

Fistula Care *Plus*

Associate Cooperative Agreement
AID-OAA-A14-00013

Annual Report
December 2013 to September 2014

Managing Partner: EngenderHealth;
Associate Partners: The Population
Council, Dimagi, Direct Relief, Fistula
Foundation, Maternal Health Task Force,
TERREWODE

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ACRONYMS AND ABBREVIATIONS

ACQUIRE.....	Access, Quality and Use in Reproductive Health
AgirPF.....	Agir pour la Planification Familiale
ANC.....	Antenatal Care
BCC.....	Behavior change communication
BD.....	Becton Dickinson
C-Section.....	Cesarean Section
CBO.....	Community Based Organization
CHEW.....	Community Health Extension Worker
CME.....	Maternal and Child Center (Centre Mère Enfant)
CRNFO.....	Centre National de Référence des Fistules Obstétricales
CSI.....	Centre de Santé Intégré
DGHS.....	Directorate General of Health Services
DGSR.....	General Directory of Reproductive Health
DRC.....	Democratic Republic of the Congo
FBO.....	Faith Based Organization
FC.....	Fistula Care
FC+.....	Fistula Care <i>Plus</i>
FIGO.....	International Federation of Gynecology and Obstetrics
FP.....	Family planning
GWINN.....	Girls and Women in Nigeria
HC.....	Health Center
HGR.....	General Reference Hospital
HIDN.....	Health, Infectious Diseases and Nutrition
HMIS.....	Health Management Information System
ICM.....	International Confederation of Midwives
IRAG.....	International Research Advisory Group
ISOFS.....	International Society of Obstetric Fistula Surgeons
J&J.....	Johnson & Johnson
MCH.....	Maternal and Child Health
MSCP.....	Maternal and Child Survival Program
ME&R.....	Monitoring, evaluation and research
M&E.....	Monitoring and evaluation
MHTF.....	Maternal Health Task Force
MSF.....	Médecins Sans Frontières
NOFWG.....	National Obstetric Fistula Working Group
OF.....	Obstetric fistula
PHC.....	Primary Health Center
PMP.....	Performance Management Plan
POP.....	Pelvic Organ Prolapse
PPP.....	Public Private Partnership
RCT.....	Randomized Controlled Trial
PROSANI.....	Le Projet de Santé Intégré
REF.....	Réseau pour l’Eradication des Fistules
SGBV.....	Sexual and Gender-based Violence (SGBV)
STTA.....	Short-term Technical Assistance
TA.....	Technical Assistance
UNFPA.....	United Nations Population Fund

USAID United States Agency for International Development
USAID/W USAID/Washington
VVF Vesico Vaginal Fistula
WDI Women with Fistula Deemed Incurable

EXECUTIVE SUMMARY

The annual report presents key accomplishments and activities for the first year (December 2013-September 2014) of *Fistula Care Plus* (FC+). EngenderHealth manages the project in collaboration with international and national partners. In FY13/14, USAID supported fistula treatment and prevention services through the FC+ project in **five** countries—Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, and Uganda. The delivery of fistula repair services accelerated dramatically in the final quarter of FY13/14 and first-year activities have developed a foundation for rapid expansion of program outputs and outcomes in the coming year. Key accomplishments during the December 2013 to September 2014 period included:

Objective 1: Strengthened enabling environment

- National fistula working group/strategy meetings in Bangladesh, Niger, Nigeria, and Uganda
- Establishment of country public-private partnerships (PPPs) in Niger, Nigeria, and Uganda
- Development of global strategy to identify and approach providers of fistula service-related commodities in FC+'s target countries as part of the PPP initiative

Objective 2: Enhanced community understanding and practices

- Orientations to community engagement for staff and partners in Niger, Nigeria, and Uganda
- Implementation of health facility “site walk-throughs” for community engagement in Uganda
- Training and support for outreach activities of religious leaders in Uganda, and Nigeria

