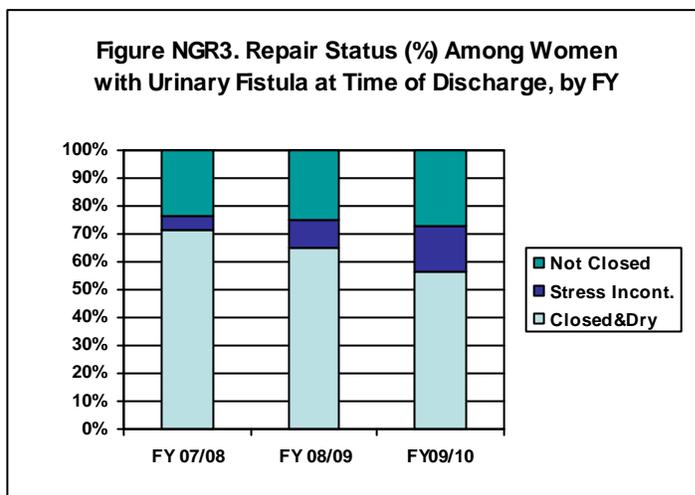
Fistula Treatment Indicators	Dosso					Lamordé				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	7	16	13	4	40	49	32	25	35	141
No. requiring FRS	7	12	13	3	35	42	31	25	35	133
No. receiving FRS	0	7	12	3	22	46	25	20	38	129
Percent receiving FRS	0%	58%	92%	100%	63%	110%	81%	80%	109%	97%
Type of FRS performed										
----- urinary only	0	6	12	3	21	44	24	18	37	123
----- urinary & RVF	0	0	0	0	0	0	0	0	0	0
----- RVF only	0	1	0	0	1	2	1	2	1	6
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	0	3	7	2	12	17	12	5	18	52
----- second repair	0	2	1	1	4	8	4	4	10	26
----- >2	0	1	4	0	5	19	8	9	9	45
Percent women with first repair (urinary only)	0%	50%	58%	67%	57%	39%	50%	28%	49%	42%
No. discharged after FRS (urinary only)	0	6	12	0	18	42	22	19	33	116
No. discharged after FRS (urinary & RVF)	0	0	0	0	0	0	0	0	0	0
No. discharged after FRS (RVF only)	0	1	0	0	1	2	1	2	1	6
Total no. discharged after FRS	0	7	12	0	19	44	23	21	34	122
No. not discharged after FRS	0	0	0	2	2	2	4	3	5	14
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	0	4	9	0	13	23	16	15	19	73
----- No. with closed fistula & stress	0	0	2	0	2	7	5	3	7	22

	Dosso					Lamordé				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
incontinence										
----- No. whose fistula was not closed	0	2	1	0	3	12	1	1	7	21
Percent with closed fistula who are dry (urinary only & urinary/RVF)	0%	67%	75%	0%	72%	55%	73%	79%	58%	63%
Outcome of FRS (RVF only)										
----- closed and dry	0	0	0	0	0	2	1	2	1	6
----- incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
----- incontinent with firm stool	0	1	0	0	1	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	0%	0%	0%	0%	0%	100%	100%	100%	100%	100%
No. with complications after FRS	0	0	0	0	0	0	0	0	0	0
----- Major surgical complications	0	0	0	0	0	0	0	0	0	0
----- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	0	0	0	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

**Table NGRI. Clinical Indicators by Site,
October 2009-September 2010, Niger (Continued)**

Fistula Treatment Indicators	Maradi					Tahoua					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	13	30	17	3	63	NS	NS	NS	10	10	69	78	55	52	254
No. requiring FRS	13	30	16	3	62	NS	NS	NS	6	6	62	73	54	47	236
No. receiving FRS	8	35	15	5	63	NS	NS	NS	6	6	54	67	47	52	220
Percent receiving FRS	62%	117%	94%	167%	102%	0%	0%	0%	100%	100%	87%	92%	87%	111%	93%
Type of FRS performed															
----- urinary only	8	35	15	5	63	NS	NS	NS	6	6	52	65	45	51	213
----- urinary & RVF	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
----- RVF only	0	0	0	0	0	NS	NS	NS	0	0	2	2	2	1	7
For 'Urinary only' or 'Urinary and RVF' repairs															
----- first repair	4	13	3	3	23	NS	NS	NS	6	6	21	28	15	29	93
----- second repair	1	3	5	2	11	NS	NS	NS	0	0	9	9	10	13	41
----- >2	3	19	7	0	29	NS	NS	NS	0	0	22	28	20	9	79
Percent women with first repair (urinary only)	50%	37%	20%	60%	37%	0%	0%	0%	100%	100%	40%	43%	33%	57%	44%
No. discharged after FRS (urinary only)	4	28	13	16	61	NS	NS	NS	6	6	46	56	44	55	201
No. discharged after FRS (urinary & RVF)	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
No. discharged after FRS (RVF only)	0	0	0	0	0	NS	NS	NS	0	0	2	2	2	1	7
Total no. discharged after FRS	4	28	13	16	61	NS	NS	NS	6	6	48	58	46	56	208
No. not discharged after FRS	4	11	13	2	30	NS	NS	NS	0	0	6	15	16	9	46
Outcome of FRS (urinary only & urinary/RVF)															
--No. with closed fistula who are dry	2	8	5	6	21	NS	NS	NS	6	6	25	28	29	31	113

Fistula Treatment Indicators	Maradi					Tahoua					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
---No. with closed fistula & stress incontinence	1	0	8	0	9	NS	NS	NS	0	0	8	5	13	7	33
--No. whose fistula was not closed	1	20	0	10	31	NS	NS	NS	0	0	13	23	2	17	55
Percent with closed fistula who are dry (urinary only & urinary/RVF)	50%	29%	38%	38%	34%	0%	0%	0%	100%	100%	54%	50%	66%	56%	56%
Outcome of FRS (RVF only)															
----closed and dry	0	0	0	0	0	NS	NS	NS	0	0	2	1	2	1	6
----incontinent with water stool and /or flatus (gas)	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
---- incontinent with firm stool	0	0	0	0	0	NS	NS	NS	0	0	0	1	0	0	1
Percent with closed and dry fistula (RVF only)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	50%	100%	100%	86%
No. with complications after FRS	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
---Major surgical complications	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
---Anesthesia-related complication	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
---Post-operative complication related to perceived success of surgery	0	0	0	0	0	NS	NS	NS	0	0	0	0	0	0	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%



The majority of repairs at all sites were urinary repairs, and nearly 60% were women who had already received at least 2 prior repairs. Table NGR1 provides detail on all repairs performed at the sites. Only 56% of women discharged after surgery were closed and dry (see Fig NGR3). The level of complexity of the surgeries and number of women receiving previous repairs were noted in regard to the high rate of women who were discharged that were not

closed and dry.

A total of 123 additional surgeries were reported during the fiscal year. This data is inflated due to an error in reporting in which wound resutures and use of anesthesia during routine fistula repair were mistakenly included in the data. When these numbers are taken into account, the number of reported additional surgeries is very low. Table NGR2 provides additional information.

Table NGR2. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Niger

	Oct-Dec	Jan – March	Apr-June	Jul-Sep	FY Total
Type of Surgery by Site					
Lamordé					
Examination under anesthesia	46*	0	0	0	46
Colostomy and reversal colostomy	2	0	2	1	5
Wound resuture	46*	0	0	0	46
Beance uretral	7	1	0	0	8
Maradi					
Urethral lengthening and other operations for concomitant stress incontinence	3	0	0	0	3
Ureteric reimplantation	3	0	0	0	3
Wound resuture	8	0	0	0	8
Dosso					
Beance uretral	0	4	0	0	4
Total	115	5	2	1	123

*All information on additional surgeries provided for Niger prior to December 2009 were provided using incorrect data definitions. All wound resutures and use of anesthesia were reported (including those part of routine fistula repair), instead of solely those that were additional procedures. Beginning with January 2010, data reported uses the correct definitions.

Training During the fiscal year, a total of 112 individuals received training. Three surgeons attended their first training in fistula repair, in the first quarter of the year. These surgeons then participated in continuing training in the third quarter. Three training sessions on infection prevention were conducted with 20 providers trained at each site (Lamordé, Maradi and Dosso). A family planning training was held in Maradi in the first quarter, and Dosso and Lamordé in the third quarter. A training on quality assurance was conducted for 19 people at Dosso. No trainings were conducted during the second and fourth quarters.

Table NGR 3. Number of Persons Trained by Topic, October 2009 – September 2010, Niger

Training Topic	Oct-Dec	Jan-Mar	Apr - Jun	Jul-Sep	FY Total
Infection prevention	60	0	0	0	60
First surgical training for fistula repair	3	0	0	0	3*
Family planning	10	0	20	0	30
Quality assurance	19	0	0	0	19
Continuing surgical training for fistula repair	0	0	3	0	3*
Total	92	0	23	0	112*

*The same three surgeons received their first training and a continuing training in fistula repair during the fiscal year. They are only counted once in the "total" which counts number of individuals trained.

Community Outreach. Throughout the fiscal year, a total of 25 community outreach events were held, reaching an estimated 1,965 people. Community meetings were held in 15 villages in Dosso with health agents, local organizations and the general community to discuss issues related to obstetric care. A workshop to discuss community self assessment was done in Maradi to help the community to identify their own health problems, prioritize them and then search for solutions to solve them. This workshop was then carried out in Dosso in the second quarter of the year. During the April-June period, training for community liaisons was conducted in Dosso, and during July-September in Maradi. Outreach information is presented below, in Table NGR4.

Table NGR4. Number of Community Outreach Events and Persons Reached, October 2009 - September 2010, Niger

Event Type	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached
Dosso	15	1563	3	101	3	100	0	0	21	1764
Maradi	3	108	0	0	0	0	1	93	4	201
Total	18	1671	3	101	3	100	1	93	25	1965

Prevention. A picture book on fistula awareness and prevention was developed in the first quarter of the fiscal year.

Family Planning. A total of 3,080 people received family planning methods during the fiscal year at the supported sites. The most common methods dispensed were the oral pill,

followed by implants, IUCDs and injectables. Lamordé has experienced a downward trend in provision of family planning methods. Not only is it a teaching hospital without a maternity ward, this year the health worker responsible for FP was transferred elsewhere and will not be replaced. In Dosso, a downward trend was noted in the fourth quarter, due to women using other health services in Dosso town, according to the staff at the maternity ward. Table NGR5 provides family planning information, by site.

Table NGR5. Number of FP Clients by Method and Number Counseled about FP, by Site. October 2009 – September 2010, Niger

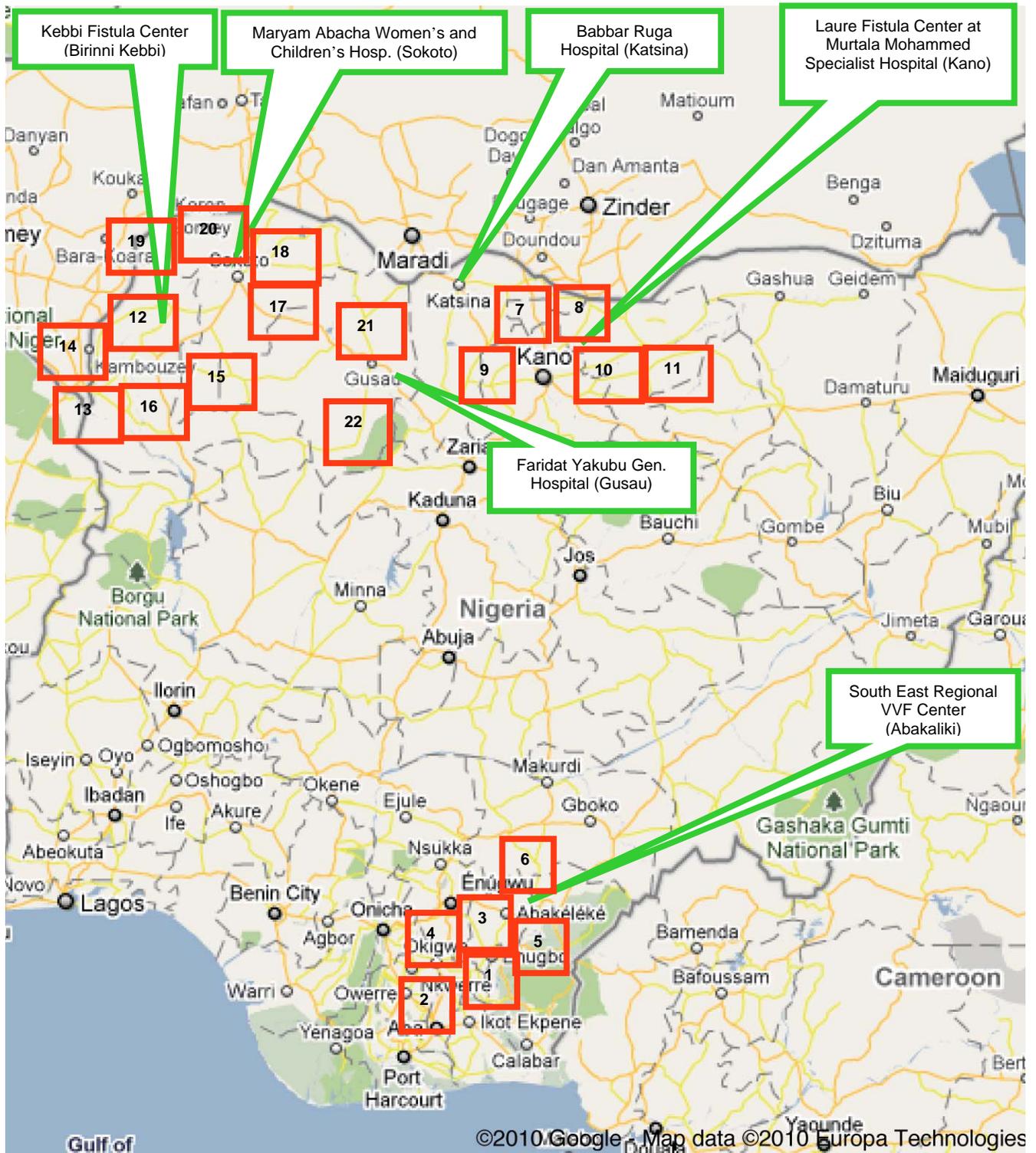
FP Methods	Dosso	Issaka Gazoby	Lamordé	Maradi	Country Total
Oral Pill	396	742	122	500	1760
IUCD	2	396	0	97	495
Condom (male)	0	0	0	0	0
Condom (female)	0	0	0	0	0
Injectable	56	0	69	172	297
Implant	0	381	0	146	527
Tubal Ligation	0	0	1	0	1
Vasectomy	0	0	0	0	0
Foaming Tablets	0	0	0	0	0
Total FP acceptors	454	1519	192	915	3080
Total Number of clients counseled about FP methods	454	1519	192	918	3083

Obstetrics. A total of 8,498 deliveries were reported at four supported sites. The overall c-section rate was nearly 50%, with Issaka Gazoby having very high rates, as well as Maradi. Information on total number of obstetric deliveries, and the percentage of deliveries by C-section can be found in table NGR6. The very high C-section rate at Issaka Gazoby is due to the role of the hospital as a National Reference Center. Only the most complicated pregnancy cases are referred there so it is expected that the C-section rate would be significantly above the norm. Maradi also functions as a referral center for its region, and its numbers fluctuate based on referrals sent to them.

Table NGR 6. Obstetric Services, by site. October 2009 – September 2010, Niger.

	Dosso	Issaka Gazoby	Lamordé	Maradi	TOTAL
Number of vaginal deliveries	1652	1481	n/a	1179	4312
Number of C-sections	315	2916	n/a	955	4186
Total number of deliveries	1967	4397	n/a	2134	8498
Percent deliveries by C-section	16%	66%	n/a	45%	49%

NIGERIA



Map Key: Prevention Sites in Red Boxes

1	Owutuedda General Hospital (Ebonyi)
2	Cottage Hospital, (Ebonyi)
3	Ebonyi State University Teaching Hospital
4	Ezangbo Maternity Hospital (Ebonyi)
5	Mother and Child Care Initiative FP Clinic (Ebonyi)
6	Mgbo Primary Health Center (Ebonyi)
7	Comprehensive Health Center, Kumbotso (Kano)
8	Takai Community/NYSC Health Center, Takai (Kano)
9	Tarauni MCH Clinic (Kano)
10	Unguku MCH Clinic (Kano)
11	Muhammadu Abdullahi Wase Hospital (Kano)
12	Jega General Hospital, (Kebbi)
13	Kamba General Hospital (Kebbi)
14	Maiyama General Hospital (Kebbi)
15	Argungum General Hospital (Kebbi)
16	Dakingari Primary Health Center (Kebbi)
17	D/D General Hospital (Sokoto)
18	Rabah General Hospital (Sokoto)
19	Iss General Hospital (Sokoto)
20	Jabo Primary Health Center (Sokoto)
21	Bakura General Hospital (Zamfara)
22	Bungudu General Hospital (Zamfara)

Program Background

Service Start Date: Funds were obligated September 2006. The EngenderHealth Office opened in February 2007.

Service Sites: Repair sites located in six states.. The sites in Kano and Katsina States are primarily **training sites:**

1. Ebonyi State: South East Regional VVF Center
2. Kebbi State: Specialist Fistula Center Birnin Kebbi
3. Sokoto State: Maryam Abacha Women and Children's Hospital (MAWCH)
4. Zamfara State: Faridat Yakubu General Hospital
5. Kano State: Laure Fistula Center at Murtala Mohammed Specialist Hospital
6. Katsina State: Babbar Ruga Hospital

Prevention only sites: In addition to the sites above, a total of 22 sites received support from Fistula Care to provide FP services. The prevention-only sites currently supported are:

1. Argungum General Hospital (Kebbi)
2. Bakura General Hospital (Zamfara)
3. Bungudu General Hospital (Zamfara)
4. Comprehensive Health Center, Kumbotso (Kano)
5. Cottage Hospital (Ebonyi)
6. Dakingari Primary Health Center (Kebbi)
7. D/D General Hospital (Sokoto)

8. Ebonyi State University Teaching Hospital
9. Ezangbo Maternity Hospital (Ebonyi)
10. Iss General Hospital (Sokoto)
11. Jabo Primary Health Center (Sokoto)
12. Jega General Hospital (Kebbi)
13. Kamba General Hospital (Kebbi)
14. Maiyama General Hospital (Kebbi)
15. Mother and Child Care Initiative FP Clinic (Ebonyi)
16. Mgbo Primary Health Center (Ebonyi)
17. Muhammadu Abdullahi Wase Hospital (Kano)
18. Owutuedda General Hospital (Ebonyi)
19. Rabah General Hospital (Sokoto)
20. Takai Community/NYSC Health Center, Takai (Kano)
21. Tarauni MCH Clinic (Kano)
22. Unguku MCH Clinic (Kano)

Five of the six fistula repair centers provide fistula repair services at least twice a week and have sufficient bed capacity to have from 14 to 50 patients admitted. Three facilities have one operating theater (Faridat, Laure Fistula Center and Maryam Abacha); Babbar Ruga and Kebbi have two and Ebonyi has three. Four of the six sites have at least two surgeons to provide routine services, only Ebonyi and Kebbi have one surgeon. Plans are underway to have at least one more surgeon assigned or trained to these facilities.

In summary, Fistula Care Nigeria provides support to 22 sites: 6 repair sites and 16 prevention-only sites. By state, the totals are:

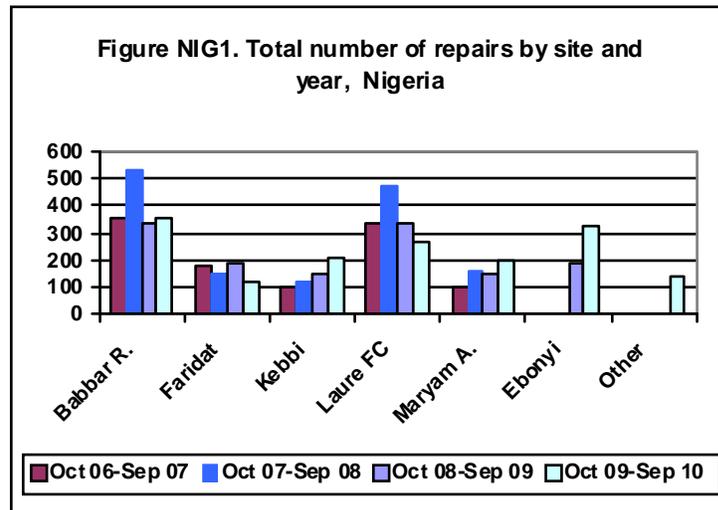
- Sokoto State: 5 sites (1 repair, 4 prevention)
- Zamfara State: 3 sites (1 repair, 2 prevention)
- Kebbi State: 6 sites (1 repair, 5 prevention)
- Kano State: 6 sites (1 repair, 5 prevention)
- Katsina State: 1 site (1 repair)
- Ebonyi State: 7 sites (1 repair, 6 prevention)

In FY 09/10 a site assessment was conducted in Bauchi state in order to expand repair services to a seventh state at the request of USAID. In consultation with state authorities a general hospital was selected and a surgeon identified for training. While the surgeon has been trained to provide simple repairs, and three nurses have been trained in pre and post operative care no progress has been made by the state government to complete the necessary renovations required before fistula surgery can begin. Fistula Care will continue to have discussions with the state authorities to try and identify another site within the state for program implementation. In consultation with USAID/Nigeria the fistula program in Nigeria is under review and discussion underway for a new strategy for FY 10/11.

Key Accomplishments October 2009-September 2010

Fistula Repairs.

From October 2009 - September 2010, a total of 1,612 fistula repairs were carried out at the six supported repair sites in Nigeria. This represents a 20% increase when compared to the total number of repairs carried out in FY 08/09 (see Fig NIG1). All sites had increases in the number of repairs conducted, except for Laure Fistula Center and Faridat Yakubu. Ebonyi, in particular, had an increase of 75%.



These increases can be attributed to several events during FY 09/10: first, there was a very high turnout of fistula clients at the Southeast Fistula Center (Ebonyi) thanks to the effective grass root mobilization of clients by the Maternal and Child Care Initiative (MCCI). This created a heavy backlog for most parts of the year. Despite the commencement of routine fistula repairs at the center, the project had to mobilize surgeons from across the country to assist the resident surgeon to clear the backlog through four pooled efforts.

Second, the Fistula Care Project ensured sustained, timely and regular supply of theater consumables such as suture materials, anesthetic drugs, antiseptics and disinfectants, surgical gloves, catheters etc to all supported sites during FY 09/10. This effort helped avoid the stock out syndrome and enhanced timely repairs of fistula clients at the facilities that we supported.

Finally, most of the fistula surgeons were available throughout the year for provision of routine surgery. Except for a one week period in December 2009 during the ISOFS meeting when five surgeons from supported facilities were attending this conference, the surgeons have largely remained in their facilities to provide routine services. There was also a relatively good industrial harmony in most states compared to the previous years (i.e. fewer strikes).

Table NIG1. Clinical Indicators by Site, October 2009 – September 2010, Nigeria

Fistula Treatment Indicators	Babbar R.					Faridat Yak.				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	91	112	81	81	365	23	29	25	43	120
No. requiring FRS	77	112	81	76	346	23	29	25	38	115
No. receiving FRS	74	89	135	61	359	23	29	25	38	115
Percent receiving FRS	96%	79%	167%	80%	104%	100%	100%	100%	100%	100%
Type of FRS performed										
----- urinary only	65	84	124	48	321	23	28	24	37	112
----- urinary & RVF	6	4	6	6	22	0	0	0	0	0
----- RVF only	3	1	5	7	16	0	1	1	1	3
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	59	69	95	38	261	12	22	17	18	69
----- second repair	8	14	27	6	55	6	6	6	15	33
----- >2	4	5	8	10	27	5	0	1	4	10
Percent women with first repair (urinary only)	83%	78%	73%	70%	76%	52%	79%	71%	49%	62%
No. discharged after FRS (urinary only)	62	78	119	52	311	32	22	32	31	117
No. discharged after FRS (urinary & RVF)	6	5	1	8	20	0	0	0	0	0
No. discharged after FRS (RVF only)	3	1	3	5	12	0	1	1	1	3
Total no. discharged after FRS	71	84	123	65	343	32	23	33	32	120
No. not discharged after FRS	13	18	30	26	87	4	10	2	8	24
Outcome of FRS (urinary only & urinary/RVF)										
--- No. with closed fistula who are dry	55	77	108	32	272	24	20	28	25	97
--- No. with closed fistula & stress incontinence	13	6	10	21	50	5	0	1	0	6
----No. whose fistula was not closed	0	0	2	7	9	3	2	3	6	14
Percent with closed fistula who are dry (urinary only & urinary/RVF)	81%	93%	90%	53%	82%	75%	91%	88%	81%	83%
Outcome of FRS (RVF only)										

Fistula Treatment Indicators	Babbar R.					Faridat Yak.				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
-----closed and dry	2	1	3	5	11	0	1	1	1	3
----incontinent with water stool and /or flatus (gas)	1	0	0	0	1	0	0	0	0	0
----incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	67%	100%	100%	100%	92%	0%	100%	100%	100%	100%
No. with complications after FRS	0	0	0	0	0	0	0	0	0	0
----- Major surgical complications	0	0	0	0	0	0	0	0	0	0
----- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	0	0	0	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table NIGI (continued2)

Fistula Treatment Indicators	Kebbi					Laure Fistula Ctr. I				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	45	65	51	58	219	159	n/a	n/a	0	159
No. requiring FRS	45	65	66	58	234	100	n/a	n/a	0	100
No. receiving FRS	45	58	54	50	207	83	n/a	98	84	265
Percent receiving FRS	100%	89%	82%	86%	88%	83%	0%	0%	0%	265%
Type of FRS performed										
----- urinary only	43	54	52	49	198	70	n/a	n/a	74	144
----- urinary & RVF	1	2	1	1	5	2	n/a	n/a	0	2
----- RVF only	1	2	1	0	4	11	n/a	n/a	10	21
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	27	31	26	31	115	39	n/a	n/a	n/a	39
----- second repair	13	13	13	5	44	23	n/a	n/a	n/a	23
----- >2	4	12	14	14	44	10	n/a	n/a	n/a	10
Percent women with first repair (urinary only)	61%	55%	49%	62%	57%	54%	0%	0%	0%	27%

Fistula Treatment Indicators	Kebbi					Laure Fistula Ctr. I				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. discharged after FRS (urinary only)	30	44	54	52	180	52	n/a	n/a	n/a	52
No. discharged after FRS (urinary & RVF)	1	2	2	1	6	1	n/a	n/a	n/a	1
No. discharged after FRS (RVF only)	0	2	0	1	3	2	n/a	n/a	n/a	2
Total no. discharged after FRS	31	48	56	54	189	55	n/a	n/a	n/a	55
No. not discharged after FRS	14	24	22	18	78	31	n/a	n/a	n/a	31
Outcome of FRS (urinary only & urinary/RVF)										
---- No. with closed fistula who are dry	28	29	32	31	120	40	n/a	n/a	n/a	40
---- No. with closed fistula & stress incontinence	3	15	18	13	49	12	n/a	n/a	n/a	12
-----No. whose fistula was not closed	0	2	6	9	17	1	n/a	n/a	n/a	1
Percent with closed fistula who are dry (urinary only & urinary/RVF)	90%	63%	57%	58%	65%	75%	0%	0%	0%	75%
Outcome of FRS (RVF only)										
-----closed and dry	0	2	0	1	3	2	n/a	n/a	n/a	2
-----incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	n/a	n/a	n/a	0
-----incontinent with firm stool	0	0	0	0	0	0	n/a	n/a	n/a	0
Percent with closed and dry fistula (RVF only)	0%	100%	0%	100%	100%	100%	0%	0%	0%	100%
No. with complications after FRS	0	0	0	0	0	0	n/a	n/a	n/a	0
----- Major surgical complications	0	0	0	0	0	0	n/a	n/a	n/a	0
----- Anesthesia-related complication	0	0	0	0	0	0	n/a	n/a	n/a	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	n/a	n/a	n/a	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table NIG1 (continued3)

Fistula Treatment Indicators	Maryam Abacha					Other I				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	42	57	53	52	204	NS	n/a	NS	NS	0
No. requiring FRS	42	45	52	44	183	NS	n/a	NS	NS	0
No. receiving FRS	64	51	53	32	200	NS	136	NS	NS	136
Percent receiving FRS	152%	113%	102%	73%	109%	0%	0%	0%	0%	0%
Type of FRS performed										
----- urinary only	62	51	51	29	193	NS	n/a	NS	NS	0
----- urinary & RVF	1	0	0	0	1	NS	n/a	NS	NS	0
----- RVF only	1	0	2	3	6	NS	n/a	NS	NS	0
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	13	30	22	12	77	NS	n/a	NS	NS	0
----- second repair	27	9	15	9	60	NS	n/a	NS	NS	0
----- >2	23	12	14	8	57	NS	n/a	NS	NS	0
Percent women with first repair (urinary only)	21%	59%	43%	41%	40%	0%	0%	0%	0%	0%
No. discharged after FRS (urinary only)	38	43	72	25	178	NS	n/a	NS	NS	0
No. discharged after FRS (urinary & RVF)	1	0	0	0	1	NS	n/a	NS	NS	0
No. discharged after FRS (RVF only)	1	1	1	3	6	NS	n/a	NS	NS	0
Total no. discharged after FRS	40	44	73	28	185	NS	n/a	NS	NS	0
No. not discharged after FRS	34	38	18	22	112	NS	n/a	NS	NS	0
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	18	10	34	12	74	NS	n/a	NS	NS	0
----- No. with closed fistula & stress incontinence	12	23	12	8	55	NS	n/a	NS	NS	0
----- No. whose fistula was not closed	9	10	26	5	50	NS	n/a	NS	NS	0
Percent with closed fistula who are dry (urinary only & urinary/RVF)	46%	23%	47%	48%	41%	0%	0%	0%	0%	0%
Outcome of FRS (RVF only)										

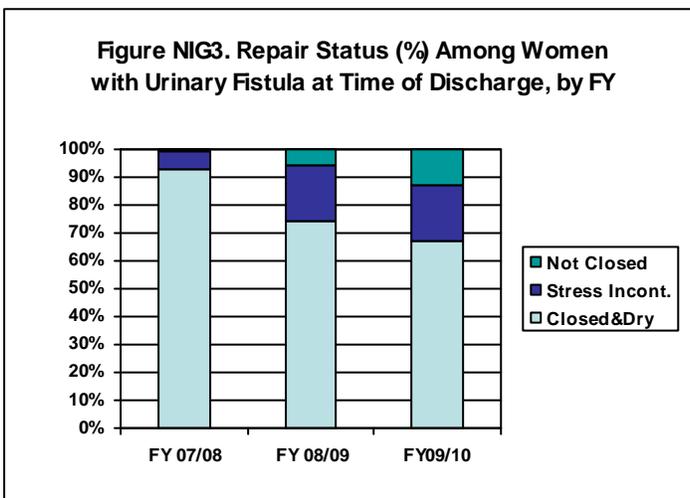
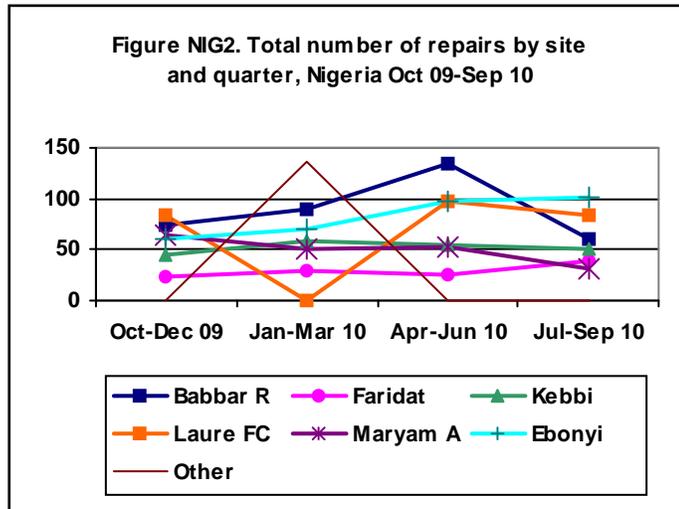
Fistula Treatment Indicators	Maryam Abacha					Other I				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
-----closed and dry	1	1	0	3	5	NS	n/a	NS	NS	0
----- incontinent with water stool and /or flatus (gas)	0	0	1	0	1	NS	n/a	NS	NS	0
-----incontinent with firm stool	0	0	0	0	0	NS	n/a	NS	NS	0
Percent with closed and dry fistula (RVF only)	100%	100%	0%	100%	83%	0%	0%	0%	0%	0%
No. with complications after FRS	0	0	0	0	0	NS	n/a	NS	NS	0
----- Major surgical complications	0	0	0	0	0	NS	n/a	NS	NS	0
----- Anesthesia-related complication	0	0	0	0	0	NS	n/a	NS	NS	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	NS	n/a	NS	NS	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table NIGI (continued4)

Fistula Treatment Indicators	Ebonyi Fistula Center					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	103	73	134	134	444	463	336	344	368	1511
No. requiring FRS	103	92	112	134	441	390	343	336	350	1419
No. receiving FRS	61	70	98	101	330	350	433	463	366	1612
Percent receiving FRS	59%	76%	88%	75%	75%	90%	126%	138%	105%	114%
Type of FRS performed										
----- urinary only	60	68	91	95	314	323	285	342	332	1282
----- urinary & RVF	0	2	0	2	4	10	8	7	9	34
----- RVF only	1	0	7	4	12	17	4	16	25	62
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	57	54	82	77	270	207	206	242	176	831
----- second repair	2	9	0	6	17	79	51	61	41	232
----- >2	1	7	9	14	31	47	36	46	50	179
Percent women with first repair (urinary only)	95%	77%	90%	79%	85%	62%	70%	69%	52%	63%

Fistula Treatment Indicators	Ebonyi Fistula Center					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. discharged after FRS (urinary only)	60	59	73	42	234	274	246	350	202	1072
No. discharged after FRS (urinary & RVF)	0	1	0	0	1	9	8	3	9	29
No. discharged after FRS (RVF only)	1	0	5	3	9	7	5	10	13	35
Total no. discharged after FRS	61	60	78	45	244	290	259	363	224	1136
No. not discharged after FRS	0	10	30	86	126	96	100	102	160	458
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	34	26	44	32	136	199	162	246	132	739
----- No. with closed fistula & stress incontinence	17	17	17	1	52	62	61	58	43	224
-----No. whose fistula was not closed	9	17	12	9	47	22	31	49	36	138
Percent with closed fistula who are dry (urinary only & urinary/RVF)	57%	43%	60%	76%	58%	70%	64%	70%	63%	67%
Outcome of FRS (RVF only)										
-----closed and dry	1	0	4	3	8	6	5	8	13	32
-----incontinent with water stool and /or flatus (gas)	0	0	1	0	1	1	0	2	0	3
-----incontinent with firm stool	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	100%	0%	80%	100%	89%	86%	100%	80%	100%	91%
No. with complications after FRS	5	0	1	7	13	5	0	1	7	13
----- Major surgical complications	5	0	1	7	13	5	0	1	7	13
----- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	0	0	0	0
Percent with complications after FRS	8%	0%	1%	16%	5%	2%	0%	0%	3%	1%

Data for Laure Fistula Center (Kano) was not available for the second quarter and limited for the third and fourth quarters. There have been ongoing challenges with data collection from the facilities located in Kano. USAID Nigeria is aware of the issues; attempts to rectify this situation are ongoing. Site specific data by quarter can be seen in Figure NIG2. The “Other” repairs consist of an additional 136 repairs performed by Dr. Kees in Kano, Bauchi and Zaria during the second quarter. Fistula Care supports Dr. Kees for performing repairs, including consumable supplies, he is not limited to where such repairs are done and these are repairs that took place outside of the FC supported sites otherwise reported.



The vast majority of repairs at all the sites were urinary only repairs, and women receiving their first repairs. Project staff report an increase in the occurrence of more difficult fistula cases in most supported centers. This phenomenon directly affects outcomes of fistula repair and closure rates on first fistula surgeries. For all women discharged after a urinary repair, 67% were closed and dry at discharge (see Fig NIG3). Reported complications rates were generally very low. Details on clinical indicators tracked by all the repair sites can be found in Table

NIG1.

A total of 21 additional surgeries were reported by the supported fistula repair sites in Nigeria during the fiscal year; see Table NIG2.

Table NIG2. Number of Additional Surgeries for Fistula Patients, October 2009--September 2010, Nigeria

	Oct- Dec	Jan – March	Apr- June	Jul- Sep	FY Total
Type of Surgery by Site					
Babbar Ruga					
Removal of bladder stones of foreign bodies in viscera	0	0	0	1	1
Ureteric reimplantation	0	0	0	1	1
Urethral lengthening and other operations for concomitant stress incontinence	0	0	0	1	1
Prolapse if associated with fistula	0	0	0	1	1
Maryam Abacha					
Vaginal reconstruction	0	0	1	0	1
SE Regional VVF					
Other (urethral reconstruction, repair of cystocele, perineorrhaphy, vaginoplasty)	0	0	3	7	10
Removal of bladder stones or foreign bodies in viscera	0	0	0	1	1
Kebbi					
Urethral lengthening and other operations for concomitant stress incontinence	0	0	0	3	3
Prolapse if associated with fistula	0	0	0	1	1
Zamfara					
3 rd /4 th Degree perineal tear repairs	0	0	0	1	1
Total	0	0	4	17	21

Twelve pooled repair efforts were conducted at four sites (Sokoto, Ebonyi, Kebbi, and Katsina) during the fiscal year to help reduce backlogs at the sites as well as to provide training and retraining of younger doctors and nurses, and for sharing of experiences and new approaches to fistula repair (see Table NIG3). A total of 342 repairs were performed through these pooled efforts, which represents 21% of all repairs carried out from October 2009 – September 2010.

The project also encouraged supported facilities to continue with routine efforts to ensure that backlogs do not build up again, except when community based organizations (CBO) increase the tempo of their community mobilization activities. The project also worked extensively with Dr. Kees, the master trainer to address very difficult repairs in two facilities – Ebonyi and Sokoto.

Table NIG3. Pooled Effort Events for Fistula Repair, October 2009-September 2010, Nigeria

Location	Date	Number repairs	Number surgeons
Sokoto	October 2009	25	1
Sokoto	December 2009	30	4
Ebonyi	January 2010	23	4
Ebonyi	February 2010	36	4
Sokoto	March 2010	18	5
Kebbi	March 2010	21	3
Katsina	April 2010	50	6
Ebonyi	April 2010	44	2
Sokoto	May 2010	23	5
Ebonyi	May 2010	22	2
Ebonyi	June 2010	30	1
Sokoto	July 2010	20	5
Total	<i>12 Pooled Efforts</i>	<i>342 repairs</i>	<i>4 (average)</i>

Strengthening Capacity. Fistula Care has supplied high quality theater consumables to all the supported repair sites. It is hoped that this effort will fully supplement the often inadequate provisions provided by the state government.

Training. A total of 215 individuals were trained in Nigeria during the fiscal year (see Table NIG4). Four surgeons received their first trainings in fistula repair, and a total of seven individuals were trained in continuing repair (one surgeon received both first and continuing training during the fiscal year and is counted only once in the total presented in Table NIG4). During the first quarter, three doctors received their first training in surgical repair for fistula at Kebbi Hospital. Additionally, three nurses were trained in pre and postoperative management of fistula clients. A team of community engagement specialists from EngenderHealth conducted community engagement training for staff of the project as well as partners in community mobilization: 14 representatives of CBOs and six clerics from Sokoto, Kebbi and Zamfara States attended the training which focused on MAP implementation and strategies for community involvement. Fifteen health facility staff from Sokoto, Kebbi and Zamfara States were trained in Basic Obstetric Care.

In the second quarter, Dr. Steve Arrowsmith provided mentoring and coaching in a master training session for Dr. Sunday Adeoye from SE Regional VVF Center (Ebonyi). In addition, he provided continuing training for four additional doctors at the Center. It is hoped that the Center will now be better able to provide routine repair services to meet the needs of Ebonyi and neighboring states.

During the third quarter, two teams were trained in fistula repair, including one surgeon having a first training and two surgeons receiving continuing training, along with five nurses receiving training in pre and postoperative care. The one new training was a surgeon from Bayara General Hospital, as part of our efforts to facilitate smooth take off of fistula care services there and one continuing training for a surgeon from the Gesse VVF Center in Kebbi during one of the pooled activity efforts. One experienced surgeon received continuing training on board the Africa Mercy Ship in Togo. Trainings in family

planning and counseling skills were conducted in Ebonyi, Kebbi and Kano. A workshop in IEC development was also held during the third quarter.

In the fourth quarter, 32 individuals were trained in topics including emergency obstetric care for medical officers, data for decision making and contraceptive technology updates.

Table NIG4. Number of Persons Trained by Topic, October 2009 – September 2010, Nigeria

Training Topic	Oct-Dec	Jan-Mar	Apr – Jun	Jul-Sep	FY Total
First training in surgical repair for fistula	3	0	1	0	4
Continuing training in surgical repair for fistula	0	5*	2	0	6*
Pre- and postoperative Care	3	0	6	0	9
Basic obstetric care	15	0	0	0	15
MAP and community engagement	20	0	0	0	20
Training of FP providers on data collection and use	7	4	0	0	11
Training for traditional & religious leaders on MH issues	46	0	0	0	46
Family Planning counseling	0	0	30	0	30
IEC development workshop	0	0	27	0	27
Family planning LAPM	0	0	15	0	15
Emergency Obstetric care for doctors	0	0	0	9	9
Data for Decision Making	0	0	0	7	7
Contraceptive Technology	0	0	0	16	16
Total	94	9	81	32	215*

*One surgeon received both first and continuing training in the fiscal year, and is thus only counted once in the FY total

Quality Improvement. The FC Project Nigeria organized and conducted quarterly meetings for partners from supported sites. Participants were drawn from a wide range of facility-based partners and officials of respective ministries of health. The invited partners exchanged stories on the successes and challenges facing their facilities and shared experiences. The engagement strategies used by the Ebonyi State team were shared, and a presentation was made on the maternal mortality and morbidity monitoring law which attracted the attention of many state representatives also in attendance.

During the fiscal year, the project concluded routine facility assessments and identified further sections of the Laure (in Kano) and Babar Ruga (in Katsina) Fistula Centers for refurbishing which were carried out over the year. The project also commissioned the refurbishing of FP clinic attached to Babar Ruga Hospital which was completed in the fourth quarter. During the routine assessment, the project also identified the lack of proper surgical instruments in most of the supported facilities and will work with facilities to procure these supplies in FY 10/11.

The project has concluded plans for procurement and supply of fistula specific instruments as well as family planning equipment for all supported sites. We believe this will alleviate the acute shortages seen by the sites in the past. As mentioned earlier, the project has also sustained timely and regular supply of high quality theater consumables to all the supported sites.

Prevention. In total, over 75,000 fistula and family planning related IEC materials were produced and distributed, including posters, handbills, stickers and pamphlets. Monthly radio slots on the Health Watch program of Radio Nigeria continue to be utilized to broadcast fistula-related messages. Recent topics included the current state of obstetric fistula and available interventions, the importance of antenatal care and information on the maternal mortality and morbidity monitoring law and what it seeks to achieve. A media blitz effort was sustained through the year with airing of episodes of a fistula prevention program on radio and a radio jingle, and with coverage on fistula issues achieved in a variety of print and broadcast media. A radio jingle was also developed and aired to advertise the availability of free repairs in Ebonyi. And finally, to prioritize fistula issues with the public, the project partnered with ten journalists covering health issues in both print and electronic media in efforts to increase media reportage.