Objective 3: Reduced transportation, communications, and financial barriers

- Initiation of desk review by Population Council to guide intervention development
- Completion of a media analysis to understand reported barriers to fistula treatment

Objective 4: Strengthened provider and health facility capacity

- 25 sites supported by FC+ for fistula treatment and prevention activities; one site supported through other USAID bilateral support
- 16 sites supported by FC+ for prevention-only activities
- 873 repairs supported by USAID, of which 813 supported through FC+
- Two surgeons attended first-time training and five continued training in fistula repair
- 154 health system personnel trained in non-surgical fistula repair and prevention topics

Objective 5: Strengthened evidence base

- FC+ research agenda developed through International Research Advisory Group meeting and consultation with USAID
- Consultation held with global experts on the quantification of the burden of fistula
- Seven papers published in peer review journals
- DHIS2 platform established for FC+ and partner data collection, analysis, and storage

Special activities

- Development of algorithm for health and psychosocial support for the girls abducted by Boko Haram from Chibok Nigeria

INTRODUCTION

This annual report represents a summary of accomplishments for the first year (December 12, 2013 – September 30, 2014) of *Fistula Care Plus* (FC+), a five year Associate Cooperative Agreement (No. AID-OAA-A14-00013) supported by USAID. In this report we present data on quantitative indicators as well as narrative updates organized into: Management Activities, Global Accomplishments, and Country Accomplishments. Global and country accomplishments are reported against the objectives of the FC+ Project Framework (Figure 1).

USAID support to EngenderHealth for fistula services began in FY 04/05 under the Access, Quality, and Use in Reproductive Health (ACQUIRE) and Action for West Africa Region (AWARE) Projects and continued through the *Fistula Care* (FC) Project, which ended on December 31, 2013. USAID/Washington (USAID/W) awarded the FC+ project to EngenderHealth, in partnership with the Population Council, Dimagi, Direct Relief, *Fistula Foundation*, Maternal Health Task Force, and TERREWODE, through a five year Global Cooperative Agreement (AID-OAA-A14-00013) on December 12, 2013. FC+ seeks to strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia. In addition to the support provided via FC+, USAID provides direct support to fistula work in DRC (through Prosani), Ethiopia (through the Integrated Family Health Program and Hamlin Hospital) and Pakistan (through the Jinnah Post Graduate Medical Center).

As of September 30, 2014, FC+ is supporting fistula prevention and treatment activities with USAID funding at the global level and in Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, and Uganda. EngenderHealth has also continued fistula-related activities in Guinea, and plans to scale these up with support from the Islamic Development Bank and other donors in 2015. The primary focus of activities for the first fiscal year was project start-up including staffing, workplan and sub-award development. With obligation of all funds complete in the third quarter, the project moved towards focusing on programmatic implementation.

Figure 1. *Fistula Care Plus* Project Framework

GOAL: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia				
<i>Obj. 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors</i>	<i>Obj. 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula</i>	<i>Obj. 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support</i>	<i>Obj. 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment</i>	<i>Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment</i>

SECTION I: MANAGEMENT ACTIVITIES

During FY13/14, the global FC+ team was focused on many aspects of project start-up. Recruitment and orientation of staff, workplan and budget development, and sub-award design were ongoing activities throughout the year. In addition, several priority-setting activities were conducted including March/April start-up meetings for FC+ staff and partners, a July meeting of the FC+ International Research Advisory Group (IRAG), and a consultation on measurement and estimation of fistula in the same month. FC+ has developed new assessment and data collection tools, as well as designed a data management system using the DHIS2 platform. Finally, ongoing field support has been provided and the FY14/15 workplan and budget have been under development.

Staffing and Recruitment

Considerable time was spent during the first nine months of the project on staff recruitment and orientation, as reflected in Table 1.

As of September 30, 2014, the FC+ global team is comprised of the following staff:

Karen Beattie: Project Director

Joseph Ruminjo: Clinical Director

Vandana Tripathi: Deputy Director

Maynard Yost: Financial Management & Administration Specialist (50% LOE)¹

Bethany Cole: Global Project Manager

Carrie Ngongo: Field Project Manager

Isaac Achwal: Senior Clinical Associate

Altine Diop: Project Coordinator

Karen Levin: Program Associate (50% LOE)

Ellen Brazier: Senior Technical Advisor, Community Engagement (short-term technical assistance (STTA))

Mark Barone: Senior Clinical Advisor (STTA)

Kacie Dragan: Intern

Staff recruitment has been ongoing at the country level. All new staff received orientations to EngenderHealth and USAID regulations and policies. Table 1 provides an update on recruitment.

Table 1: Country Level Recruitment, FY13/14

Country	Filled Positions	Open Positions
Bangladesh	Project Manager Program Officer Program Officer (Coordination and BCC) Program Officer (M&E)	Program Officer (Admin and Finance) FY14/15
DRC	National Coordinator	None

¹ Maynard Yost departed EngenderHealth on September 30. As this is a Key Personnel role, FC+ has submitted a request to USAID for approval of his proposed replacement, Joseph Osei.

Country	Filled Positions	Open Positions
Niger	Project Officer	M&E Advisor Administrative Assistant (to be shared with AgirPF)
Nigeria	Country Project Manager RH&FP Advisor (Sokoto) Clinical Associate (Abuja) Community Mobilization Officer Data Coordinator (Sokoto) Finance and Operations Manager Accounts Officer Project Officer Drivers (4) Administrative and Logistics Officer (Abuja) Administrative and Logistics Officer (Sokoto) Program Assistant (Sokoto)	MER Advisor (Abuja) Clinical Associate (Sokoto) RH&FP Advisor (Abuja) Finance Assistant (Abuja)
Uganda	M&E Program Associate Community Engagement Program Associate Accountants (2) Assistant Driver	Senior Clinical Associate FY14/15

Project Management

Key management activities during this first fiscal year of the project have focused on project start-up. FC+ leadership have participated in meetings with USAID/W; the development of both FY13/14 and FY14/15 workplans and budgets; securing USAID Mission concurrence and USAID/W approvals; development of a Performance Management Plan (PMP); and working with partners and country-level staff to facilitate startup of FC+ finance and M&E systems, staffing and program support.

FC+ coordinated with USAID/W on the announcement of the project to USAID Missions and a broader set of stakeholders interested in maternal and reproductive health. Project staff have worked with EngenderHealth to establish a branding and marking plan, in discussion with USAID/W.

In order to identify a low-cost, flexible and robust data collection and management system, the project undertook extensive research into possible database software and online platforms. FC+ has moved forward with the development of a DHIS2 database for data collection and management and will be orienting staff and partners to the new system in the beginning of FY14/15. Activities related to this topic are described under Section II, Objective 5.

Partnership: Global and Country-Level

In its first fiscal year, FC+ core staff focused attention on embracing a new set of international project partners and developing plans for their engagement in project activities. At the country level, identification and development of partnerships, sub-awards and activity planning dominated FY13/14 activities.

The project held its first partners' meeting on April 3-4, 2014 in New York City. Partners were introduced to an overview of the project and discussed a vision for the future. Country project managers provided an introduction to their activities and initial workplans. The PMP, funding and sub-award expectations, branding and marking, and publications requirements were also discussed.

Following this meeting, one-on-one consultations have been held with other project partners. For example, we have worked with Direct Relief to secure commodities and equipment for project partners in some countries. Staff have negotiated a scope of work and budget with the Population Council to conduct research on barriers to fistula treatment with a particular emphasis on the financial constraints to fistula services. This work will be conducted with field support from participating countries (Nigeria and Uganda. The Bangladesh mission declined to participate). Discussions have been ongoing with Dimagi to identify an mHealth activity that will address mHealth initiatives in Nigeria and DRC. There are mHealth initiatives in maternal health ongoing in most countries at the present time and our focus is to ensure that we are collaborating or coordinating with those initiatives wherever possible, rather than establishing stand-alone initiatives that address fistula specifically. Global staff have provided technical and management input to TERREWODE, a resource partner on the FC+ project, for the development of a scope of work specifically targeted women with fistula deemed incurable (WDI). This sub-award awaits USAID approval and is expected to begin early in FY14/15.