During the third quarter, the project conducted a workshop to develop materials for use in community outreach activities in Ebonyi state and the South East Zone. A total of 27 participants attended the workshop (fistula clients, male relatives and community members, health providers (nurses, doctors), MCCI members, Ministry of Health, Ministry of Women Affairs, religious and traditional leaders and the media). The participants reviewed existing materials and developed new messages. The materials developed have been pre-tested with traditional and religious leaders, women's groups (whose members are of reproductive age), men, youth (in school and out of school) etc. in the Okaria community in Ebonyi state.

The project organized a script writers' workshop to develop a script for a radio drama program. Key persons from the Nigeria movie industry and Nigeria script writers, as well as popular artists, participated in the workshop. The participants developed synopsis, episodes, and episode breakdowns with themes, scenes and characters. The final product will also be shared with the Fistula Care Global team for review and approval. .

Community Outreach. By the end of the fourth quarter, over 1,000 events had been held by the CBOs, Religious Leaders Advocacy Champions (RLAC) and community action teams (CATs) reaching over 415,000 people. Table NIG5 provides details on the number of community outreach events conducted and the number of persons reached during the fiscal year.

The RLACs from Sokoto, Kebbi and Zamfara States conducted community outreach activities in over 30 communities, which included using sermons and relevant sections of the Koran to focus on stigma reduction, relevance of regular ANC attendance, hospital delivery and child spacing. The clerics also focused on Female Genital Cutting and called for total abolishing of this practice emphasizing that such practices have no place in Islam. In addition, CATs received training and in turn spread their message to their communities about the availability of fistula repair services, the need for ANC and hospital delivery, etc. Specific messages about female genital cutting were incorporated. Workshops with traditional birth attendants (TBAs) were conducted to emphasize the prevention of long labors and the need for early referral to appropriate health facilities.

In addition to efforts of the religious leaders to prevent fistula through preaching, FC also supports drama troupes to deliver messages about fistula prevention, care and support, stigma reduction, child spacing and reintegration of repaired fistula clients back into their communities through drama presentations. Over 15,000 people were reached through these dramatic presentations.

Forty-six participants from Ebonyi State attended a workshop for traditional leaders to increase knowledge of key maternal health issues, policy, fistula prevention, family planning, and child spacing. This is an attempt to replicate the great success this approach has found in the North (Sokoto, Kebbi and Zamfara).

CBOs in Zamfara held brainstorming sessions focused on Men as Partners (MAP) and the importance of supporting women. Kebbi CBOs also engaged Imams and religious leaders in a sensitization workshop. The CBOs took additional steps of engaging the road traffic workers (including commercial motorcyclists) to communicate messages through rallies about ANC attendance, female genital cutting, family planning and fistula. The rally was tagged “*Attending ANC service and hospital delivery can prevent Fistula*”. The organizers chose market days for such rallies and targeted strategic places in the communities where men and women are known to gather after work, (e.g., major streets, markets, motor parks, and stopovers at major road junctions and other popular spots) to give talks, answer questions and distribute IEC materials. In all the rallies, the CBOs involved the town criers and local musicians, which added color to the event and made it more attractive to the villagers.

In Ebonyi State, MCCI could not carry out community outreach activities during the third quarter because the state authorities placed a temporary ban on all group gatherings across the state as part of security measures to prevent outbreak of violence in the local government primary elections in the state.

Table NIG5. Number of Community Outreach Events and Persons Reached by State, October 2009 – September 2010, Nigeria

State	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached
Kebbi	21	6645	26	16400	27	20183	221	74,021	295	117,249
Sokoto	22	6873	27	17388	27	21731	275	90,595	351	136,587
Zamfara	31	6108	22	17900	21	19572	305	34,316	379	77,896
Ebonyi	4	16087	4	12925	0	0	7	54,838	15	83,850
Total	78	35,713	79	64,613	75	61486	808	253,770	1040	415,582

Family Planning. During the fiscal year, a total of 10,249 individuals accepted family planning methods at supported sites and 13,269 received family planning counseling. The most popular methods provided were injectables, followed by the oral pill and IUCD. Table NIG6 presents all the family planning data available for the supported sites. During this year, FC scaled up family planning services in several clinics in Kebbi and Ebonyi states. In Sokoto state the project was able to revive its support for four FP clinics. There was some difficulty obtaining counseling data from the newly supported prevention only sites because there was a lack of initial data capturing tools set up. However, those systems are now functional and counseling is now being reported.

Table NIG 6. Number of FP Clients by Method and Number Counseled about FP, by state. October 2009 – September 2010, Nigeria

STATE	SOKOTO	ZAMFARA	KEBBI	KANO	KATSINA	EBONYI	Country Total
# sites	5	3	6	6	1	7	28
Fistula FP Methods	Total	Total	Total	Total	Total	Total	FY Total
Oral Pill	317	145	809	650	61	46	2028
IUCD	138	81	128	372	19	27	765
Condom (male)	21	8	7	21	79	32	168
Condom (female)	0	0	0	11	1	0	12
Injectable	1870	1194	976	2502	62	453	7057
Implant	28	46	63	0	8	47	192
Tubal Ligation	5	7	15	0	0	0	27
Vasectomy	0	0	0	0	0	0	0
Foaming Tablets	0	0	0	0	0	0	0
Total FP acceptors	2379	1481	1998	3556	230	605	10249
Total clients counseled about FP	3339	1582	3322	3617	404	1005	13269

Obstetrics. Of the 2,349 deliveries reported by the seven supported sites that also handle obstetric care, only 12% were C-sections. Table NIG7 provides site specific data, by quarter. Only two of the sites (Faridat and Maryam Abacha) provided data for all four quarters, all other sites provided only fourth quarter data.

Table NIG 7. Obstetric Services, by site. October 2009 – September 2010, Nigeria.

	Faridat General Hospital	Maryam Abacha	GH D/D	GH Kamba	Maiyama Gh	Argungu GH	GH Jega	TOTAL
Number of vaginal deliveries	584	419	32	198	260	310	264	2067
Number of C-sections	161	43	4	14	17	21	22	282
Total number of deliveries	745	462	36	212	277	331	286	2349
Percent deliveries by C-section	22%	9%	11%	7%	6%	6%	8%	12%

Policy. There were many policy-related activities carried out during the fiscal year. Several of these activities include actions at the national level and others at the state level.

National Level. FC encouraged the Senate Committee on Health to visit some of the project-supported facilities and a five day visit took place to four fistula facilities in Sokoto, Kebbi, Zamfara and Ebonyi states in October 2009. A major outcome of this activity was the pledge made by the Senate chair to create a budget line specifically for fistula intervention in the budget in 2010. The budget now awaits approval by the President.

At the request of USAID/Nigeria, the Fistula Care project organized a Stakeholder Meeting in April 2010 to review progress on implementation of the National Plan for 2005 – 2010 VVF, to discuss accomplishments and progress made, to identify gaps and to discuss strategies to address identified gaps. The Federal Ministry of Health, Family Health Department and UNFPA were invited to collaborate in this activity. This meeting was one component of an environmental scan of fistula prevention, treatment and reintegration services in Nigeria. A report has been prepared with recommendations and is under review by USAID/Nigeria.

Fistula Care partnered with the Chairperson of the Senate Committee on Health, Society for Family Health, DFID Funded PRRINN project and the Federal Ministry of Health to organize the second annual Mother’s Night event. The highlight of this occasion was the recognition of persons who have played major roles in the improvement in the health of women in rural communities. Among the recipients this year were two persons working in the area of fistula, Mrs. Josephine Elechi, the Wife of the Governor of Ebonyi State and founder of the South East Regional Center, for her role in addressing fistula challenges in Ebonyi State, and Dr. Abba Wali for his untiring efforts at providing succor to women in Sokoto state through fistula repairs. The event was attended by the wife of the then-Acting, current President, Mrs. Patience Goodluck Jonathan, who presented the awards to the recipients. A total of five recipients were given the award. Several top government functionaries and members of the diplomatic corps were present at this year’s event.

Fistula Care participated in a two day meeting of the National RH Working Group (NRHWG) in Lagos in June 2010. The objective of the meeting was to review the final

draft of the National Reproductive Health policy and disseminate the Report on Key Interventions Promoting Maternal Health. The NRHWG is a national forum with representation from key stakeholders working in the area of reproductive health including public health regulatory bodies. At this meeting the fistula desk officer from FMOH made presentations on the fistula intervention in the country. During his presentation he highlighted the need to reconstitute the national fistula taskforce and the need to increase budgetary allocations for fistula interventions at the national level. The national taskforce on fistula, when reconstituted, will be an affiliate of the forum. About 68 people participated at this meeting including USAID implementing partners, Federal ministries, department and agencies, NGO/CSO groups, universities, health institutions and professional groups

Ebonyi State. The Mother and Child Care Initiative (MCCI), in collaboration with FC, UNICEF and UNFPA, organized a two-day dissemination and monitoring tool development workshop for 102 members of the Ebonyi state level multi-sector Maternal Mortality and Morbidity Monitoring committee. This included representatives of religious and traditional institutions as well as civil society organizations, the legislature and line ministries in Health and Development. The project is working towards finalizing data monitoring/reporting tools and training in their use, as well as printing and disseminating a reader friendly version of the Mother and Child Care Law currently in place.

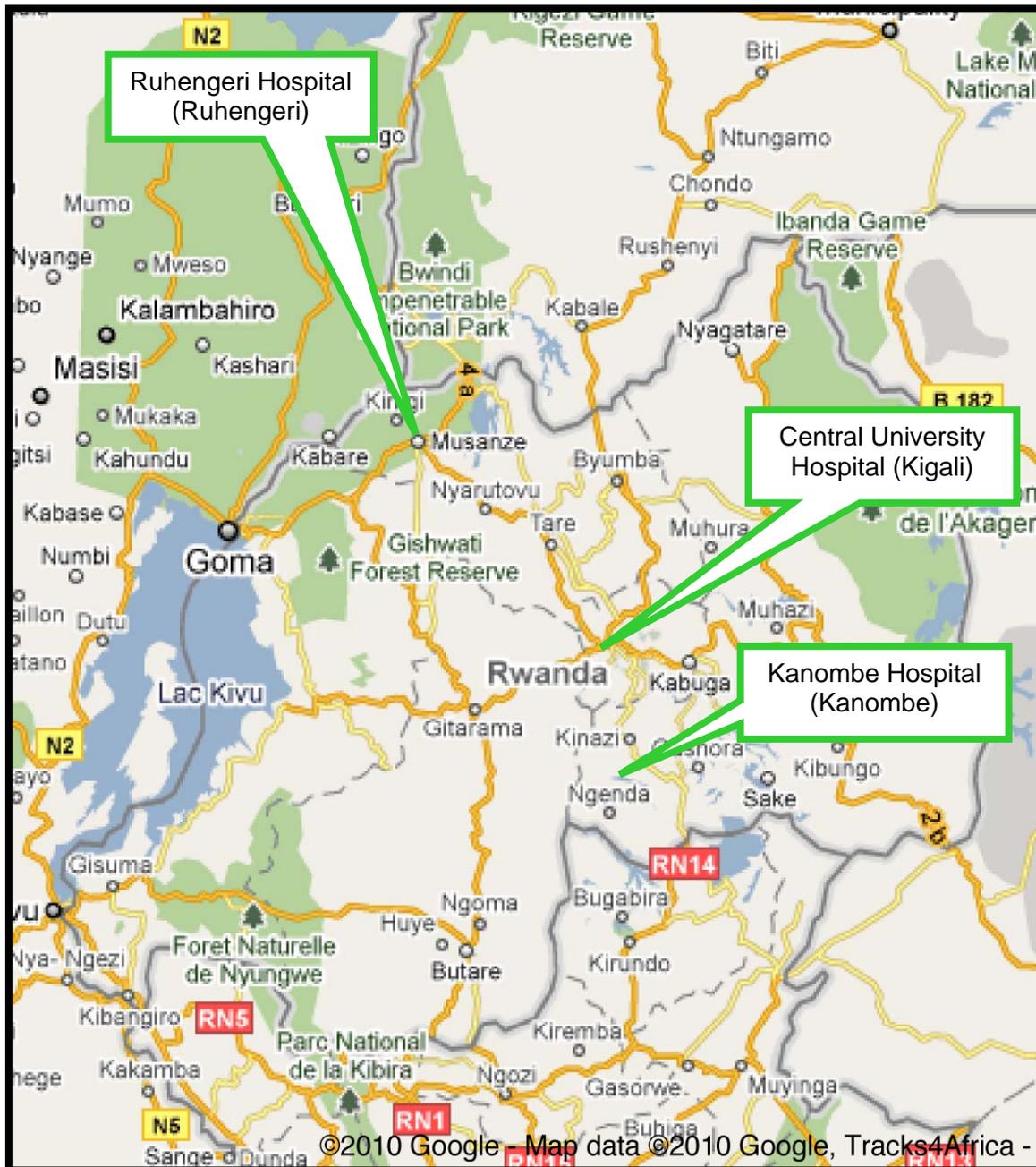
In the second quarter, FC collaborated with the Government of Ebonyi State to perform a “Public Presentation of the Maternal Mortality and Morbidity Monitoring Law”. This event was hosted by the Governor of Ebonyi State and the USAID/Nigeria mission director as Special Guest of Honor. Also in the second quarter, FC participated in the dissemination of the 2008 Nigeria DHC report in Ebonyi State.

Sokoto State. The Nigeria Fistula Care Project held a policy dialogue with the Sokoto State Commissioner for Women Affairs to further discuss the need to establish a state level taskforce on fistula. As part of its advocacy activities, the project worked with the Honorable Commissioner to develop an initial list of possible members from different sectors of the government and CSOs.

Other Activities. During the third quarter, the project supported two partners from the South East Regional Fistula Center Ebonyi State to attend the Women Deliver Conference in Washington DC. Dr. Ileogben Sunday-Adeoye, the Center Director and Mrs. Josephine Elechi, Founder and Facilitator of the Mother and Child Care Initiative were the two partners who presented papers on “Innovations in Fistula Prevention, Treatment, and Reintegration”. The two also had the opportunity to participate in a congressional briefing organized by the End Fistula Campaign where the first lady presented her activities and the strategies used to address women’s issues in Ebonyi State. The presentation and the congressional briefings were very well received and the partners were very happy to have had the opportunity to participate in the conference.

Efforts to engage journalists around fistula-related issues resulted in a two day media round table with journalists from different media organizations to raise awareness of fistula and highlight challenges to fistula management and prevention as well as how to lessen stigma. Eighteen journalists attended, and a few days after the event, stories on fistula appeared in four separate daily newspapers, as well as a story being aired over the Radio Nigeria Network News.

RWANDA



Program Background

Service start up: March 2006

Service sites: Activities in Rwanda are focused on three public sites:

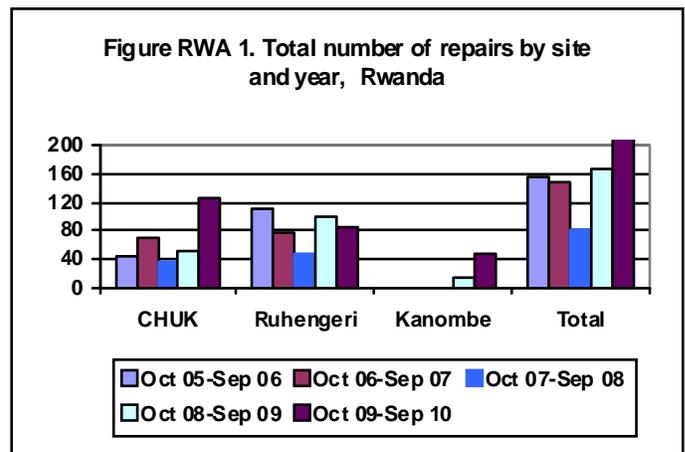
- Central University Hospital of Kigali (CHUK)
- Ruhengeri District Hospital
- Kanombe Hospital

In the third quarter of FY 08/09, Fistula Care opened a project office in Kigali, Rwanda. The office is now staffed and operative, and has raised the visibility of the fistula program. The in-country presence has strengthened the project's image with the USAID mission and the MOH as a dedicated program making a valuable contribution. Kanombe Hospital was added as a repair site in FY 09/10. The surgeon at Kanombe had already been trained through Fistula Care and began providing repairs in the last quarter of FY 08/09

At the request of the USAID/Rwanda mission, Fistula Care supported the Ministry of Health in a fistula site assessment to increase the availability of fistula services in the various regions of Rwanda. A team composed of Dr. Isaac Achwal and Dr. Jeanne Kabagema of FC, Dr. Ferdinand from the MOH, and the MCH taskforce conducted the assessment at Nyamata Mission Hospital in Eastern Province, Centre Hospitalized Universitaire de Butare (CHUB) in the Southern Province and Kibogora Mission Hospital in the Western Province. Based on this assessment, FC will be supporting the following sites in FY 10/11: one additional treatment site (Kibogora) and three prevention sites (Gahini, Kabgayi and Nyamata. The project has already begun training one surgeon and nursing staff in fistula repair and care from Kibogora hospital.

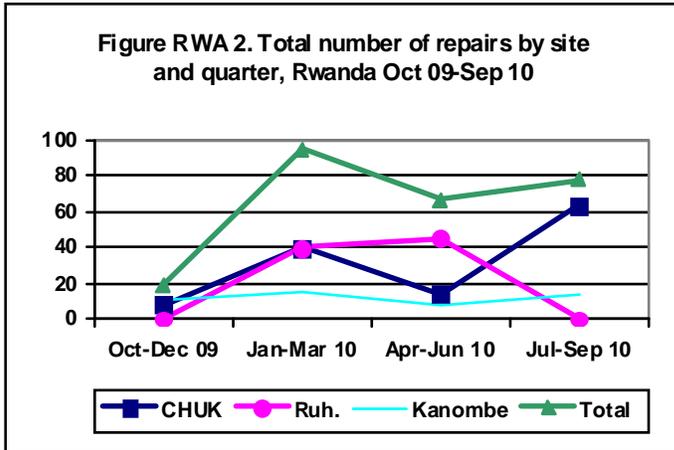
Key Accomplishments October 2009-September 2010

Fistula Repairs. During the fiscal year, 259 women received fistula repairs in Rwanda at the three supported sites. This represents an increase of 55% compared to FY 08/09, with performance more than doubling at CHUK and Kanombe (see Fig RWA 1). Several factors contributed to this increase. First, the renovation of the operating theater at CHUK was completed which enabled the facility to organize two repair and training sessions in January and September 2010, and continue providing routine fistula services. Secondly, Kanombe is now a fully operational supported site, whereas the site was only supported during the final quarter of the previous year. Finally, fistula repair kits and instruments were provided or replaced at all three fistula sites which contributed to their ability to perform more cases. Table RWA1 has clinical indicator details for all sites, for the fiscal year.



There were no repairs in Ruhengeri in the first quarter, due to the cancellation of a repair session during that period (see Fig RWA 2). Fistula Care in collaboration with the MOH, UNFPA and GTZ have traditionally organized workshops at Ruhengeri. One partner was unable to continue support for repairs in the first quarter which resulted in the delay of the session. FC has continued to collaborate with the MOH and GTZ to organize sessions at Ruhengeri. In addition, the project, in collaboration with the MOH has organized additional sessions at Ruhengeri and CHUK. These additional sessions have dramatically

increased the number of repairs at CHUK and Ruhengeri between the first and second



quarters. CHUK has a large backlog of clients due to the limited availability of the surgeon (who is currently pursuing postgraduate studies in Ob/Gyn) and due to limited pre/post operation bed space. In addition to the work to increase surgeon availability to provide routine repairs, a room has been identified by CHUK, that will be renovated by FC to serve as a pre/post operation ward next year. Public awareness of the availability

of fistula surgery at facilities besides CHUK and Ruhengeri hospital is still limited. The surgeon from Kanombe reports that fewer women are seeking fistula services at Kanombe Military hospital because they are not able to afford the treatment cost, so they prefer to go to Ruhengeri where it is known that the treatment is fully covered by Fistula Care. The project will work with the MOH to build community awareness of the availability of free treatment at Kanombe next year.

The majority of women at CHUK and Kanombe were receiving their first repairs, while only 37% received first repairs at Ruhengeri. At all sites, the vast majority of repairs were urinary only repairs. Over 83% of women discharged after urinary or urinary/RVF repairs were closed and dry at discharge (see Fig RWA3).