Building on successful programmatic activities carried out under Fistula Care, EngenderHealth has also worked with its partner the Fistula Foundation, the Islamic Development Bank and the Alcoa Foundation to provide funding to support fistula activities in Guinea in the amount of \$440,000. This work has been delayed because of the Ebola epidemic and will begin in January 2015, following a similar program of activities as FC+, with a particular emphasis on infection control and prevention. We will incorporate Guinea into a community of practice that will be developed with other USAID-supported initiatives on fistula.

In April 2014, in an activity supported by private funds to introduce a rights and choice framework for family planning (FP) (see Section II, Objective 4), members of the FC+ project management team met with staff from the West Africa regional *Agir pour la Planification Familiale* (AgirPF) project to consider ways in which we could coordinate activities. Both projects receive funding from the West Africa Regional Mission of USAID. Initial plans for collaboration in Niger, Togo, and with regional institutions were discussed and are continuing to be developed.

The FC+ Project Director also traveled to London for discussions with International Federation of Gynecology and Obstetrics (FIGO) representatives. During this meeting, plans for dissemination of findings from the randomized controlled trial (RCT) on duration of catheterization after fistula surgery, conducted under the previous Fistula Care (FC project, were discussed. FIGO held a meeting focused on training in Dar es Salaam in early June 2014 during

which FC+ presented RCT findings to representatives from FIGO training centers and master trainers who have been certified by FIGO. Outcomes from this meeting are further discussed under Section II, Objective 5.

As part of efforts to define a research agenda for the project, as well as strengthen information-sharing and global partnerships, FC+ collaborated with the Maternal Health Task Force (MHTF) to hold IRAG and measurement consultation meetings in Boston in July 2014. This activity is described in greater detail in Section II, Objective 5. FC+ has also collaborated with MHTF to disseminate project research activities and publications through the MHTF Buzz and Blog communications features (see Appendix F and Section II, Objective 5).

The Project Director and Deputy Director have participated in numerous meetings led by USAID and its flagship projects to identify ways in which we might coordinate and collaborate. These have included participation in the HIDN Partners Meeting; quarterly USAID Service Delivery Improvement (SDI) partners' meetings; and meetings convened by MCHIP, now the Maternal and Child Survival Program (MCSP).

During FY13/14, country programs have progressed in identifying in-country partnerships and preparing paperwork for sub-awards for facilities that will receive support. As of September 30, 2014, one in-country sub-award has been approved by USAID approval – for Kitovu Hospital in Uganda for the period August 1, 2014 – September 30, 2015. Appendices A and B provide greater detail on anticipated supported sites and partnerships, by country. Several sub-awards are under review by USAID and/or under revision by EngenderHealth, including based on USAID comments.

Travel

FC+ global staff and consultants have carried out international technical assistance (TA) visits to four countries during FY13/14 (see Table 2). The focus of this travel included:

- Orientation of staff and partners (DRC, Niger, Nigeria, Uganda);
- Site/needs assessments (Nigeria, Uganda); and
- Development of community engagement strategy and activities (Niger)

Additionally, program leaders from each FC+ country traveled to New York to participate in a March 2014 Managers' Meeting, where they were oriented to FC+ aims and received feedback on program plans for FY 13/14. Selected field staff have also traveled to HQ for orientations (e.g., Agnes Empeire and Stanley Obinna, finance staff from Uganda and Nigeria, respectively).

Table 2: Technical Assistance Travel, December 2013 – September 2014

Traveler	Dates/Location	Purpose
Joseph Ruminjo	27 April – May 6 2014 Nigeria	At request of USAID/Nigeria: Rapid needs assessment and recommendations for services for girls abducted in Chibok by Boko Haram. Interviews for potential clinical associates.
Carrie Ngongo	9-18 May 2014 Niger	Provision of TA including orientation for staff, activity planning, budgeting, meetings with key stakeholders.
Carrie Ngongo	15-21 June 2014 Uganda	Orientation for new staff, working with partners on sub-award development (Kitovu and TERREWODE). Visit to Kamuli Mission Hospital (a new site/sub-award recipient) to discuss the process of coming on board and project expectations.
Ellen Brazier	21-25 July 2014 Uganda	Support to the FC+ Uganda team in planning community engagement activities to be conducted during the remainder of Year 1 and during Year 2.
Isaac Achwal	27 July – 8 August 2014 Uganda	Site assessments, including human capacity development, infrastructure, expendable supplies, and managerial support required to provide quality fistula prevention services. Documentation of baseline information for FC+ and level of effort that will be required to continue strengthening the facilities that were supported under the FC project.
Karen Beattie Carrie Ngongo Joseph Ruminjo	20 August – 3 September 2014 Nigeria	Orientation of 17 new staff in Nigeria to the project and to EngenderHealth. Discussion of Y2 workplan/budget with staff and with the USAID Mission. Introduction of project management to Federal Ministry of Health (FMOH) and USAID/Nigeria. Participation in a provider network meeting.
Joseph Ruminjo	8-13 September 2014 Nigeria	Needs assessment for new and existing supported sites. Medical waste management compliance and orientation for new clinical staff.
Bethany Cole	28 August - 8 September 2014 DRC	HEAL Africa: Orientation on FC+ and reporting requirements for the new sub-award. Panzi Hospital: Orientation on FC+ and reporting requirements for new sub-award and attendance at partners' meeting.
Ellen Brazier	23-28 September 2014 Niger	Orientation of new FC+ staff from Niger and Nigeria to community engagement, including EngenderHealth experience, approaches and tools. Support to FC+ Niger staff in conducting exploratory consultations with regional and district partners in Maradi about planned community-level fistula prevention activities.

Meetings

FC+ core staff convened, attended and presented at numerous meetings throughout the fiscal year, as noted above and summarized in Table 3.

Table 3: Meetings and Presentations, December 2013 – September 2014

Meeting	Dates/Location	Convened by FC+?	Attending ²	FC+ Inputs / Presentations
USAID PRH SDI Quarterly Meeting	30 Jan 2014 Washington, DC	No	Karen Beattie Bethany Cole	N/A
PRH Gender CAs Meeting	12 Feb 2014 Washington, DC	No	Bethany Cole	N/A
Global Health Mini-University	7 March 2014 Washington, DC	No	Bethany Cole	Presentation on integration of FP and fistula services in Nigeria
Fistula Care <i>Plus</i> Partners' Meeting	3-4 April 2014 New York City	Yes	<u>FC+</u> : HQ staff Country Program Managers <u>External</u> : Dimagi Population Council Terrewode Direct Relief Fistula Foundation	Presentations from all participating organizations, including FC+ staff
Leadership and Impact Meeting	6-8 May 2014 Lomé, Togo		Isaac Achwal Karen Beattie Carrie Ngongo Bethany Cole	N/A Note: Participation in this meeting was funded with EngenderHealth private resources.
PRB/Pop Council Research to Practice Workshop	12-13 May 2014, Silver Spring, MD		Vandana Tripathi	N/A
MEASURE Evaluation Phase III End-of-Project Meeting	22 May 2014, Washington, D.C		Vandana Tripathi Karen Levin	N/A
USAID PRH SDI Quarterly Meeting	7 May 2014 Washington D.C.		Vandana Tripathi	N/A
USAID Acting on the Call	25 June 2014, Washington, D.C.		Vandana Tripathi	N/A
MCHIP End-of-Project Meeting	26 June 2014, Washington, D.C.		Vandana Tripathi	N/A
30 th Congress of the International Confederation of Midwives (ICM) 2014	1-5 June 2014 Prague, Czech Republic		Vandana Tripathi Celia Pett	FC+ Panel/Workshop on “The role of midwives in the prevention and management of childbirth injury: catheterization and obstetric fistula” Facilitation and reporting for Partograph Side Meeting, co-hosted by WHO, MCHIP, EngenderHealth and the University of Manchester

² External participants are summarized for meetings convened by FC+ only.