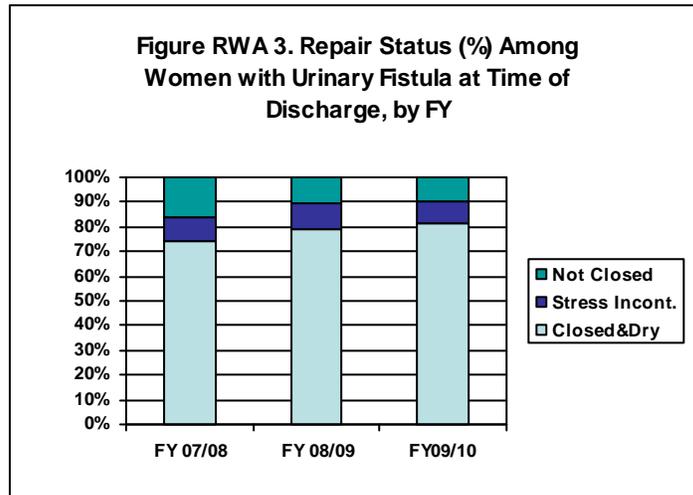


Table RWA 1. Clinical Indicators by Site, October 2009 – September 2010, Rwanda

	CHUK					Kanombe				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	15	165	20	146	346	16	17	8	16	57
No. requiring FRS	11	114	20	123	268	11	17	8	16	52
No. receiving FRS	8	40	14	64	126	11	15	8	14	48
Percent receiving FRS	73%	35%	70%	52%	47%	100%	88%	100%	88%	92%
Type of FRS performed										
----- urinary only	6	37	12	62	117	10	12	7	11	40
----- urinary & RVF	0	3	0	0	3	0	0	0	0	0
----- RVF only	2	0	2	2	6	1	3	1	3	8
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	4	36	10	44	94	9	10	5	9	33
----- second repair	0	4	1	13	18	0	2	2	2	6
----- >2	2	0	1	5	8	1	0	0	0	1
Percent women with first repair (urinary only)	67%	90%	83%	71%	78%	90%	83%	71%	82%	83%
No. discharged after FRS (urinary only)	6	37	12	16	71	10	12	7	11	40
No. discharged after FRS (urinary & RVF)	0	3	0	0	3	0	0	0	0	0
No. discharged after FRS (RVF only)	2	0	2	0	4	1	3	1	3	8
Total no. discharged after FRS	8	40	14	16	78	11	15	8	14	48
No. not discharged after FRS	0	0	0	48	48	0	0	0	0	0
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	5	33	10	14	62	8	10	6	9	33
----- No. with closed fistula & stress incontinence	0	3	2	1	6	0	0	1	2	3

	CHUK					Kanombe				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
----- No. whose fistula was not closed	1	4	0	1	6	2	2	0	0	4
Percent with closed fistula who are dry (urinary only & urinary/RVF)	83%	83%	83%	88%	84%	80%	83%	86%	82%	83%
Outcome of FRS (RVF only)										
----- closed and dry	2	0	2	0	4	0	3	1	3	7
----- incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0
----- incontinent with firm stool	0	0	0	0	0	1	0	0	0	1
Percent with closed and dry fistula (RVF only)	100%	0%	100%	0%	100%	0%	100%	100%	100%	88%
No. with complications after FRS	0	0	0	0	0	0	0	0	0	0
----- Major surgical complications	0	0	0	0	0	0	0	0	0	0
----- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	0	0	0	0
Percent with complications after FRS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table RWA I. Clinical Indicators by Site, October 2009 – September 2010, Rwanda (continued)

	Ruhengeri I					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	0	52	65	0	117	31	234	93	162	520
No. requiring FRS	0	52	48	0	100	22	183	76	139	420
No. receiving FRS	0	40	45	0	85	19	95	67	78	259
Percent receiving FRS	0%	77%	94%	0%	85%	86%	52%	88%	56%	62%
Type of FRS performed										

	Ruhengeri I					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
----- urinary only	0	39	43	0	82	16	88	62	73	239
----- urinary & RVF	0	0	2	0	2	0	3	2	0	5
----- RVF only	0	1	0	0	1	3	4	3	5	15
For 'Urinary only' or 'Urinary and RVF' repairs										
----- first repair	0	17	14	0	31	13	63	29	53	158
----- second repair	0	18	21	0	39	0	24	24	15	63
----- >2	0	4	10	0	14	3	4	11	5	23
Percent women with first repair (urinary only)	0%	44%	31%	0%	37%	81%	69%	45%	73%	65%
No. discharged after FRS (urinary only)	0	0	82	0	82	16	49	101	27	193
No. discharged after FRS (urinary & RVF)	0	0	2	0	2	0	3	2	0	5
No. discharged after FRS (RVF only)	0	0	1	0	1	3	3	4	3	13
Total no. discharged after FRS	0	0	85	0	85	19	55	107	30	211
No. not discharged after FRS	0	40	0	0	40	0	40	0	48	88
Outcome of FRS (urinary only & urinary/RVF)										
----- No. with closed fistula who are dry	0	0	70	0	70	13	43	86	23	165
----- No. with closed fistula & stress incontinence	0	0	9	0	9	0	3	12	3	18
----- No. whose fistula was not closed	0	0	9	0	9	3	6	9	1	19
Percent with closed fistula who are dry (urinary only & urinary/RVF)	0%	0%	83%	0%	83%	81%	83%	83%	85%	83%
Outcome of FRS (RVF only)										
----- closed and dry	0	0	0	0	0	2	3	3	3	11
----- incontinent with water stool and	0	0	0	0	0	0	0	0	0	0

	Ruhengeri I					Country Total				
Fistula Treatment Indicators	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
/or flatus (gas)										
----- incontinent with firm stool	0	0	1	0	1	1	0	1	0	2
Percent with closed and dry fistula (RVF only)	0%	0%	0%	0%	0%	67%	100%	75%	100%	85%
No. with complications after FRS	0	0	3	0	3	0	0	3	0	3
----- Major surgical complications	0	0	0	0	0	0	0	0	0	0
----- Anesthesia-related complication	0	0	0	0	0	0	0	0	0	0
----- Post-operative complication related to perceived success of surgery	0	0	3	0	3	0	0	3	0	3
Percent with complications after FRS	0%	0%	4%	0%	4%	0%	0%	3%	0%	1%

During FY 09/10, 31 additional surgeries were performed, with the most common being examination under anesthesia and 3rd/4th degree perineal tears. Details are provided in Table RWA2.

Table RWA 2. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Rwanda

	Oct-Dec	Jan – March	Apr-June	Jul-Sep	FY Total
Type of Surgery by Site					
CHUK					
3 rd /4 th degree perineal tear	1	2	3	0	6
Examination under anesthesia	0	3	4	3	10
Colostomy and reversal colostomy	0	0	2	0	2
Ureteric reimplantation	0	0	1	1	2
Kanombe					
Biopsy	1	0	0	0	1
Examination under anesthesia	0	2	0	0	2
Ureteric reimplantation	0	1	0	0	1
Ruhengeri					
Removal of bladder stones or foreign bodies in viscera	0	2	2	0	4
3 rd /4 th degree perineal tear	0	0	3	0	3
Total	2	10	15	4	31

Strengthening Capacity. During the second quarter, four complete new fistula repair kits, operating theater lights and an operating bed were donated to Kanombe Hospital, two additional complete fistula repair kits and additional scissors were donated to CHUK, and one additional complete fistula repair kit and additional scissors were donated to Ruhengeri Hospital.

Training A total of 46 individuals received training during the fiscal year. During the second quarter, four surgeons received their first training in fistula followed by a second training. Twelve nurses were trained in each of these sessions, for a total of 24 nurses. One additional surgeon and two nurses received continuing training in repair in the third quarter aboard the *Africa Mercy* in Togo. In the third quarter, a fistula counseling training was organized in Rwanda, with 15 providers attending. In May 2010, Levent Cagatay, Senior Technical Adviser/EngenderHealth and Sita Millimono, Senior Medical Associate, Guinea program conducted fistula counseling training, using the Counseling Curriculum for Fistula Clients, for 15 providers supporting fistula services at the 3 supported sites and Kibogora. The curriculum is designed to prepare providers to meet the information and counseling needs of obstetric fistula patients before, during and following treatment, including referral for services and treatment for complications that can not be provided at the facility.

No trainings were held in the fourth quarter. Training information is presented in Table RWA3.

Table RWA 3. Number of Persons Trained by Topic, October 2009 – September 2010, Rwanda

Training Topic	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total
First surgical training for fistula repair	0	4	0	0	4
Continuing surgical training for fistula repair	0	4*	1	0	5
Pre- and post-operative fistula care for nurses	0	24	2	0	26
Fistula counseling	0	0	15	0	15
Total	0	28*	18	0	46*

* The same surgeons received both first training and continuing training during the quarter. Therefore, they are only counted once towards the number of persons training.

Quality Improvement. During training sessions at CHUK and Ruhengeri and during medical monitoring visits it was noted that some supplies such as ureteric catheters, and some sutures were not available at the sites (these materials cannot be found in Rwanda.) As a result, Fistula Care provided provision these supplies to the sites as mentioned above. Meetings were held with all three sites to orient them on data management and grants management.

Family Planning. Over 1,100 people accepted family planning methods during the fiscal year in FC-supported sites. The most popular method is the injectable, followed by oral contraceptives. Information on the number of individuals counseled is unavailable for all sites, as a system to record this information is not yet in place. Kanombe Hospital did not report on FP activities in the fourth quarter because this service is no longer provided in the facility. The room that was previously used for family planning is scheduled to be renovated for use as a pre and post-operative care space. Table RWA4 provides all available family planning information for the sites.

Table RWA 4. Number of FP Clients by Method and Number Counseled about FP, by Site. October 2009 – September 2010, Rwanda.

Fistula FP Methods	CHUK	Kanombe	Ruhengeri	Total
Oral Pill	5	361	18	384
IUCD	38	0	0	38
Condom (male)	0	0	34	34
Condom (female)	0	0	0	0
Injectable	1	603	38	642
Implant	4	3	16	23
Tubal Ligation	20	9	23	52
Vasectomy	2	0	8	10
Foaming Tablets	0	0	0	0
Total FP acceptors	70	976	137	1183
Total Number of clients counseled about FP methods	n/a	n/a	n/a	n/a

Obstetrics. Of the 9,845 deliveries recorded at the three supported sites during the fiscal year, 31.6% were C-section deliveries. Additional obstetric information is included in Table RWA5.

**Table RWA 5. Obstetric Services, by site.
October 2009 – September 2010, Rwanda.**

	CHUK	Kanombe	Ruhengeri	Total
Number of vaginal deliveries	1015	2146	3570	6731
Number of C-sections	959	1012	1143	3114
Total number of deliveries	1974	3158	4713	9845
Percent deliveries by C-section	48.6%	32%	24.3%	31.6%

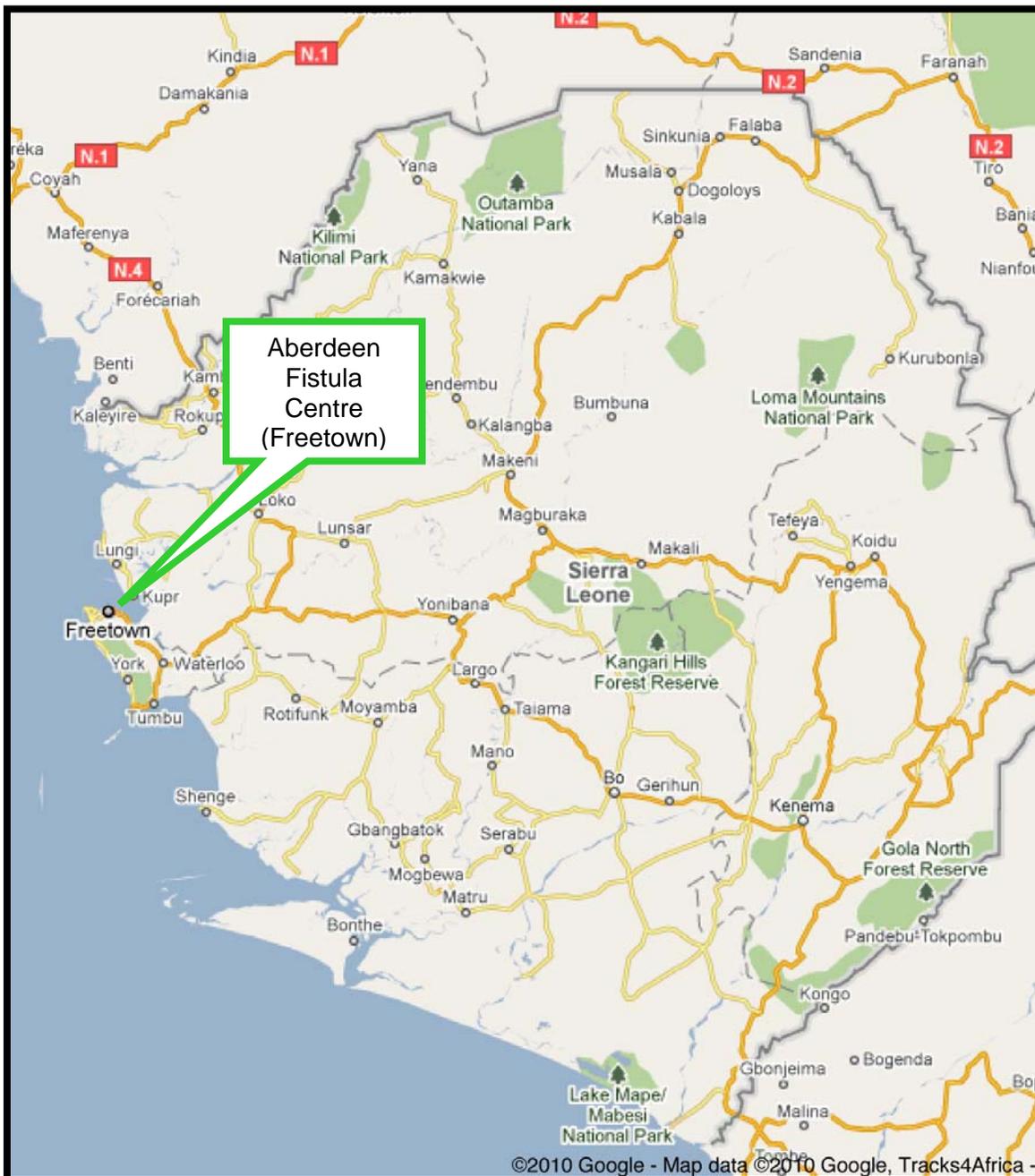
Policy. During the first quarter (December 2009), a national MCH stakeholders meeting was held in Kigali in December 2009, resulting in suggestions and recommendations for integrating fistula care activities into other maternal health services.

The Ministry of Health would like to have a fistula strategy and is currently reviewing a draft developed by Fistula Care. A meeting will be held in the coming months to finalize the draft.

In June 2010, FC participated in the Safe Motherhood Technical Working Group, which recommended that Fistula Care organize a meeting on fistula for clinical stakeholders. The meeting will bring stakeholders together towards the development of a fistula strategy. As a follow up on the meeting, the MOH has set up a fistula steering committee composed of a Maternal and Child Health unit representative and partners who support fistula services in Rwanda.

Fistula Care supported and co-chaired the meetings of the fistula steering committee, to better coordinate fistula work taking place in Rwanda. Finally, Fistula Care participated in meetings of the family planning technical working group, working towards the drafting of a family planning strategy.

SIERRA LEONE



Program Background

Service start up: January 2007

Service sites: Aberdeen Women's Centre

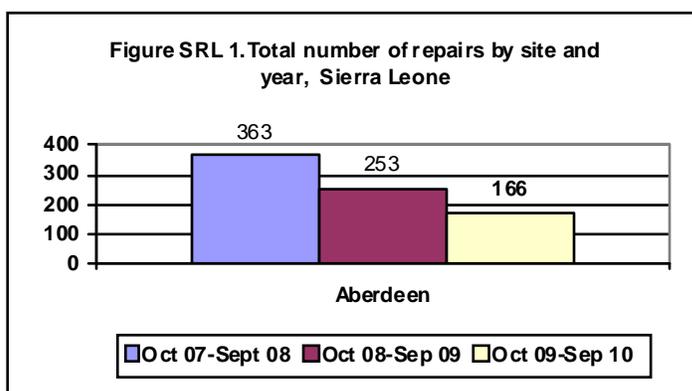
In Sierra Leone, the Fistula Care Project supports the Aberdeen Women's Centre (AWC, formerly known as the Aberdeen West Africa Fistula Centre). The AWC was managed by Mercy Ships International through January 1, 2010, at which point Mercy Ships transferred its authority to The Gloag Foundation (TGF) in order to concentrate its efforts

on the ship. The Gloag Foundation is a sister organization of the Balcraig Foundation and the Freedom from Fistula Foundation, which is largely funded by Ann Gloag and has implemented fistula programs in Kenya, Liberia, and Malawi. Fistula Care’s subaward with the Gloag Foundation began July 1, 2010.

The idea for the AWC originated in 2000, when the Ministry of Health in Sierra Leone requested Mercy Ships International (MSI) to provide fistula treatment on board its hospital ship, *Anastasis*. To be able to continue serving the largely unmet needs of women suffering from fistula after the ship’s departure, Mercy Ships carried out construction of the fistula center at Aberdeen. Since its opening in April 2005, the mission of this center is to provide high quality gynaecological surgeries for childbirth injuries and holistic fistula treatment services. The AWC has an outpatient clinic for children that is funded through other sources.

Fistula surgery is normally provided four days a week by the resident surgeon, Dr. Alyona Lewis. In addition there is usually one visiting international surgeon each quarter to provide additional support, especially in complex repairs. A new maternity wing, housed in the former pre fistula surgery hostel, opened in May 2010. The Obstetric Unit contains 3 delivery areas and 8 antenatal/postnatal beds with an overflow ward of 12 beds that can be used by either department (fistula or obstetrics). There are two functioning theaters for surgery. As of October 2010, family planning services are now being provided in-house to patients in both the repair and obstetrics programs.

Key Accomplishments October 2009-September 2010



Fistula Repairs. Aberdeen Women’s Centre carried out 166 repairs from October 2009 to September 2010. This represents a decrease of 34% from FY 08/09 (see Fig. SRL1). This decrease is due to several factors. Visiting international fistula surgeons have been less available in the past year. The transition in management from Mercy Ships to

The Gloag Foundation involved some staff turnover and a reduction in the number of screening trips made to the field. The opening of a maternity unit required a great deal of energy and focus from AWC management and staff.

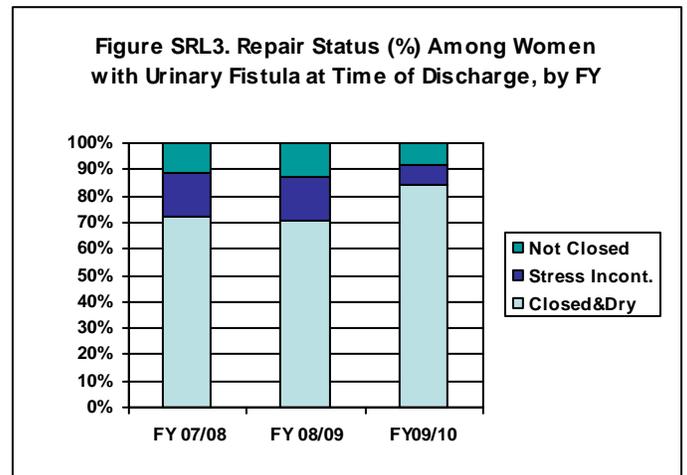
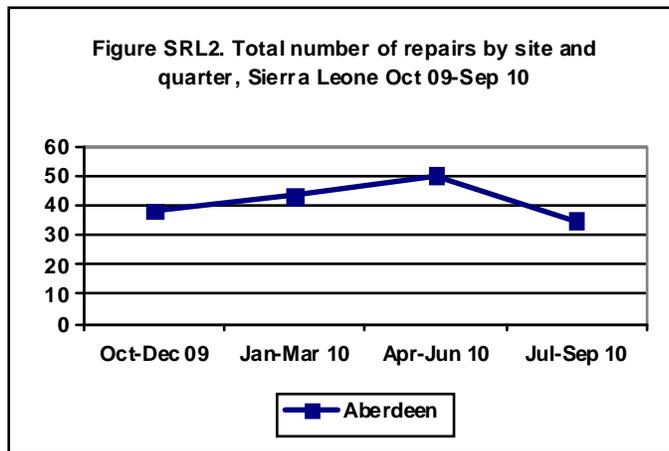
**Table SRLI. Clinical Indicators, Aberdeen Women's Centre, by Quarter,
October 2009-September 2010**

Fistula Treatment Indicators	Aberdeen / Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	42	69	93	69	273
No. requiring FRS	34	46	54	37	171
No. receiving FRS	38	43	50	35	166
Percent receiving FRS	112%	93%	93%	95%	97%
Type of FRS performed					
----- urinary only	36	43	50	32	161
----- urinary & RVF	2	0	0	1	3
----- RVF only	0	0	0	2	2
For 'Urinary only' or 'Urinary and RVF' repairs					
----- first repair	28	33	45	26	132
----- second repair	10	6	3	4	23
----- >2	0	4	2	3	9
Percent women with first repair (urinary only)	74%	77%	90%	79%	80%
No. discharged after FRS (urinary only)	49	23	62	34	168
No. discharged after FRS (urinary & RVF)	2	0	0	4	6
No. discharged after FRS (RVF only)	1	0	0	0	1
Total no. discharged after FRS	52	23	0	38	113
No. not discharged after FRS	0	20	13	8	41
Outcome of FRS (urinary only & urinary/RVF)					
--- No. with closed fistula who are dry	44	20	53	29	146
---- No. with closed fistula & stress incontinence	2	2	6	4	14
----No. whose fistula was not closed	5	1	3	5	14
Percent with closed fistula who are dry (urinary only & urinary/RVF)	86%	87%	85%	76%	84%
Outcome of FRS (RVF only)					
----closed and dry	1	0	0	0	1
---- incontinent with water stool and /or flatus (gas)	0	0	0	0	0
---- incontinent with firm stool	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	100%	0%	0%	0%	100%
No. with complications after FRS	2	0	3	1	6
-----Major surgical complications	1	0	2	1	4
-----Anesthesia-related complication	0	0	1	0	1
---- Post-operative complication related to perceived success of surgery	1	0	0	0	1
Percent with complications after FRS	4%	0%	0%	3%	5%

Lastly, several nonprofits (such as MSF, Medecins Sans Frontieres) and government health workers have opted to refer patients to the VVF centre located in Bo, the West African Fistula Foundation. This center pays providers for referrals, and its location is more accessible than Freetown for patients in the Southern Province although waiting times may be long because fistula repairs are not offered there routinely. AWC staff are working to rebuild relationships with other nonprofits. They do not believe that their decrease in patient volume are indicative of a dwindling need for surgeries, but rather that it is related to poor levels of public awareness.

The third quarter of the year (April-June) had the highest number of women presenting and receiving surgery (Fig. SRL3). That quarter had a particularly effective strategy including screening teams, radio broadcasts and local medical personnel which will be utilized again in the future.

Of the 166 repairs carried out during the year, 80% of women were receiving their first repair and 84% of women were closed and dry upon discharge (see Fig. SRL2). The vast majority of women needing repair presented with VVF cases. Table SRL1 provides additional detail on clinical indicators for Sierra Leone.



A total of 128 additional surgeries were performed during FY 09/10. The most common surgeries were examination under anesthesia and urethral lengthening and other operations for concomitant stress incontinence. Details on the types of surgeries performed can be found in Table SRL2.

**Table SRL2. Number of Additional Surgeries for Fistula Patients,
October 2009 – September 2010, Sierra Leone**

Type of Surgery	Oct- Dec	Jan – March	Apr- June	Jul- Sep	FY Total
Examination under anesthesia	3	6	26	17	52
Removal of bladder stones or foreign bodies in viscera	1	1	5	3	10
Ureteric implantation	3	1	2	0	6
Urethral lengthening and other operations for concomitant stress incontinence	8	11	8	8	35
3 rd /4 th degree perineal tear repairs	3	2	1	3	9
Prolapse associated with fistula	0	1	0	0	1
Other	5	1	6	3	15
Total	23	23	48	34	128

Training. A total of 175 individuals were trained in Sierra Leone during the fiscal year. Two surgeons received continuing training in fistula repair. In the first quarter, Dr. Alyona Lewis continued her surgical repair training on board Mercy Ships and is now qualified to perform complex repairs. In the fourth quarter, Dr. Binta Leigh, a Sierra Leonean/German obstetrician completed her fistula training and also worked in the maternity unit during her stay. Several on-the-job training sessions took place in the second, third and fourth quarters, focusing on maternity and fistula issues. This training is related to staff changes and the opening of the obstetric program. Table SRL3 provides information on the number of persons trained, by topic.

A discussion has been held with the Minister for Reproductive Health, Dr. Samuel Karbo, about the possibility of a national surgeon being identified by the Ministry to train under Dr. Alyona Lewis. This is an attempt to address the current problem of having a single resident surgeon, who is also the only one in the entire country providing repairs on a routine basis. This has become an area of high-priority for the Ministry and is expected to be addressed in the next few months.

**Table SRL3. Number of Persons Trained by Topic,
October 2009 – September 2010, Sierra Leone**

Training Topic	Oct- Dec	Jan- Mar	Apr - Jun	Jul- Sep	FY Total
Training in Fistula Repair (continuing training)	1	0	0	1	2
OJT sessions for nursing staff by topic					
Adult CPR/Catheter/ Stent Care	0	21	0	0	21
Antenatal Care	0	0	0	8	8
Postnatal Care	0	20	0	0	20
Infant and Child CPR	0	14	0	0	14
Instrumental Deliveries	0	0	0	10	10
Febrile Seizures	0	10	0	0	10
HIV/AIDS	0	0	6	0	6
Documentation and Medication Errors	0	0	18	0	18
Neonatal Resuscitation	0	0	7	0	7
Disease in pregnancy (sickle cell, malaria)	0	0	0	11	11
C-section	0	0	6	4	10
Breastfeeding	0	0	20	0	20
Obstetric Emergencies	0	0	0	18	18
Totals	1	65	57	52	175

Community Outreach. AWC Screening Teams have traveled upcountry less frequently because they are beginning to see increases in patients referring themselves to the center, and coming with newer fistula. The teams have been utilizing radio broadcasts as part of their screening efforts, and are currently working to strengthen linkages and referrals with other health NGOs in the area including Marie Stopes and Health Poverty Action.

Together with Health Poverty Action, AWC has implemented a well established advocacy workshop, which focuses on imparting advocacy skills to fistula patients who are recovering from surgery. In the last two quarters of the year, 62 recovering women have been taught how to advocate for the healing and prevention of fistula and related birth injuries.

A meeting was held with a local drama group to create a drama within an existing radio soap series taking place in a national hospital. The story line will highlight the issue of fistula and will be followed with information about a hotline to AWC for referral and further enquiries. Future plans include expanding this to the provinces and linking the presentations to screening team visits.

Prevention. As mentioned above, the Obstetric Unit at the Fistula Centre opened in May 2010, addressing a need for quality obstetric care as a component of fistula prevention. The AWC is also serving as a training site for eleven national midwives on staff, providing ongoing in-house training on delivering a high standard of care, promoting evidence-based practice and developing national leaders in midwifery. AWC will explore partnering with the School of Midwifery in the future to develop a training program that will contribute to improving rates of fistula and maternal mortality rates nationally.

Family Planning. Family planning numbers have traditionally been very low at the site, due to the absence of a consistent family planning provider. There were no family services available for the January to June 2010 period, due to the failure of Marie Stopes to provide previously agreed upon services. However, beginning in October 2010 family planning services are now being provided in-house for patients in the maternity and fistula wards. The available family planning data is presented below, in Table SRL4.

Table SRL 4. Number of FP Clients by Method and Number Counseled about FP, by site. October 2009 – September 2010, Sierra Leone

Fistula FP Methods	Aberdeen Women's Centre				
	Oct-Dec	Jan-Mar	Apr- Jun	July -Sept	FY Total
Oral Pill	0	0	0	0	0
IUCD	0	0	0	0	0
Condom (male)	0	0	0	0	0
Condom (female)	0	0	0	0	0
Injectable	8	0	0	9	17
Implant	0	0	0	0	0
Tubal Ligation	6	0	0	4	10
Vasectomy	0	0	0	0	0
Foaming Tablets	0	0	0	0	0
Total FP acceptors	14	0	0	13	27
Total Number of clients counseled about FP methods	29	0	0	22	51

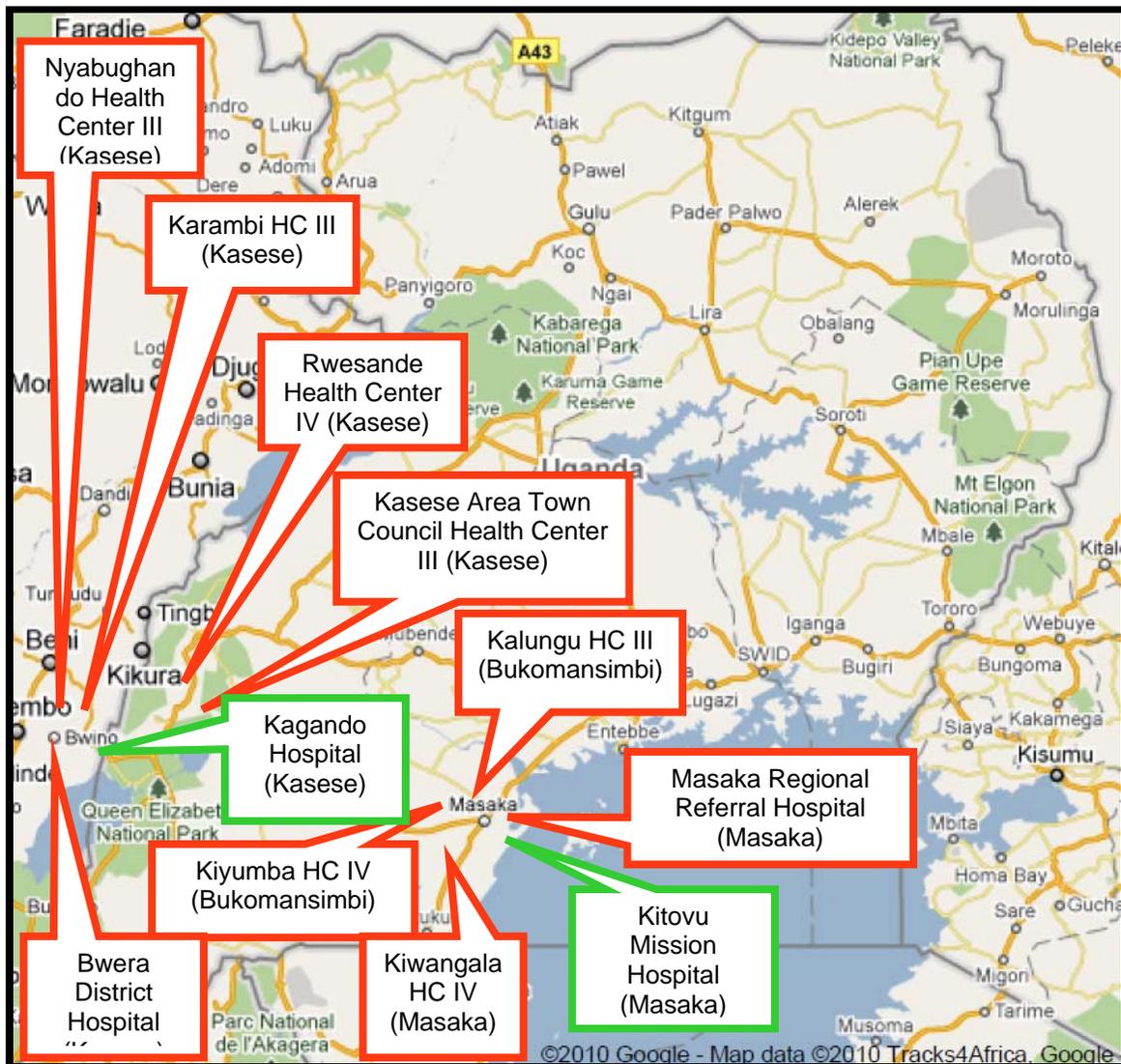
Obstetrics. The Aberdeen Women's Centre opened its maternity unit and began providing care in May 2010. The first baby was born at the Centre in May, and his mother is one of the nurses at the centre. Training and mentoring of 11 national midwives is on-going to raise in-country capacity for high quality obstetric care. Since opening, 217 deliveries have taken place with 16% being c-sections. There have not been any maternal deaths. Table SRL5 provides information on total number of deliveries and c-section rates by quarter.

**Table SRL5. Obstetric Services, by site.
October 2009 – September 2010, Sierra Leone.**

	Aberdeen Women's Centre				
	Oct- Dec	Jan- Mar	Apr- Jun	Jul- Sept	Total
Number of vaginal deliveries	n/a	n/a	46	136	182
Number of C-sections	n/a	n/a	9	26	35
Total number of deliveries	n/a	n/a	55	162	217
Percent deliveries by C-section	n/a	n/a	16.4%	16%	16.1%

Policy. A series of meetings have been held by the Ministry of Health and Sanitation and have included Aberdeen Women's Centre, in-country NGOs and UNFPA. The Ministry is keen to promote multi-agency collaboration and AWC has been identified by them as the leading facility in-country for effective care. This is a part of the governmental strategy "Agenda for Change," which includes developing a wider screening program to sensitize appropriate patients and lead to increased awareness of VVF and thus access of patients to the full array of care available at AWC.

UGANDA



Program Background

Service Start Date: January 2005

Service Sites:

- Kitovu Mission Hospital in Masaka, in collaboration with Masaka Regional Referral Hospital
- Kagando Mission Hospital in Kasese, in collaboration with Bwera District Hospital.

In addition, there are nine supported prevention-only sites:

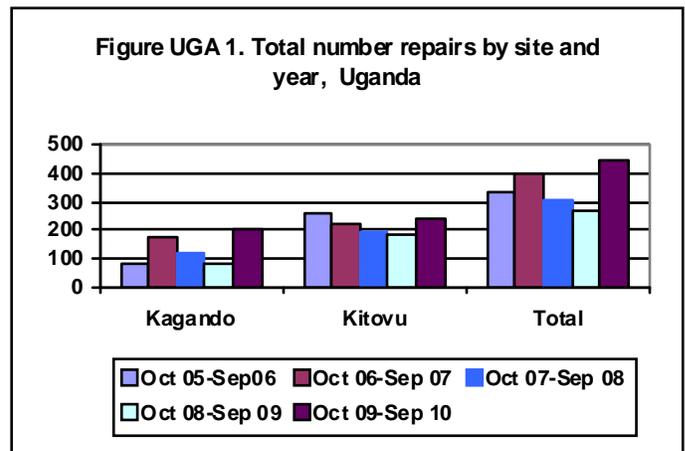
- Masaka area: Masaka RR Hospital, Kiwangala HCIV, Kalungu HC III, and Kiyumba HCIV.
- Kasese area: Bwera Hospital, Rwesande HC IV, Karambi HC III, Nyabugando HC III and City Council HC III.

Key Accomplishments October 2009-September 2010

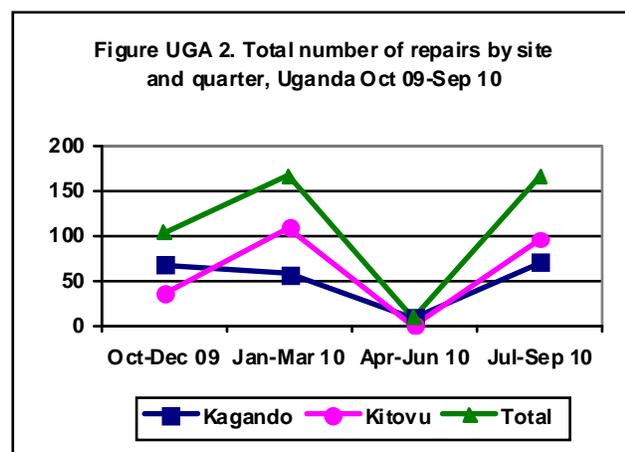


Health providers meeting fistula clients on their tour around the Kitovu VVF unit.

Fistula Repairs. During the 2009-2010 fiscal year, 449 women received fistula repairs at the two supported sites in Uganda. This represents a 68% increase in repairs (142% at Kagando, 33% at Kitovu; see Fig UGA1) when compared to FY 08/09. This increase is attributed to community mobilization efforts. The in-country partners now have more resources for community mobilization, leading to increases in repairs. This trend is expected to continue in the coming years.

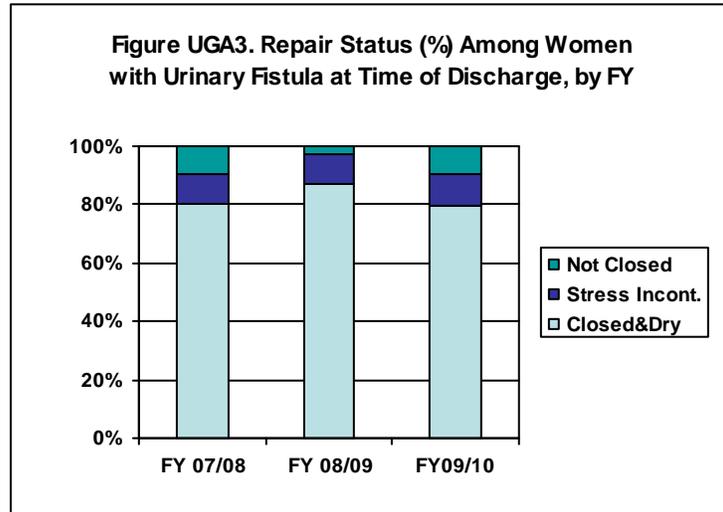


In the second quarter, Kitovu greatly increased the number of women seeking and receiving repairs due to an increase in community mobilization. Kagando experienced a slight decrease attributable to less effective community mobilization. Due to a subagreement amendment not yet finalized, Kagando did not have funds for outreach. In the third quarter, there was no fistula repair campaign conducted at Kitovu, and therefore no repairs took place. The number of women arriving, seeking and receiving fistula repair surgery at Kagando was low in the third quarter, compared to previous quarters because there was no organized campaign during the quarter, meaning no community mobilization efforts (see Fig UGA2). In the fourth quarter, Kagando and



Kitovu both had increases due to community outreach and mobilization efforts as part of organized repair sessions.

There is no substantial backlog of clients waiting for surgery. The majority of women were receiving their first repairs, and 79% of all urinary repairs were closed and dry upon discharge (see Fig UGA 3). Table UGA1 provides detailed information on clinical indicators tracked at both sites. The high rate of urinary incontinence for urinary repairs at Kagando in the second quarter was attributed to many of these being second repairs. Due to the timing of the Kagando repair session, many women were not yet discharged at the end of the second quarter.



Kagando Hospital is in a period of transition with fistula surgeon staffing. During FY 09/10 two fistula surgeons resigned, including the senior surgeon with advanced skills in complex repairs, and one is on leave outside of Uganda. One of the surgeons who resigned earlier in the year has agreed to act as a consulting surgeon at Kagando, conducting repair surgeries when enough clients are present on the ward. With the departure of the senior surgeon with the advanced skills there is a backlog of complex cases. FC is working with the hospital to address this issue and has advised Kagando to recruit surgeons with more advanced skills or to refer clients to Kitovu for services. A new surgeon is scheduled to be hired in October 2010; with a skill level to do simple to moderate repairs. Complex cases must still be referred to Kitovu or held over for visiting expert surgeons.

Table UGA I. Clinical Indicators by Site, October 2009 – September 2010, Uganda

Fistula Treatment Indicators	Kagando					Kitovu					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
No. seeking FRS	99	89	20	82	290	60	144	0	155	359	159	233	20	237	649
No. requiring FRS	79	69	16	79	243	37	117	0	97	251	116	186	16	176	494
No. receiving FRS	68	58	9	71	206	36	110	0	97	243	104	168	9	168	449
Percent receiving FRS	86%	84%	56%	90%	85%	97%	94%	0%	100%	97%	90%	90%	56%	95%	91%
Type of FRS performed															
-- urinary only	67	55	9	55	186	31	94	0	78	203	98	149	9	133	389
-- urinary & RVF	0	1	0	4	5	1	2	0	2	5	1	3	0	6	10
-- RVF only	1	2	0	12	15	4	14	0	17	35	5	16	0	29	50
For 'Urinary only' or 'Urinary and RVF' repairs															
--first repair	47	29	5	43	124	26	86	0	54	166	73	115	5	97	290
---second repair	14	15	2	11	42	4	6	0	25	35	18	21	2	36	77
--->2	6	12	2	5	25	2	4	0	1	7	8	16	2	6	32
Percent women with first repair (urinary only)	70%	52%	56%	73%	65%	81%	90%	0%	68%	80%	74%	76%	56%	70%	73%
No. discharged after FRS (urinary only)	67	27	35	54	183	31	94	0	77	202	98	121	35	131	385
No. discharged after FRS (urinary & RVF)	0	0	1	4	5	1	2	0	2	5	1	2	1	6	10
No. discharged after FRS (RVF only)	1	2	0	12	15	4	14	0	17	35	5	16	0	29	50
Total no. discharged after FRS	68	29	36	70	203	36	110	0	96	242	104	139	36	166	445
No. not discharged after FRS	1	29	2	3	35	0	0	0	1	1	1	29	2	4	36
Outcome of FRS (urinary only & urinary/RVF)															
---No. with closed fistula who are dry	42	16	25	42	125	28	85	0	76	189	70	101	25	118	314
---No. with closed fistula & stress incontinence	11	9	6	1	27	4	11	0	2	17	15	20	6	3	44

Fistula Treatment Indicators	Kagando					Kitovu					Country Total				
	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total	Oct-Dec	Jan-Mar	Apr-June	July-Sep	FY Total
---No. whose fistula was not closed	14	2	5	15	36	0	0	0	1	1	14	2	5	16	37
Percent with closed fistula who are dry (urinary only & urinary/RVF)	63%	59%	69%	72%	66%	88%	89%	0%	96%	91%	71%	82%	69%	86%	79%
Outcome of FRS (RVF only)															
--closed and dry	1	2	0	12	15	4	14	0	17	35	5	16	0	29	50
---incontinent with water stool and /or flatus (gas)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-- incontinent with firm stool	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent with closed and dry fistula (RVF only)	100%	100%	0%	100%	100%	100%	100%	0%	100%	100%	100%	100%	0%	100%	100%
No. with complications after FRS	4	1	0	5	10	0	1	0	1	2	4	2	0	6	12
---Major surgical complications	2	1	0	0	3	0	0	0	0	0	2	1	0	0	3
---Anesthesia-related complication	2	0	0	5	7	0	0	0	0	0	2	0	0	5	7
---Post-operative complication related to perceived success of surgery	0	0	0	0	0	0	1	0	1	2	0	1	0	1	2
Percent with complications after FRS	6%	3%	0%	7%	5%	0%	1%	0%	1%	1%	4%	1%	0%	4%	3%

A total of 103 additional surgeries were performed in the first two quarters, the details of which are provided in table UGA2. The most common additional surgeries were examination under anesthesia, urethral lengthening and other operations for concomitant stress incontinence and ureteric reimplantation.

Table UGA 2. Number of Additional Surgeries for Fistula Patients, October 2009 – September 2010, Uganda

	Oct-Dec	Jan – March	Apr-Jun	Jul-Sept	FY Total
Type of Surgery by Site					
Kagando Hospital					
Examination under anesthesia	4	1	0	5	10
Colostomy and reversal colostomy	3	1	0	0	4
Ureteric reimplantation	3	3	1	2	9
Urethral lengthening and other operations for concomitant stress incontinence	0	1	0	2	3
3 rd /4 th degree perineal tear repairs	4	3	1	2	10
Removal of bladder stones or foreign bodies in viscera	0	1	0	1	2
Wound resuture	0	2	0	0	2
Other	0	3	0	4	7
Kitovu Hospital					
Examination under anesthesia	2	4	0	6	12
Colostomy and reversal colostomy	1	0	0	1	2
Ureteric reimplantation	3	3	0	6	12
Urethral lengthening and other operations for concomitant stress incontinence	4	5	0	14	23
3 rd /4 th degree perineal tear repairs	4	0	0	0	4
Vaginal Hysterectomy	0	1	0	0	1
Removal of bladder stones or foreign bodies in viscera	0	0	0	1	1
Other	0	0	0	1	1
Total	28	28	2	45	103

Training. A total of 310 individuals received training during FY 09/10. In total, nine surgeons received first or continuing training during FY 09/10. If these nine surgeons, six were from non-FC supported sites. In the first quarter, an AMREF surgeon conducted surgical training for five providers: one surgeon receiving first repair training, one for continuing surgical repair training, one anesthetist and two nurses. At Kitovu, six providers were trained: one surgeon in continuing repair, one anesthetist and four nurses. One experienced surgeon and one nurse attended training for fistula care on the *Africa Mercy* in October 2009. In the second quarter, trainings occurred during the scheduled training sessions in Kitovu and Kagando, with two surgeons receiving first repair training, three surgeons receiving continuing training (two of whom had also received continuing training in the first quarter) and twelve nurses and anesthetists participating in pre- and post-operative care.