Meeting	Dates/Location	Convened by FC+?	Attending ²	FC+ Inputs / Presentations
AidEx Development Conference	5-6 June 2014 Nairobi, Kenya		Carrie Ngongo Isaac Achwal	N/A
mHealth Working Group Meeting: Evidence Generation: A Focus on Evaluation Design	16 June 2014 Washington DC		Karen Levin	N/A
FIGO Fistula Initiative Meeting	23-27 June 2014 Dar es Salaam, Tanzania		Joseph Ruminjo, Mark Barone	Presentations on: Findings of RCT on non-inferiority of short term catheterization, development of protocol and rationale for methodological approaches, and moderated discussion on strategy for moving research findings to practice.
IRAG Meeting	8-9 July 2014 Boston, MA	YES	<u>FC+</u> : Mark Barone Karen Beattie Ellen Brazier Bethany Cole Kacie Dragan Joseph Ruminjo Vandana Tripathi <u>External</u> : FC+ IRAG members FC+ partners (e.g. UNFPA, FIGO, NIH) USAID AORs	Facilitation/Coordination Presentations on: Research under FC project, potential research topics and prioritization criteria, findings of selected research activities, outcomes of research prioritization
Consultation on Measurement and Estimation of Fistula Incidence and Prevalence	10-11 July 2014 Boston MA	YES	<u>FC+</u> Mark Barone Karen Beattie Bethany Cole Kacie Dragan Joseph Ruminjo Vandana Tripathi <u>External</u> : FC+ IRAG members Global measurement/estimations experts USAID AORs	Facilitation / Coordination Presentations on: Household surveys, HMIS/surveillance, priority research topics identified by participants
Fistula Care Provider Network meeting / FC+ Launch	1-2 September 2014 Abuja, Nigeria	YES	<u>FC+</u> : Joseph Ruminjo Carrie Ngongo	Facilitation / Coordination

Meeting	Dates/Location	Convened by FC+?	Attending ²	FC+ Inputs / Presentations
			Nigeria FC+ staff <u>External:</u> Nigerian fistula providers State Commissioners for Health and Women Affairs Representatives of the FMOH and FMWASD State FP Coordinators Religious leaders Former fistula clients (now fistula advocates) Assorted media	
Nigerian Fistula National Technical Working Group	3-4 September 2014 Abuja, Nigeria		Joseph Ruminjo	Presentation on catheterization in prevention and conservative treatment of fistula. Facilitation of discussion on measurements and estimates in fistula programming.
USAID PRH SDI Quarterly Meeting	17 September 2014 Washington D.C.		Karen Beattie Vandana Tripathi	Presentation and dissemination of materials on FC+ and youth
M&E Tech meeting	25-26 September 2014 Washington DC		Karen Levin	N/A

Funding

Funding for the project was obligated over the first three quarters of FY13/14 by both USAID/W and local USAID Missions. The delay in field support obligations hampered project abilities to develop activities and sub-awards relating to fistula treatment during this first year of the project. With full funding now in place, all countries have moved ahead with sub-award preparations and programmatic activity. EngenderHealth has also put procedures in place to document cost share. The FC+ team is conducting a cost analysis and will report on overspending or high unit costs at the management review scheduled with USAID for December 3, 2014.

At the country level, the USAID Mission in Bangladesh has indicated its desire to fund the project at an increased level of \$1 million per year, and a revised workplan has been prepared and shared with the Mission. However, the Mission has tied this support to a doubling of fistula repair targets and removal of research activities. Additionally, the Nigeria mission has indicated it will provide an additional \$500,000 per year for the life of the FC+ project to support increased efforts in regards to family planning.