Additional trainings were held on EmOC (including partograph use and immediate catheterization), family planning, fistula counseling and quality improvement approaches. A one-day training on data for decision making was implemented for fistula and maternity ward staff from Kagando and Kitovu. Additional information on all trainings supported this fiscal year, and the number of persons trained, are presented in table UGA3.



Right: Post fistula clients give their testimonies about obstetric fistula to participants of obstetric counseling training.

about fistula

Follow up in the third quarter for earlier EmOC training in Kasese indicated that partograph use was still not occurring consistently, and as a result mentoring and coaching at the sites has been initiated. During Kitovu's organized repair session in the fourth quarter, women arriving for repair participated in group and individual counseling sessions with nurses attending the concurrent obstetric fistula counseling training. This counseling was greatly appreciated by the clients.

Table UGA 3. Number of Persons Trained by Topic, October 2009 – September 2010, Uganda

Training Topic	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	FY Total
First surgical training in fistula repair	1	2	0	0	3
Continuing surgical training in fistula repair	3	3*	0	2	6*
Pre- and post-operative care for fistula repair	8	12	0	0	20
Quality Improvement	28	0	52	0	80
Facilitative Supervision	22	0	0	23	45
EmOC: Partograph and immediate catheterization	0	22	21	0	43
Family Planning Orientation	0	37	0	0	37
Family Planning	0	15	20	0	35
Data for Decision Making	0	0	20	0	20
Fistula Counseling	0	0	0	21	21
Total	62	91	113	46	310*

*Two of the continuing training surgeons in the second quarter also received training in the first quarter, so are only counted once in the total number of persons trained.

Quality Improvement. COPE and facilitative supervision activities were conducted at Kitovu, Kagando and Kasese during the fiscal year (see Table UGA3). In follow up visits, staff observed that many developed action plans were already being implemented. FC notes quality improvement advances at both Kitovu and Kagando, including: increased signage for patients in the local languages, institution of staff meetings on customer care, improvements on use of existing space and infrastructure, infection prevention measures and clearer articulation of staff roles and responsibilities.

In the second quarter, medical monitoring visits took place at Kitovu and Kagando. As part of the obstetric fistula counseling training, a lack of job aides was identified as a challenge. Therefore, service providers developed job aides for use in their practicum (at Kitovu's organized repair session) which were very helpful and well received by clients. FC intends to further develop these tools for broader use.

Community Outreach. Community outreach efforts were carried out in the fourth quarter, comprised of general outreach, education and recruitment efforts tied to the organized repair sessions at the sites, as well as outreach mailings to religious leaders and medical in-charges to provide them with information on fistula prevention and the availability of repair services. Table UGA4 provides information on the numbers of events and persons reached during the fiscal year.

Table UGA 4. Number of Community Outreach Events and Persons Reached, October 2009 – September 2010, Uganda

State	Oct-Dec		Jan-Mar		Apr-Jun		Jul-Sep		FY Total	
	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached	Events	Persons Reached
Community Awareness	0	0	0	0	0	0	47	6018	47	6018
Outreach mailing to religious leaders	0	0	0	0	0	0	1	60	1	60
Outreach mailing to medical in-charges	0	0	0	0	0	0	1	30	1	30
Total	0	0	0	0	0	0	49	6108	49	6108

Prevention. In the first quarter, materials were distributed to supported sites to promote family planning, antenatal and postnatal care. Plans to implement training in EmOC for service providers involving the districts surrounding Masaka started at the end of the second quarter with the involvement of the MOH. In addition, a Family Planning Stakeholder's Meeting was held in Kasese to inform district leaders in Kasese about family planning.

Family Planning. During the fiscal year, 4,209 people received family planning methods from Kagando Hospital. The most popular methods are injectables, male condoms, female condoms and oral pills. Kitovu Hospital only provides natural family planning methods. The nine prevention only sites have begun reporting on family planning provision. Information on family planning methods and counseling for all sites is presented in table UGA5. We have noted that

the number of clients counseled for FP is lower than the number of clients receiving FP. This is due to weaknesses in family planning data collection and will be addressed.

Other than Kagando Hospital and Bwera, none of the health centers in Kasese District (Karambi, Myambugando, Town Council HC III, or Rwesande) have received training in FP. Since FC began working with these five facilities, FC has been working with them to strengthen their procurement of FP commodities and FP data collection and has provided them with FP job aides. Unfortunately we have been unable to obtain FP data from Rwesande Health Centre. When visited in October, their FP Register was not available. We provided them with a new MOH approved FP Register and hope that this will facilitate the process of data collection going forward

Table UGA 5. Number of Clients by Method and Number counseled about FP, by Site. October 2009 – September 2010, Uganda

Fistula FP Methods	Bwera	Kagando	Kalungu	Karambi	Kitovu	Kiwangala	Kiyumba	Masaka RRH	Nyabugando	Rwesande	Town Council HC III	Country Total
Oral Pill	113	84	6	53	0	89	12	72	0	0	21	450
IUCD	0	0	0	0	0	0	0	2	0	0	0	2
Condom (male)	768	3	0	196	0	12	8	6	7	0	11	1011
Condom (female)	0	0	0	0	0	720	0	0	0	0	0	720
Injectable	1056	151	32	132	0	193	52	218	0	0	99	1933
Implant	10	0	0	0	0	4	0	41	0	0	0	55
Tubal Ligation	13	22	0	0	0	0	0	0	0	0	0	35
Vasectomy	0	3	0	0	0	0	0	0	0	0	0	3
Foaming Tablets	0	0	0	0	0	0	0	0	0	0	0	0
Total FP acceptors	1960	263	38	381	0	1018	72	339	7	0	131	4209
Total Number of clients counseled about FP methods	n/a	304	38	n/a	246	143	72	214	n/a	n/a	n/a	1017

Obstetrics. Of the 5,739 deliveries recorded at the two supported sites during the fiscal year, 36.6% were C-sections. Additional data on deliveries is provided below in Table UGA6.

**Table UGA 6. Obstetric Services, by site.
October 2009 – September 2010, Uganda.**

	Kagando	Kitovu	Total
Number of vaginal deliveries	2217	1421	3638
Number of C-sections	1238	863	2101
Total number of deliveries	3455	2284	5739
Percent deliveries by C-section	35.8%	37.8%	36.6%

Policy. The process of developing the National Fistula Strategy, with support from UNFPA, began this fiscal year. A situational assessment and a draft National Strategy were prepared. During the second quarter, Dr. Isaac Achwal, Senior Medical Associate for FC, served as a resource person for UNFPA’s writing of Uganda’s National Fistula Strategy.

Fistula Care continued to support the Fistula Technical Working Group (FTWG) meetings and supported Fistula Partnership Forum meetings. The Levels of Care Framework was well received by the FTWG and recommendations were made to adopt the framework for inclusion in the National Guidelines for Sexual and Reproductive Health as well as the National Fistula Strategy currently under development. Other policy related issues discussed by the working group included adoption of a list for essential drugs, equipment and consumables for fistula, a formal system of certification for surgeons and other service providers and standardization of partograph usage in Uganda.

FC has been working with UNFPA and USAID/Uganda on the inclusion of questions about fistula in Uganda’s upcoming DHS. Fistula Care participated in the National Safe Motherhood Day Celebrations that were held in Mayuge District in October 2009.

FC staff also participated in several national and international maternal health related activities, including the Maternal Health Task Force, Baby! International Film Festival, the Launch of the Campaign to Accelerate Reduction of Maternal Mortality in Uganda (CARMMU), meetings of the Maternal Health Task Force: Commodities Security, and the Women Deliver Conference in Washington DC. Two surgeons from supported sites and the FC/Ugandan senior medical associate attended the ISOFS conference in Nairobi in December 2009. FC Project participated in the International FP Conference in Kampala in November 2009, presenting on increasing access to FP for people living with HIV/AIDS.

FC has worked with the Ugandan Bureau of Statistics to ensure that more relevant questions on fistula will be included in the country’s next DHS to take place in 2011. FC has also worked with the USAID/Uganda GIS Specialist to initiate the process of mapping fistula services in Uganda.

Uganda photo credits: Edith Ronah Mukisa

V. Management

The Fistula Care Project was awarded on September 25, 2007, and this report marks the completion of the third year of project implementation. During the third year of the project, global and regional staff focused their efforts on continuing to strengthen our partnerships with country organizations and working toward increasing access to both treatment and prevention services.

Staffing. During this fiscal year we added one new global staff person (senior monitoring, evaluation and research associate) and began recruitment for an additional project assistant and replacement for one project assistant. Ms. Bethany Cole who had been providing part time support for the DR Congo program will join the FC team full time October 1, 2010.

The Global FC team includes the following:

- Isaac Achwal, Senior Medical Associate
- Karen Beattie , Project Director
- Beverly Ben Salem, Operations Manager
- Sarah Burgess, Project Assistant
- Bethany Cole, Senior Program Associate
- Julianne Deitch , Project Assistant
- Altiné Diop, Project Coordinator
- Renée Fiorentino, Senior M&E/Research Associate
- Jeanne Kabagema, Senior Medical Associate
- Evelyn Landry, Deputy Project Director
- Karen Levin, Program Associate for Monitoring and Evaluation
- Mieke McKay, Senior Program Associate
- Carrie Ngongo, Senior Program Associate
- Joseph Ruminjo, Clinical Director
- Dana Swanson, Project Assistant

The team also has received part-time support from the following EngenderHealth staff and consultants:

- Mark Barone and Vera Frajzyngier – Fistula research on Determinants of Outcomes of Fistula Surgery
- Macka Barry, financial support for Niger
- Ellen Brazier,- community engagement
- Levent Cagatay– training support
- Betty Farrell– support for prevention activities
- Gabrielle Hecker, MAP
- Sita Millimono, counseling training in Mali and Rwanda
- Maynard Yost – budget and financial management
- Steve Arrowsmith —fistula surgeon training, research design

Intern Dr. Josephine Muhairwe's assignment was extended from the previous FY in order to conduct the retrospective record review at Kitovu Hospital in Uganda in February 2010

Five Subawards Authorized During the Fiscal Year. During the past year a total of five new or replacement subawards were issued. Three of the awards are managed by the New York-based team (the two awards to Mercy Ships and the Gloag Foundation). The total amount of funding awarded was \$ 925,773.00; see Table 19. Cost extensions were provided to other sub recipients in Bangladesh, Ethiopia, Mali, Niger, Rwanda and Uganda.

Table 19. Sub-awards Issued, October 2009 thru September 2010

Institution	Country	Start Date	End Date	Subaward Number	Total obligated
Awards Made October to December 2009					
The Ad-Din Foundation	Bangladesh	November 1, 2009	December 31, 2010	BGD-071-02	64,990.00
Mercy Ships	Benin	October 1, 2009	December 31, 2009	FCA-100-02	\$55,433.00
No Awards Made January to March 2010					
Awards Made April to June 2010					
Mercy Ships	Togo	April 1, 2010	August 31, 2010	FCA-100-03	\$105,260.00
Gloag Foundation	Sierra Leone	July 1, 2010	June 30, 2011	FCA-500-01	\$550,178
Kanombe Hospital	Rwanda	May 1, 2010	April 30, 2011	FCA-401-01	\$149,912
No Awards Made July to September 2010					

International Technical Assistance Provided to 11 Countries. During the third year of the project, considerable effort was put into working with sites to increase capacity for training and planning for expansion and introduction of prevention activities. Global staff worked with all the country programs to support the development of strategies, workplans and the development and management of sub-awards. Fistula Care global staff, country staff, EngenderHealth staff, and consultants conducted a total of 43 in-country technical assistance visits to 11 countries during the October 2009 –September 2010 period. We utilized staff from the Guinea office to provide technical support to programs in Mali, Niger, and Rwanda. The focus of the technical assistance included (see Table 20):

- Organization, coordination, or co hosting of national meetings to formulate strategies for fistula prevention and treatment (DR Congo, Nigeria, Rwanda)
- Site Assessments (DR Congo, Ethiopia, Niger, Nigeria, Rwanda)
- Program support for clinical issues (training, medical sites visits), counseling, quality improvement, FP integration, community engagement, and MAP (DR Congo, Mali, Niger, Nigeria, Rwanda, Uganda)
- Program management support and coordination (Guinea, Ethiopia, Rwanda, Sierra Leone Uganda)
- Training for research teams for retrospective cesarean record review study (Bangladesh, Guinea, Mali, Uganda)
- Other data management activities (Ethiopia, Nigeria)

Table 20. International Technical Assistance, October 2009-September 2010

Country	Purpose	Who	When
Bangladesh	Train research teams for cesarean record review study	Evelyn Landry	March 2010
DR Congo	Meeting with USAID/DR Congo and Project AXxes and to participate in fistula country situation analysis and solution	Karen Beattie Isaac Achwal Bethany Cole	November 2009
DR Congo	Medical site visits	Isaac Achwal Jeanne Kabagema	March 2010
DR Congo	Co-hosted a meeting to bring together the network of fistula surgeons and other key stakeholders working in fistula programming in the DR Congo	Karen Beattie Isaac Achwal Bethany Cole Beverly Ben Salem	April 2010
DR Congo	Need Assessment Visit at Beni and Kindu in Eastern DR Congo	Isaac Achwal	July 2010
DR Congo	Need Assessment Visit at St Josph hospital and its other branches and at Mutombo hospital and outreach sites Eastern DR Congo	Isaac Achwal Beverly Ben Salem	August 2010
DR Congo	Need Assessment Visit at Kindu in Eastern DR Congo	Isaac Achwal	September 2010
DR Congo	Site assessments for program expansion	Isaac Achwal Beverly Bensalem	August 2010
Ethiopia	Workshop on data for decision making for Pre Repair Centers; program management updates	Karen Beattie Evelyn Landry	January 2010
Ethiopia	Site assessments for program expansion	Carrie Ngongo	March 2010
Guinea	Participate in the annual national fistula day and Review program activities in Kissidougou and Labé	Karen Beattie	May 2010
Guinea	Training research teams for cesarean record review study and development of Levels of Care evaluation plan	Renee Fiorentino	August 2010
Mali	Follow-up visit to assess counseling skills of fistula counseling trainees	Mieko McKay Levent Cagatay	March-April 2010
Mali	Medical monitoring visit	Mieko McKay Isaac Achwal	June-July 2010
Mali	Train research team for cesarean record review study	Mieko McKay	July 2010
Mali	Support preparation and facilitation of training in Medical Monitoring and Facilitative Supervision/data for Decision Making	Mieko McKay Sita Millimono	September – October 2010
Niger	Quality improvement for obstetric services at Dosso Regional Hospital	Carrie Ngongo Maj Britt Dohlie (C)	October 2009
Niger	Medical monitoring visits to Lamordé Hospital, Dosso Regional Hospital, and Maradi Regional Hospital; and assessment for expansion to Tahoua and Tera	Jeanne Kabagema	June 2010
Nigeria	Monitoring visit for the prospective determinants study	Mark Barone	October 2009
Nigeria	Orientation and training for community engagement and MAP	Ellen Brazier Gabrielle Hecker	November 2009
Nigeria	Document success stories and follow up about community engagement, family planning, and policy/advocacy activities and strategies	Carrie Ngongo Ana Langer Brenda Drake	December 2009
Nigeria	Training follow-up	Steve Arrowsmith (C)	January 2010
Nigeria	Site assessment for program expansion	Karen Beattie Joseph Ruminjo Veronica Frajzyngier	April 2010

Country	Purpose	Who	When
Rwanda	Development of a national strategy for fistula	Mieko McKay	October 2009
Rwanda	Office management	Beverly Ben Salem	October and December 2009
Rwanda	Planning for a training session Development of new subawards	Mieko McKay	January 2010
Rwanda	Site assessments for program expansion	Isaac Achwal Jeanne Kabagema	January 2010
Rwanda	Training on fistula repairs; pilot the FIGO training manual	Prof. Magueye Gueye (C)	January 2010
Rwanda	Preparation of workplan, subaward management, prepare upcoming repair workshop and fistula counseling workshop	Mieko McKay	May 2010
Rwanda	Fistula counseling workshop	Sita Millimono Levent Cagatay	May 2010
Rwanda	Rwanda office management	Beverly Ben Salem	May 2010
Rwanda	Training in Fistula Repair in Ruhengeri	Dr. Ambaye Wolde Michael Geda (C) and Dr. Weston Khisa (C)	May 2010
Rwanda	Rwanda office management	Beverly Ben Salem	August 2010
Rwanda	Training in Fistula Repair at CHUK	Dr. Ambaye Wolde and Michael Geda (c)	September – October 2010
Rwanda	Draft FY10 workplan and provide financial and subaward management support	Mieko McKay	September 2010
Sierra Leone	Receive orientation to the Aberdeen Women's Centers activities, operations, and procedures and provide an orientation about EngenderHealth's financial and programmatic reporting processes	Carrie Ngongo	September 2010
Uganda	Office and program support	Beverly Ben Salem	October 2009
Uganda	Orientation to new Senior Medical Associate and participate in Quality Improvement training	Mieko McKay	November 2009
Uganda	Office and program support	Beverly Ben Salem, Isaac Achwal, Mieko McKay	December 2009
Uganda	Introduce FP Integration with Fistula Care services at Kagando Hospital	Betty Farrell	January 2010
Uganda	Collect data for cesarean record reviews study	Josephine Muhairwe (C)	February 2010
Uganda	Follow up training with Dr. Frank Asimwe in Kagando Hospital	Steve Arrowsmith(C)	March 2010
Uganda	Facilitate training on management of labor in Masaka District	Jeanne Kabagema	March 2010
Uganda	Leadership for Quality FP/RH services Workshop	Isaac Achwal Jeanne Kabagema	April 2010

(C)consultant

Working with USAID/Washington. The Fistula Care holds regular face-to-face meetings or meetings via teleconference. We have consulted routinely on management, funding, program implementation, and research priorities. We met with USAID in February 2010 for an extended management review.

Leveraging Other Funds in Support of Fistula Care Services. EngenderHealth has been able to leverage funds from private donors in three countries to support selected services and activities for fistula : in Bangladesh private funds are used to cover patient transport cost, additional repairs in Niger and some community activities in Guinea.

Financial Management. We routinely submit monthly pipeline reports to USAID/W that describe the current state of 35 funds. The monthly monitoring enables us to determine which country programs or sub-awardees (n=14) are implementing activities on track, and which might need some additional support. The project has also established standardized budgeting procedures to assist in project management.

Workplans, PMP and Other Contractual Requirements. As required by the cooperative agreement, the project has prepared and submitted an annual workplan and has collaborated with USAID/W in the development of the PMP for the project. Comments have been received on the workplan submitted in September 2010 and we will be submitting a revised version by the end of the November 2010. The project submitted the third annual *Environmental Screening Report* in September 2010 to USAID. In accordance with the branding and marking plan, we have consulted with USAID/W in the development of logos, brochures and other project materials.

Challenges. Fistula surgery is complex and requires a high level of skill. Managing expectations of both Ministries of Health and USAID Missions on the speed with which capacity can be developed while quality is maintained is a constant challenge.

Another challenge has been managing operations and maintaining appropriate communications with USAID Missions from New York in countries where EngenderHealth has no office. These include the DR Congo, Rwanda, Niger, Sierra Leone, and Benin. In FY08/09, we established an office in Rwanda which eased the situation in that country. However, if additional funding is not forthcoming in FY10-11, it is likely we will need to begin to close down that office in June, 2011. Although the project is expanding the number of supported sites in the D.R. Congo in the coming year, we will not be opening an office in that country at this time in the project life cycle. We are discussing alternatives for managing in-country activities in both Kinshasa and in Eastern Congo. For Niger, the project has relied on EngenderHealth staff from Guinea to provide periodic backstopping to REF, as well as extensive programmatic support from New York. The subaward with The Gloag Foundation to support work in Sierra Leone has required some initial assistance from EngenderHealth in its day to day compliance with USAID rules and regulations.

The project has benefited throughout from significant funding from USAID, and as a consequence has a healthy pipeline. Part of the pipeline includes \$1.35 million which allocated for work on a randomized controlled trial. Those funds are now beginning to be spent down as we embark on the implementation of that research study. A budget was recently submitted to USAID on the full anticipated costs of the study, incorporating the involvement of WHO. We await USAID's comments on this budget and on the mechanism for supporting WHO's costs.

Annex I. USAID Fistula Care Sites and Partners

As of September 2010 – Fistula sites ever supported through EngenderHealth or USAID bilateral projects and planned expansion for FY 10/11 by Country

Country	Supported Sites	Type of Facility (NGO, FBO or public)	Current Repair sites ⁴⁶	Current Prevention only sites	In development ⁴⁷	No longer supported ⁴⁸
Bangladesh	Ad-Din Hospital, Dhaka	NGO	X			
	Kumudini Hospital	NGO	X			
	LAMB Hospital	FBO	X			
	Memorial Christian Hosp. ⁴⁹	FBO				X
	Ad-Din Hospital, Jessore	NGO	X			
Benin	Mercy Ships - Africa Mercy ⁵⁰	FBO				X
DR Congo	HEAL Africa Hospital. Goma	FBO	X			
	Panzi Hospital, Bukavu	FBO	X			
	Project AXxes (USAID Bilateral) ⁵¹	Public	X			
	Imagerie des Grands Lacs – Beni	FBO			X (T)	
	Maternite Sans Risque – Kindu	FBO			X (T)	
	St. Joseph's Hospital, Kinshasa	FBO			X (T)	
	DOCS, Goma	NGO			X (T)	
Biamba Marie Mutombo Hospital, Kinshasa	NGO			X (T)		
Ethiopia	Adet Health Center	Public		X		
	Arba Minch Hospital	FBO	X			
	Bahir Dar Fistula Center	FBO	X			
	Dangla Health Center	Public		X		
	Mekelle Fistula Center	FBO	X			

⁴⁶ Most repair sites include one or more fistula prevention interventions such as family planning information and/or services or provision of maternity services (e.g., monitoring of deliveries with the partograph, cesarean surgery). The exception is the *Africa Mercy*.

⁴⁷ (T): treatment for fistula repair; (P): prevention only

⁴⁸ USAID support for Mercy Ships ended in September 2010. We consider the country site no longer supported when the ship leaves the dock in a given country.

⁴⁹ The fistula surgeon from this faith-based hospital returned to the United States and they decided not to proceed with fistula services at this site.

⁵⁰ In partnership with Mercy Ships, their floating hospital moves between ports approximately once a year. Fistula services and training are provided while the ship is based in country. Other fistula services, supported by UNFPA, are available in Benin.

⁵¹ Project AXxes has used the services fistula surgeons to provide repairs on a periodic rotating basis at five sites (Lodja, Kaziba, Kole, Kabongo, and Kolwezi). Because no capacity exists at these sites for repair, we are counting the work of this project as one site. USAID funding for this project ended in September 2010. A new bilateral agreement was awarded; no information available at the time of this report as to whether the new project will support fistula repairs going forward.

Country	Supported Sites	Type of Facility (NGO, FBO or public)	Current Repair sites ⁴⁶	Current Prevention only sites	In development ⁴⁷	No longer supported ⁴⁸
	Woreta Health Center	Public		X		
	Yirga Alem Fistula Center	Public		X		
	Tefera Hailu Hospital, Sekota	Public			X (P)	
Ghana	Mercy Ships – Anastasis ⁵²	FBO				X
Guinea	Ignace Deen University Teaching Hospital ⁵³	Public	X			
	Jean Paul II Hospital, Conakry	Public	X			
	Kissidougou District Hospital	Public	X			
	Labé Regional Hospital	Public	X			
	Boké Regional Hospital	Public		X		
	Kindia Regional Hospital	Public		X		
	Nzerekore Regional Hospital	Public		X		
	Mamou Regional Hospital	Public		X		
	Faranah Regional Hospital	Public		X		
Liberia	Mercy Ships - Africa Mercy ⁵⁴	FBO				X
Mali ⁵⁵	Gao Regional Hospital	Public	X			
	Ansongo District Hospital	Public		X		
	Bourem District Hospital	Public		X		
	Ménaka District Hospital	Public		X		
	Gao District Hospital	Public		X		
Niger	Dosso Regional Hospital	Public	X			
	Lamordé Hospital (Niamey)	Public	X			
	Maradi Regional Hospital	Public	X			
	Issaka Gazoby Maternity Hospital (Niamey)	Public		X		
	Téra District Hospital	Public			X (P)	
	Tassigui Maternity Hospital ⁵⁶ (Tahoua)	Public	X			
Nigeria	Babbar Ruga Hospital (Katsina)	Public	X			
	South East Regional VVF Center (Ebonyi)	Public	X			
	Faridat Yakubu General Hospital (Zamfara)	Public	X			
	Kebbi Fistula Center (Kebbi)	Public	X			
	Laure Fistula Center at Murtala Mohammed	Public	X			

⁵² See previous note about partnership with Mercy Ships.

⁵³ In FY 10/11 Ignace Deen will no longer be supported to provide fistula repair services due to limited space. It will be supported for prevention activities. Trained surgeons from Ignace Deen will be used for surgical sessions at other sites in Guinea on a periodic basis.

⁵⁴ Services are now available in Liberia through the JFK Memorial Hospital supported by the Gloag Foundation.

⁵⁵ Fistula Care provides counseling training to fistula treatment sites in Bamako, Segou and Mopti to strengthen the quality of services.

⁵⁶ Fistula Care conducted a site assessment of this facility in July 2010 and recommended it be supported. Support for repairs began in the last quarter and will continue into next FY.

Country	Supported Sites	Type of Facility (NGO, FBO or public)	Current Repair sites ⁴⁶	Current Prevention only sites	In development ⁴⁷	No longer supported ⁴⁸
	Specialist Hospital (Kano)					
	Maryam Abacha Women's and Children's Hospital (Sokoto)	Public	X			
	Bayara Hospital (Bauchi)	Public			X (T)	
	Cross Rivers State				X (P)	
	TBD				X (T)	
	Owutuedda General Hospital (Ebonyi)	Public		X		
	Cottage Hospital, (Ebonyi)	Public		X		
	Ebonyi State University Teaching Hospital	Public		X		
	Ezangbo Maternity Hospital (Ebonyi)	Public		X		
	Mother and Child Care Initiative FP Clinic (Ebonyi)	Public		X		
	Mgbo Primary Health Center (Ebonyi)	Public		X		
	Comprehensive Health Center, Kumbotso (Kano)	Public		X		
	Takai Community/NYSC Health Center, Takai (Kano)	Public		X		
	Tarauni MCH Clinic (Kano)	Public		X		
	Unguku MCH Clinic (Kano)	Public		X		
	Muhammadu Abdullahi Wase Hospital (Kano)	Public		X		
	Jega General Hospital, (Kebbi)	Public		X		
	Kamba General Hospital (Kebbi)	Public		X		
	Maiyama General Hospital (Kebbi)	Public		X		
	Argungum General Hospital (Kebbi)	Public		X		
	Dakingari Primary Health Center (Kebbi)	Public		X		
	D/D General Hospital (Sokoto)	Public		X		
	Rabah General Hospital (Sokoto)	Public		X		
	Iss General Hospital (Sokoto)	Public		X		
	Jabo Primary Health Center (Sokoto)	Public		X		
	Bakura General Hospital (Zamfara)	Public		X		
	Bungudu General Hospital (Zamfara)	Public		X		
Rwanda	Central University Hospital, Kigali (CHUK)	Public	X			

Country	Supported Sites	Type of Facility (NGO, FBO or public)	Current Repair sites ⁴⁶	Current Prevention only sites	In development ⁴⁷	No longer supported ⁴⁸
	Kanombe Hospital	Public	X			
	Ruhengeri Hospital	Public	X			
	Kabgayi Hospital	FBO			X (P)	
	Gahini Hospital	FBO			X (P)	
	TBD				X (T)	
Sierra Leone	Aberdeen Women's Centre	NGO	X			
Togo	Africa Mercy	FBO	X			
Uganda	Kagando Mission Hospital	FBO	X			
	Kitovu Mission Hospital	FBO	X			
	TBD				X (T)	
	Kasese area City Council HC III.	Public		X		
	Bwera District Hospital (Kasee)	Public		X		
	Rwesande HCIV (Kasee)	Public		X		
	Karambi HC III (Kasee)	Public		X		
	Nyabugando HC III (Kasee)	Public		X		
	Masaka Regional Hospital	Public		X		
	Kiwangala HCIV (Masaka)	Public		X		
	Kalungu HC III (Masaka)	Public		X		
	Kiyumba HC IV(Masaka)	Public		X		
	Total		32	45	5 P 9T	5

Annex 2. Fistula Care Results by Indicator and Benchmarks

RESULT NAME: SO: To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in Sub-Saharan Africa & South Asia		
INDICATOR 1: # of sites supported by Fistula Care /USAID support		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	23 fistula repair only
2007/2008	37 total; 9 repair only; 16FP & Repair; 12 FP only	37 total; 10 repair only; 14 FP & Repair; 12 FP only; 1 unknown
2008/2009	68 Total Repair only: 12 Repair & FP: 3 Repair &OC: 2 Repair, OC, FP: 17 OC & FP: 13 FP only: 3 OC only: 18 Unknown: 1	45 Total Repair only: 7 Repair & FP: 2 Repair &OC: 2 Repair, OC, FP: 16 OC & FP: 5 FP only: 12 OC only: 0 Community outreach: 1
2009/2010	70 Total Repair only: 8 Repair & FP: 4 Repair &OC: 3 Repair, OC, FP: 17 OC & FP: 14 FP only: 16 OC only: 7 Community outreach: 1	77 Total Repair only: 8 Repair & FP: 2 Repair &OC: 2 Repair, OC, FP: 20 OC & FP: 18 FP only: 22 OC only: 4 Community outreach: 1
2010/2011	85 Total Repair only: 5 Repair & FP: 2 Repair &OC: 3 Repair, OC, FP: 20 OC & FP: 24 FP only: 22 OC only: 4	
<p>UNIT OF MEASURE: Number SOURCE: Project reports, annually INDICATOR DESCRIPTION: Fistula Care will support facilities for fistula repair and/or obstetric and family planning services disaggregated by type of site: a. Facilities providing fistula repair services: can include training, equipment, minor renovation or rehabilitation of facilities. Support to clients can include: transport costs to hospitals for surgery, temporary shelter, costs for repair, post-operative hospitalization costs, and client rehabilitation services during post-operative recovery, pre and post operative counseling. b. Sites providing obstetric services (OC) with <i>immediate interventions to help prevent fistula.</i> We will track three key immediate term interventions which will be a focus of strengthening at selected sites:</p>		

RESULT NAME: SO: To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in Sub-Saharan Africa & South Asia

INDICATOR 1: # of sites supported by Fistula Care /USAID support

- Correct use of the partograph to manage labors
- Availability of c section services
- Routine use of catheterization for women who had prolonged/obstructed labor.

c. Sites providing **Family Planning services** as a *medium term fistula prevention intervention*

Sites will be classified as a) Fistula Repair only; b) Fistula Repair & OC; c) Fistula Repair &FP; d)Fistula Repair, OC, & FP; e) OC only; f)FP only; g) OC & FP

FY 2006/2007 (baseline actual)

23 sites in 10 countries. All sites were classified as fistula repair only sites.

Countries (number sites) included: Bangladesh (3) DRC (2), Ethiopia (4) Guinea (2), Niger (4), Nigeria (5), Rwanda (2), Sierra Leone (1), Uganda (1). Mercy Ships provided support in Ghana.

FY 2007/2008 (actual):

	Repair only	Repair & FP	FP only	Unknown	Total
Bangladesh	0	3	0	0	3
DRC	2	0	0	0	2
Ethiopia*	2	0	3	1	6
Guinea	0	3	0	0	3
Liberia	1	0	0	0	1
Niger	3	0	1	0	4
Nigeria	2	3	8	0	13
Rwanda	0	2	0	0	2
Sierra Leone	0	1	0	0	1
Uganda	0	2	0	0	2
Total	10	14	12	1	37

- One site in Ethiopia, managed by AAFH provides community outreach with prevention messages. No information about other prevention activities.

FY 2008/2009 (actual):

	Repair only	Repair & FP	FP only	Unknown	Total
Bangladesh	0	3*	0	0	3*
Benin	1	0	0	0	1
DRC	0	2	0	0	2
Ethiopia*	2	0	3	1	6
Guinea	1	3	3	0	7
Liberia	0	0	0	0	0
Mali	0	1	0	0	1
Niger	0	3	1	0	4
Nigeria	3	3	10	0	16
Rwanda	0	2	0	0	2
Sierra Leone	0	1	0	0	1
Uganda	0	2	0	0	2
Total	7	20	17	1	45

*MCH for only the 1st quarter

FY 2009/2010 (actual):

	Repair only	Repair & FP	FP only	Total
Bangladesh	0	4	0	4
Benin	1	0	0	1
DRC	0	3	0	3

RESULT NAME: SO: To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in Sub-Saharan Africa & South Asia

INDICATOR 1: # of sites supported by Fistula Care /USAID support

Ethiopia*	3	0	4	7
Guinea	0	4	5	9
Liberia	0	0	0	0
Mali	0	1	4	5
Niger	2	2	1	5
Nigeria	2	4	22	28
Rwanda	0	3	0	3
Sierra Leone	0	1	0	1
Togo	1	0	0	1
Uganda	0	2	9	11
Total	8	24	45	77

RESULT NAME: SO To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in sub-Saharan Africa & south Asia

INDICATOR 2: # of women receiving fistula repair surgery

YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	3,437
2007/2008	3,882	4,107
2008/2009	5,076	4,183
2009/2010	4,245	4,972
2010/2011	4,500	

UNIT OF MEASURE: Number

SOURCE: Project reports, quarterly

INDICATOR DESCRIPTION: # women undergoing fistula repair surgery at supported sites This includes all types of fistula repairs: urinary and RVF together, and RVF alone. Each time a woman has surgery it will be counted, therefore the number of women getting fistula repair surgery = number of surgeries. It is unlikely that any woman would get more than one repair surgery during a reporting period

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	Total to date
Bangladesh	119	122	131	143			515
Benin	NS	NS	110	21			131
DRC	586	695^^	924^^	986^^			3,191
Ethiopia^	479	596	463	587			2,116
Ghana	42	NS	NS	NS			42
Guinea	292	229	316	392			1,229
Liberia	NS	59	NS	NS			59
Mali	NS	NS	46	40			86
Niger*	27	213	158	220			618

RESULT NAME: SO To establish and/or strengthen fistula prevention, repair & reintegration programs in at least 12 institutions in sub-Saharan Africa & south Asia

INDICATOR 2: # of women receiving fistula repair surgery

Rwanda	147	83	167	259			656
Sierra Leone**	272	363	253	166			1,054
Togo	NS	NS	NS	97			97
Uganda***	401	310	268	449			1,428
Total	3,437	4,107	4,183	4,972			16,699

NS=No USAID support.

^Data for Ethiopia sites in FY 06/07 & FY 07/08 are corrected.

^^Data for DRC in 07/08, 08/09 and 09/10 include Project AXxes data

*in FY 07/08, Niger: 63 repairs not supported w/USAID funds

** in FY 07/08, Sierra Leone: 85 repairs not supported w/USAID funds

*** in FY 07/08, Uganda: 101 repairs not supported w/USAID funds

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

INDICATOR 3: % of women who received fistula surgery who have a closed fistula and are dry upon discharge

YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	87%
2007/2008	75%	79%
2008/2009	75%	75%
2009/2010	75%	73%
2010/2011	75%	

UNIT OF MEASURE: Number

SOURCE: Project reports, quarterly

INDICATOR DESCRIPTION: # of women who received any type of fistula repair surgery (urinary only, Urinary and RVF) who when discharged, had a closed fistula and were dry at time of discharge.
women who fistula repair surgery (urinary, urinary/RVF) with a closed fistula and dry at time of discharge / # women who had fistula repair surgery (urinary, fistula and/or urinary/RVF) and were discharged X 100

2006/2007: Does not include Niger (missing). Ranges were from 55% (Ghana) to 99% (Nigeria).

2007/2008: Ranges were from 67% (Ethiopia) to 93% (Nigeria). See individual country reports.

2008/2009: Ranges were from 64% (Niger) to 80% or higher (Ethiopia, Guinea, Uganda, Mali and Rwanda). See individual country reports.

2009/2010: Ranges were from 55% (Niger) to 80% or higher (Guinea, Rwanda and Sierra Leone)

RESULT NAME: IR 1: Strengthen the capacity of centers to provide quality services to repair and care for women with obstetric and traumatic gynecologic fistula		
INDICATOR 4: % of women who had fistula surgery who experienced a reportable complication⁵⁷		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	9%
2007/2008	20% or less	5%
2008/2009	20% or less	3%
2009/2010	20% or less	3%
2010/2011	20% or less	
<p>UNIT OF MEASURE: Number SOURCE: Project reports INDICATOR DESCRIPTION: Reportable Complications can either be major or minor related to the fistula surgery or to anesthesia. Deaths will be reported under complications. #women who had any type of fistula repair surgery who experienced a reportable complication / total # women discharged after any type of fistula repair surgery X 100 <u>2006/2007 (Baseline):</u> Does not include data for Ethiopia and Niger (missing). Ranges from 1% (Nigeria) to 50% (Sierra Leone) <u>2007/2008:</u> Ranges were from 0% (Niger) to 15% (Bangladesh). Data not reported from Ethiopia. See individual country reports. <u>2008/2009:</u> Ranges were from 0% (Mali) to more than 20% (Bangladesh and Benin). See individual country reports. <u>2009/2010:</u> Ranges were from 0% (Mali, Niger) to 11% (Bangladesh)</p>		

RESULT NAME: IR 1: Strengthen the capacity of centers to provide quality services to repair and care for women with obstetric and traumatic gynecologic fistula		
INDICATOR 5: # of people trained, by type of training		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	603
2007/2008	1,800	4,858
2008/2009	5,000	5,531
2009/2010	3,034	6,922
2010/2011	7,545	
<p>UNIT OF MEASURE: Number SOURCE: Project reports INDICATOR DESCRIPTION: # of persons attending training in support of fistula care. Type of training reported will be for the primary training category. Training in surgical repair will be reported separately. Training will be reported for specific topics such as counseling, use of the partograph, QI, etc. Details by country are summarized in annual reports (total at bottom may not equal sum because some surgeons receive more than one training in a fiscal year, but are only counted once in the total).</p>		

⁵⁷ During the April 2008 meeting in Accra we discussed complications reporting during small group discussion. Based on these discussions we have developed guidelines for reporting complications.

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

INDICATOR 5: # of people trained, by type of training

Topic	06/07 Total trained	07/08 Total trained	08/09 Total trained	09/10 Total Trained
Surgeons for 1 st fistula repair training:	58	52	12	16
Continuing training in Fistula repair	8	29	29	47
Pre /Post operative care for fistula	116	99	161	64
Obstetric Care	32	0	147	525
Infection Prevention	n/a	135	128	137
Quality assurance	n/a	60	64	183
Fistula Counseling	n/a	76	156	177
FP Counseling	n/a	42	29	50
FP methods, including Contraceptive Technology Updates	n/a	40	16	236
Men as Partners	n/a	134	0	0
Community Outreach and Advocacy	n/a	4,105	2,586	2157
Fistula Screening and Prevention for health workers	n/a	n/a	1,933	3210
Quality improvement (COPE, IP, counseling)	101	n/a	n/a	n/a
Prevention/referral/advocacy:	112	n/a	n/a	n/a
Data management:	87	9	145	91
Other:	89	77	125	36
Total	603	4,858	5,531	6,922

RESULT NAME: 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

INDICATOR 6: # of community outreach events for fistula prevention

YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	513
2007/2008	625	1,323
2008/2009	1,500	4,113
2009/2010	4,670	5,728
2010/2011	3,500	

UNIT OF MEASURE: Number

SOURCE: Project reports

INDICATOR DESCRIPTION: # events carried out by program partners to provide information about fistula prevention and other safe mother hood issues.

	# of Events		
	FY 07-08	FY 08-09	FY 09-10
Bangladesh	232	29	140
DRC	206	0	0
Ethiopia	591**	3,659	3,894
Guinea	37	13	100

RESULT NAME: 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

INDICATOR 6: # of community outreach events for fistula prevention

Liberia	0	0	0
Mali	0	0	481
Niger	136	65	25
Nigeria	121	307	1040
Rwanda	0	0	0
Sierra Leone	0	0	0
Uganda	0	0	48
Total	1,323	4,113	5,728

**data from Ethiopia is underestimated. Data was not provided for each quarter on the number of events carried out by community volunteers. These data represent activities in July-September 2008

RESULT NAME: 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

INDICATOR 7: # persons reached about fistula prevention at outreach events

YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	239,675
2007/2008	350,000	442,534
2008/2009	500,000	720,058
2009/2010	710,500	1,026,674
2010/2011	558,000	

UNIT OF MEASURE: Number

SOURCE: Project reports

INDICATOR DESCRIPTION: Number of persons attending fistula prevention outreach events. Numbers of persons reached will be estimates.

	# Persons Reached		
	FY 07/08 (baseline)*	FY 08/09	FY 09/10
Bangladesh	15,138	2,521	6,697
DRC	17,224	0	0
Ethiopia	297,292	531,724	535,982
Guinea	2,230	3,633	55,036
Liberia	0	2,593	0
Mali	0	0	5,394
Niger	5,982	2,110	1,965
Nigeria	104,668	177,477	415,582
Rwanda	0	0	0
Sierra Leone	0	0	0
Uganda	0	0	6,018
Total	442,534	720,058	1,026,674

* Includes community outreach in Bangladesh & Ethiopia, advocacy in Bangladesh and village safe motherhood committees in Guinea. Persons reached include community members, NGOs and community health workers.

RESULT NAME: 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		
INDICATOR 7 : # persons reached about fistula prevention at outreach events		
RESULT NAME: 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		
INDICATOR 8: % of all labors at fistula supported sites, for which partographs are correctly completed and managed according to protocol		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	N/A	N/A
2008/2009	80%	N/A
2009/2010	80%	37%
2010/2011	80%	
<p>UNIT OF MEASURE: percentage of labors monitored (in sub sample) SOURCE: Project reports INDICATOR DESCRIPTION: # of all partographs in a given facility in a reference period that are correctly completed and show adherence or a justified deviation from management protocol/ # all labors in a given facility in a reference period X 100</p> <p>This information will be collected during the medical monitoring supervision visits using the FC medical monitoring tool. A sample of delivery records for the reference period will be reviewed (10% random sample of all records for all the months preceding the supervision visit. Instructions for drawing a sample are included in the monitoring tool.) Data will <u>only</u> be collected from sites where FC is working to strengthen the correct use of the partograph.</p>		

RESULT NAME: 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		
INDICATOR 9: # of births at FC supported sites		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	N/A	N/A
2008/2009	N/A	30,002
2009/2010	N/A	58,930
2010/2011	N/A	
<p>UNIT OF MEASURE: Number SOURCE: Project reports INDICATOR DESCRIPTION: Number of births at FC supported sites that provide delivery service. This is a new indicator and we have no baseline information about services in the past. We will collect this information in the first quarter.</p>		

RESULT NAME: 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		
INDICATOR 10: Number/Percent of births that were by c section		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	N/A	N/A
2008/2009	N/A	34%
2009/2010	N/A	40%
2010/2011	N/A	
<p>UNIT OF MEASURE: Number SOURCE: Project reports INDICATOR DESCRIPTION: Number of total births for the reporting period that were by c section. # of c-section births/total number of births (indicator 9) X 100 This is a proposed new indicator as of September 2008. We do not have data on past performance and unable to develop benchmarks at this time. will asses the feasibility of collecting and reporting on this indicator by conducting a small qualitative study in selected countries.</p>		

RESULT NAME: 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		
INDICATOR 11: Number/Percent of c-sections that that were a result of obstructed labor		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	N/A	N/A
2008/2009	N/A	N/A
2009/2010	N/A	N/A
2010/2011	N/A	
<p>UNIT OF MEASURE: number/percent SOURCE: Project reports INDICATOR DESCRIPTION: % of all CS, at fistula supported sites that provide c section services, for reasons of prolonged/obstructed labor Number of c sections for reasons of prolonged/ obstructed labor/# c sections (indicator 10) X100 This is a proposed new indicator. We will asses the feasibility of collecting and reporting on this indicator by conducting a small qualitative study in selected countries.</p>		

RESULT NAME: IR 3: Gather, analyze and report data to improve the quality and performance of fistula services		
INDICATOR 12: % of supported sites reporting and reviewing quarterly fistula monitoring data for improving fistula services		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	45%	48%
2008/2009	80%	20% of sites met 4 times; 83%

RESULT NAME: IR 3: Gather, analyze and report data to improve the quality and performance of fistula services		
INDICATOR 12: % of supported sites reporting and reviewing quarterly fistula monitoring data for improving fistula services		
		met at least 1 x
2009/2010	80%	14% met once per quarter; 97% met at least 1 x
2010/2011	80%	
<p>UNIT OF MEASURE: Number/percent SOURCE: Project reports INDICATOR DESCRIPTION: Proportion of supported sites with a functioning process for reporting <u>AND</u> reviewing quarterly fistula monitoring data in order to improve services. Functioning review process is defined as a team of staff from the site who meet once a quarter, with or without outside assistance (e.g., supervisory teams, FC program staff) to review and discuss the data and make program decisions to improve fistula services based on these data. # sites in which quarterly data is reported and reviewed at the facility to assess program progress / # of supported sites X 100</p>		

RESULT NAME: IR 3. Gather, analyze and report data to improve the quality and performance of fistula services		
INDICATOR 13: # of evaluation and research studies completed		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	1	0
2008/2009	3	1
2009/2010	2	3
2010/2011	13	
<p>UNIT OF MEASURE: Cumulative SOURCE: Project reports INDICATOR DESCRIPTION: # of evaluation research studies completed that address fistula care service delivery. This includes evaluation of models of service delivery for fistula. Annual report will list studies by study name, location, ongoing/complete 2007/2008: Ongoing: Global Study: Determinants of post-operative outcomes in fistula repair surgery- A prospective study. This study is being implemented in 6 countries—Bangladesh, Guinea, Niger, Nigeria, Rwanda and Uganda. Data collection began in all countries during the year. The last country-Niger—will begin activities in the first quarter of 2008/2009. As of September 2008, 372 women have been recruited into the study. Planned Studies: Planning for two studies began in the last month of the fiscal year—a study to review current practices of fistula surgeons in the care and treatment of women with fistula focused on three topics: use of prophylactic antibiotics, management of stress in continence and role of catheterization. This study will help in the process of developing one more clinical trail studies in 2008/2009. Data collection will begin in January 2009. The second study we began planning is to review the quality of data on indications/reasons for c sections in FC supported facilities. Data collection for this study will begin in January 2009. 2008/2009: Completed Study: <i>Qualitative Study of Current Practices in Fistula Treatment</i> Ongoing: 1) <i>A Multi-Centre Retrospective Review of Data Collection Procedures and Data Quality of Indications for</i></p>		

RESULT NAME: IR 3. Gather, analyze and report data to improve the quality and performance of fistula services
INDICATOR 13: # of evaluation and research studies completed
<p><i>Cesarean Deliveries.</i></p> <p>2) <i>Determinants of Post-Operative Outcomes in Fistula Repair Surgery</i></p> <p>Planned Studies:</p> <p><i>Cost Study</i></p> <p>2009/2010:</p> <p>Completed Study:</p> <p>1) <i>Retrospective Record Review Study of Indications for Cesarean Delivery at Kagando Hospital, Uganda,</i></p> <p>2) <i>Retrospective Record Review Study of Indications for Cesarean Delivery at Kitoru Hospital, Uganda,</i></p> <p>3) <i>Use Of The Partograph: Effectiveness, Training, Modifications And Barriers:A Literature Review</i></p> <p>Ongoing:</p> <p>1) <i>A Multi-Centre Retrospective Review of Data Collection Procedures and Data Quality of Indications for Cesarean Deliveries.</i></p> <p>2) <i>Determinants of Post-Operative Outcomes in Fistula Repair Surgery</i></p> <p>3) <i>Literature review of uterine prolapse</i></p> <p>Planned:</p> <p><i>Randomized Clinical Trial for Short Term Catheterization</i></p> <p><i>Cost Study</i></p>

RESULT NAME: IR 4: Strengthen a supportive environment to institutionalize fistula prevention, repair and reintegration programs		
INDICATOR 14: Number of countries receiving support from Fistula Care where governments or supported facilities have revised/adopted/initiated policies for fistula prevention or treatment		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	TBD	4
2008/2009	5	6
2009/2010	7	7
2010/2011	8	
<p>UNIT OF MEASURE: Cumulative</p> <p>SOURCE: Project reports</p> <p>INDICATOR DESCRIPTION: # of countries or facilities (some private sites may develop their own policies) that have revised/adopted or initiated policies in support of fistula prevention and treatment services. Policies can be part of reproductive and/or maternal health policies. Ideally countries should also include the necessary budgetary and policy frameworks to execute these policies</p> <p>Annual report will include the name of policy, location, status (under development/approved/implemented)</p> <p>2007/2008</p> <p>Bangladesh, Guinea, Nigeria, Uganda</p> <p>2008/2009</p> <p>Bangladesh, Guinea, Mali, Nigeria, Rwanda</p> <p>2009/2010</p> <p>Bangladesh, DRC, Guinea, Nigeria, Rwanda, Sierra Leone, Uganda</p>		

RESULT NAME: IR 4: Strengthen a supportive environment to institutionalize fistula prevention, repair and reintegration programs		
INDICATOR 15: .Number of facilities using Fistula Care technical products, by product, for improving fistula treatment and prevention services.		
YEAR	PLANNED	ACTUAL
2006/2007 (Baseline)	N/A	N/A
2007/2008	TBD	25
2008/2009	68 sites	36 sites using 9 tools
2009/2010	70 sites	64 sites using 9 tools
2010/2011	85	
<p>UNIT OF MEASURE: Number SOURCE: Project reports INDICATOR DESCRIPTION: Technical products include quality improvement tools, training curricula, supervision tools, program strategies, lessons learned reports, a searchable web site, etc.</p> <p>Quarterly Reporting Tools: 2007/2008: 25 sites; 2008/2009: 36 sites; 2009/2010: 60 sites Monitoring for Service Delivery Checklist: 2007/2008: 8 sites; 2008/2009: 12 sites; 2009/2010: 39 sites Medical Waste Management: 2007/2008: 0 sites; 2008/2009: 11 sites; 2009/2010: 27 sites Training Strategy: 2007/2008: 0 sites; 2008/2009: 6 sites; 2009/2010: 6 sites Training Knowledge Assessment Tool 2007/2008: 0 sites; 2008/2009: 4 sites; 2009/2010: 10 sites Monitoring and Supervision for Training Sites 2007/2008: 0 sites; 2008/2009: 3 sites; 2009/2010: 2 sites Fistula Site Assessment Tool 2007/2008: 1 site; 2008/2009: 7 sites; 2009/2010: 3 sites Fistula Standard Equipment List: 2007/2008: 0 sites; 2008/2009: 5 sites; 2009/2010: 3 sites Fistula Counseling Curriculum: 2007/2008: 8 sites; 2008/2009: 2 sites; 2009/2010: 5 sites</p>		

Annex 3. Other Surgeries by Country and FY

Type of Surgery	Bangladesh				DR Congo				Ethiopia				Guinea			
	FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Examination under anesthesia (as a separate, discrete procedure)	0	0	6	18.8	11	16.4	71	47.7	NA	NA	52	14.6	16	53.3	0	0.0
Removal of bladder stones or foreign bodies in viscera	0	0	2	6.3	4	6.0	9	6.0	NA	NA	14	3.9	3	10.0	3	17.6
Colostomy and reversal colostomy	0	0	1	3.1	0	0.0	4	2.7	NA	NA	0	0.0	5	16.7	1	5.9
Ureteric reimplantation, Ureteroneocystostomy, and related surgery	5	10.6	7	21.9	1	1.5	15	10.1	NA	NA	0	0.0	1	3.3	0	0.0
Urethral lengthening and other operations for concomitant stress incontinence	1	2.1	1	3.1	9	13.4	29	19.5	NA	NA	185	52.1	4	13.3	6	35.3
Wound resuture	0	0.0	0	0.0	2	3.0	1	0.7	NA	NA	0	0.0	0	0.0	4	23.5
Prolapse IF associated with fistula	0	0.0	0	0.0	31	46.3	3	2.0	NA	NA	3	0.8	0	0.0	1	5.9
3rd/4th degree perineal tear repairs	41	87.2	11	34.4	7	10.4	10	6.7	NA	NA	55	15.5	1	3.3	0	0.0
Sling Procedures	0	0	0	0	0	0.0	0	0.0	NA	NA	0	0.0	0	0.0	0	0.0
Abdominal exploration	0	0	0	0	0	0.0	0	0.0	NA	NA	0	0.0	0	0.0	0	0.0
Other (urethral reconstruction, repair of cystocele, perineorrhaphy, vaginoplasty)	0	0	0	0	0	0.0	0	0.0	NA	NA	0	0.0	0	0.0	0	0.0
Other	0	0	4	12.5	2	3.0	7	4.7	NA	NA	46	13.0	0	0.0	2	11.8
Total	47	100.0	32	100.0	67	100.0	149	100.0	NA	NA	355	100.0	30	100.0	17	100.0

NA-not available

Type of Surgery	Mercy Ships				Mali				Niger ^{58*}				Nigeria			
	FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Examination under anesthesia (as a separate, discrete procedure)	7	28.0	4	14.8	0	0.0	0	0.0	16	59.3	46	66.7	0	0.0	0	0.0
Removal of bladder stones or foreign bodies in viscera	2	8.0	2	7.4	1	7.7	0	0.0	0	0.0	0	0.0	30	62.5	2	9.5
Colostomy and reversal colostomy	0	0.0		0.0	0	0.0	0	0.0	0	0.0	5	7.2		0.0		0.0
Ureteric reimplantation, Ureteroneocystostomy, and related surgery	6	24.0	7	25.9	2	15.4	3	42.9	0	0.0	3	4.3	5	10.4	1	4.8
Urethral lengthening and other operations for concomitant stress incontinence	4	16.0	13	48.1	6	46.2	3	42.9	11	40.7	3	4.3	5	10.4	4	19.0
Wound resuture	1	4.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	5	10.4	0	0.0
Prolapse IF associated with fistula	0	0.0	0	0.0	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0	2	9.5
3rd/4th degree perineal tear repairs	1	4.0	0	0.0	3	23.1	0	0.0	0	0.0	0	0.0	3	6.3	1	4.8
Sling Procedures	2	8.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Abdominal exploration	2	8.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Other (urethral reconstruction, repair of cystocele, perineorrhaphy, vaginoplasty)	0	0.0	0	0.0	0	0.0	0	0.0		0.0	0	0.0	0	0.0	10	47.6
Other		0.0	1	3.7	0	0.0	1	14.3	0	0.0	12	17.4	0	0.0	1	4.8
Total	25	100.0	27	100.0	13	100.0	7	100.0	27	100.0	69	100.0	48	100.0	21	100.0

⁵⁸ Other includes Beance uretral; and in Niger data prior to Dec 2009 were provided using incorrect data definitions. All wound resutures and use of anesthesia were reported (including those part of routine fistula repair), instead of solely as separate procedures

	Rwanda				Sierra Leone				Uganda				Total			
	FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10		FY 08-09		FY 09/10	
Type of Surgery	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Examination under anesthesia (as a separate, discrete procedure)	6	25.0	12	38.7	64	46.7	52	40.6	12	11.0	22	21.4	132	25.0	265	28.2
Removal of bladder stones or foreign bodies in viscera	2	8.3	4	12.9	7	5.1	10	7.8	3	2.8	3	2.9	52	9.9	49	5.2
Colostomy and reversal colostomy	5	20.8	2	6.5	6	4.4	0	0.0	6	5.5	6	5.8	22	4.2%	19	2.0%
Ureteric reimplantation, Ureteroneocystostomy, and related surgery	4	16.7	3	9.7	8	5.8	6	4.7	27	24.8	21	20.4	59	11.2%	68	7.2%
Urethral lengthening and other operations for concomitant stress incontinence	0	0.0	0	0.0	11	8.0	35	27.3	32	29.4	26	25.2	83	15.7%	303	32.3%
Wound resuture	0	0.0	0	0.0	8	5.8	0	0.0	1	0.9	2	1.9	17	3.2%	7	0.7%
Prolapse IF associated with fistula	0	0.0	0	0.0	0	0.0	1	0.8	2	1.8	0	0.0	34	6.5%	10	1.1%
3rd/4th degree perineal tear repairs	7	29.2	9	29.0	12	8.8	9	7.0	14	12.8	14	13.6	89	16.9%	109	11.6%
Sling Procedures	0	0.0	0	0.0	0	0.0	0	0.0	10	9.2	0	0.0	12	2.3%	0	0.0%
Abdominal exploration	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.4%	0	0.0%
Other (urethral reconstruction, repair of cystocele, perineorhaphy, vaginoplasty)	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0%	10	1.1%
Other	0	0.0	1	3.2	21	15.3	15	11.7	2	1.8	9	8.7	25	4.7%	99	10.5%
Total	24	100.0	31	100.0	137	100.0	128	100.0	109	100.0	103	100.0	527	100.0	939	100.0%

Annex 4. Presentations: October 2007 thru September 2010

October 2009-September 2010		
Title of Presentation	Presenter(s)	Format
FIGO World Congress of Gynecology and Obstetrics, Cape Town October 4th-October 9th, 2009		
Determinants of Postoperative Outcomes in Fistula Repair Surgery - Preliminary Results	Joseph Ruminjo, Mark Barone, Veronica Frajzyngier	Oral
Social Immersion Strategy for Reintegration and Empowerment of Obstetric Fistula Survivors	Moustapha Diallo, Yaya Kassé	Oral
Network of Clinical Providers Improves Management of Obstetric Fistula Treatment Programs	Adamu Isah	Poster
Prevention and Treatment of Obstetric Fistula: Community Work Makes a Difference	Dr. S. M. Shahidullah, Dr. Abu Jamil Faisel	Poster
Ninth Annual Global Health Mini University, Washington D.C. October 9th, 2009		
Networking to Improve Fistula Treatment in Nigeria	Evelyn Landry and Erin Mielke	Oral
APHA 137th Annual Meeting, Philadelphia November 7th-11th, 2009		
Identification of Current Practices in Fistula Treatment: A Qualitative Review	Joseph Ruminjo, Steven Arrowsmith, Evelyn Landry	Poster
Pre Repair Centers for Fistula Care in Ethiopia	Evelyn Landry, Marsha Hamilton	Oral
ISOFS Third Annual Meeting, Nairobi November 25th-November 27th, 2009		
Identification of Current Practices in Fistula Treatment: A Qualitative Review	Joseph Ruminjo	Oral presentation
Unite for Sight 7th Annual Global Health & Innovation Conference, Yale University April 17th-April 18th, 2010		
Holistic Prevention, Treatment, Reintegration, and Governance Program for Fistula Survivors in Kissidougou, Guinea	Mieko McKay	Poster
Women Deliver Conference, Washington D.C. June 7th-June 9th, 2010		
Innovations in Fistula Prevention, Treatment, and Reintegration	Karen Beattie (moderator), Josephine Elechi, Mariama Moussa, Suzy Elneil, Cindy Berg	Panel
37th Annual International Conference on Global Health, Washington, D.C. June 15th, 2010		

October 2009-September 2010		
Title of Presentation	Presenter(s)	Format
Integrating Family Planning into Fistula Repair Services in Nigeria	Betty Farrell	Poster
Maternal Health Taskforce Global Maternal Health Conference, New Delhi, India August 30th-September 1st, 2010		
Use of the partograph: what do we know and what do we need to find out	Jeanne Kabagema	Oral presentation
The necessity of waiting houses for pregnant women in the DR Congo	Ahuka Longombe	Oral presentation
Ruptured Uterus in Western Uganda, a 2 year retrospective review ⁵⁹	Peter Mukasa	Oral presentation
Identifying research needs and priorities for obstetric and gynecologic fistula	Joseph Ruminjo	Oral presentation/panel
Improving the use of the partograph – a case study from a rural integrated health and development project	Kris Prenger	Oral presentation/panel
Strengthening cesarean section services: a case from a rural integrated health and development project in Bangladesh	Kris Prenger	Oral presentation/panel
Retrospective record review of cesarean deliveries at two hospitals in Uganda	Evelyn Landry	Oral presentation/panel
Engagement of clerics improves fistula prevention and reintegration efforts in northern Nigeria	Adamu Isah	Poster
Evolution of maternal mortality in a conflict area	Manga Pascal	Poster

October 2008-September 2009		
Title of Presentation	Presenter(s)	Format
American Public Health Association Meeting, November 2008.		
Digital Stories for Public Health.: an emerging strategy for participatory media-making”. The Fistula Care-produced digital stories DVD “Learning from My Story: Women Confront Fistula in Rural Uganda”	Joseph Ruminjo, co facilitator of discussion panel	Panel
Global Health Conference Washington, D.C. June 2009		
For the Common Good: Good Governance and Democracy Improve Maternal Health Systems	Moustapha Diallo	round table discussion
Counseling of Women With Traumatic Genital Fistula From Sexual Violence; Development of an Evidence-Based Counseling Module.	Joseph Ruminjo, Elizabeth Rowley, Mieke McKay	Panel

⁵⁹ Paper presented by Fistula Care Uganda Medical Associate; research was conducted prior to Dr. Mukasa joining Fistula Care.

October 2008-September 2009		
Title of Presentation	Presenter(s)	Format

October 2007-September 2008		
Title of Presentation	Presenter(s)	Format
Mini University, Washington, D.C. October 2007		
Addressing Fistula through the use of digital stories.	Katie Tell	Presntation/Discussion
Women Delivery Conference, London, England October 2007.		
Community, NGO and Government collaboration on Fistula: The Zamfara experience”	Dr. Sa’ad and Dr. Adamu Isah	Paper
“Digital stories: the Uganda experience” presented	Dr. Henry Kakande	Paper
French College of Ob/Gyns Annual Meeting, Paris, France, December 2007.		
“Fistula care: The Guinea experience”.	Professor Namory Keita	Paper
Reproductive Health in Emergencies Conference, Kampala, Uganda June 2008		
Traumatic Gynecologic Fistula in Reproductive Health Emergencies	by I. Achwal, J. Ruminjo, C. Ngongo	Paper
Voices from the field: Community research on the experiences of survivors and perpetrators of sexual violence	H. Akullu [Uganda]	Paper
La prise en charge des fistules génitales de la femme en RDC: Contexte, ampleur et perspectives	M.A. Kalume, L. Ahuka [DR Congo]	Paper
Psychosocial effects of sexual violence in conflict situations	M. Mungherera [Uganda]	Paper

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).

Annex 5. Fistula Care in the News October 2009-September 2010

July to September 2010

EngenderHealth board member Belle Taylor-McGhee wrote “The Right of Every Woman,” recently published in the [Summer 2010 Issue of Ms. Magazine](#). The article discusses maternal mortality and morbidity in Uganda, mentioning Fistula Care and EngenderHealth and quoting Dr. Peter Mukasa, our Senior Medical Associate in Uganda.

January to March 2010

Bethany Cole’s [comment](#) was featured on Nicholas Kristof’s [article](#) on eastern Congo and Panzi Hospital. Ms. Cole explained how EngenderHealth and Fistula Care support Panzi Hospital and HEAL Africa and the importance of prevention as a part of Fistula Care.

October 2009-December 20 09

Karen Beattie was quoted throughout the article [“Mothers of Ethiopia Part III: Battling Pregnancy Complications”](#) in the Huffington Post (October 1, 2009). She sheds light on the physical and social causes and consequences of obstetric fistula to help tell the story of a fistula survivor at the USAID-supported Mekelle branch of the Hamlin Fistula Hospital in Ethiopia.

Carrie Ngongo won an honorable mention for Nicholas Kristof’s [“Half the Sky” Contest](#) (October 2, 2009) in The New York Times, in which readers were asked to contribute person stories about their work with women’s issues worldwide. [Ms. Ngongo reflected](#) on her own experience as a first-time mother in contrast with the reality faced by fistula survivors in Niger.

[“How improved care is taming VVF in Nigeria”](#) was featured in the Daily Trust, a Nigerian online publication. Program Manager Iyeme Efem is interviewed and the article describes Fistula Care Project and states the total number of repairs done by the project in Nigeria.

Joseph Ruminjo and Karen Beattie both had comments published to Nicholas Kristof’s blog entry, [“A Heroic Doctor, a Global Scourge”](#) (October 31, 2009). [Ms. Beattie’s comment](#) brought readers’ attentions to the work of the Fistula Care Project and the importance of prevention. [Dr. Ruminjo argues](#) for the importance of integrated health care and strengthening national health care systems and strategies in order to eradicate fistula.

Fistula Care’s FP Integration Meeting in Rwanda was featured in [an article on allafrika.com](#) (December 8, 2009). The article gave an overview of obstetric fistula and the situation in Rwanda.

Carrie Ngongo’s visit to Nigeria with EngenderHealth President Ana Langer and Board Chair Brenda Drake was covered in several Nigerian news publications. An article in the Sunday Triumph, [“ZMSG, USAID to partner on maternal, child healthcare”](#) (December 20, 2009), outlines the problem of obstetric fistula in Nigeria and discusses the government’s plans to improve maternal and child health in Zamfara State. [“VVF: Fighting the Debilitating Condition”](#) in This Day Online (December 27, 2009) explains the causes and consequences of obstetric fistula in more detail, and quotes Ms. Langer and Mr. Iyeme Efem to express the importance of addressing VVF.