SECTION II: GLOBAL ACCOMPLISHMENTS

Fistula Care *Plus* Achievements

During the first fiscal year of the project, along with activities in the approved workplans, considerable effort was devoted to project start-up. Delays in funding obligations hampered project ability to meet first year benchmarks at the country, and thus, the aggregate global level. With all funds now obligated and sub-awards in process, it is expected that the project will be able to accelerate progress towards targets in year 2. Newly developed data collection and analysis tools are being implemented in the first quarter of FY14/15, including back entry of data from the first year of the project. At that time, we will be able to provide greater detail on all project indicators. Table 4 provides a partial snapshot of FC+ achievements in FY13/14. Training is one of the key mechanisms by which FC+ advances project aims across objectives; training outputs are summarized in Table 5. Neither Niger nor DRC were able to begin implementing training activities during this fiscal year, due to delays in fund release and sub-award development. Training activities were fewer than projected for similar reasons in all countries, but activities are expected to reach projected levels during FY14/15. Accomplishments are described in greater detail below, by project objective, and in Appendix L.

Table 4: Fistula Care *Plus* Achievements and Benchmarks

	FY 13/14 Planned	FY 13/14 Actual
Number of countries supported by FC+	5	5
Number of sites supported by FC+ for fistula repair and prevention	26	25
Number of prevention-only sites supported by FC+	43	16
Number of community volunteers/educators trained in tools and approaches to raise awareness regarding fistula prevention and repair	227	114
Number of community awareness-raising activities/events conducted by program partners	570	12
Number of participants reached through community awareness-raising events/activities conducted by program partners	155,150	10,745
Number of fistula repairs	1,300	873
Number of health systems personnel trained, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider)	526	161

Table 5: Total Number Trained, by Country, by Topic, for FY 13/14

	Bangladesh	DRC	Niger	Nigeria	Uganda	Total
First Training in Surgical Fistula Repair	1	0	0	0	1	2
Continuing Training in Surgical Fistula Repair	5	0	0	0	0	5
FP Methods	7	0	0	0	23	30
Fistula Counseling	52	0	0	0	12	64
Infection Prevention	0	0	0	0	18	18
Pre- and Post-Operative Care	0	0	0	0	17	17

	Bangladesh	DRC	Niger	Nigeria	Uganda	Total
Quality Assurance	0	0	25	0	0	25
Community Volunteers/Educators	0	0	0	0	114	114
TOTAL	65	0	25	0	185	275

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

Activities to strengthen the enabling environment for fistula services have begun across countries. National working groups have been meeting with FC+ support and participation in Bangladesh, Niger, Nigeria and Uganda to revise and update national strategies for the elimination of fistula. Both Nigeria and Uganda have committed funds for fistula services in their national budgets.

In Niger and DRC, FC+ participated in UNFPA International Day to End Obstetric Fistula and National Women’s Day activities, utilizing those opportunities to network and raise the visibility of fistula and the importance and availability of prevention, treatment and reintegration services.

The Project Director and Clinical Director consulted with the USAID/Ethiopia Mission in its desire to develop a plan to eliminate fistula by the year 2020. Several phone conversations and communications providing input to the proposed plans took place. The Mission is proceeding with its plans with the Evidence to Action (E2A) project providing technical support.

FC+ conducted several activities during FY13/14 to promote the availability of improved data about fistula and encourage the advancement of fistula services. FC+, in partnership with the World Health Organization (WHO), provided comments to the review of the Demographic and Health Survey (DHS) core module, advocating for the inclusion of basic questions related to fistula awareness and prevalence in all DHS surveys in countries where fistula may be a problem (i.e., in sub-Saharan Africa and South Asia). FC+ submitted a comment to the Lancet Commission for Global Surgery, to encourage the prioritization of safe surgery services for women’s health, including emergency obstetric care (EmOC) and fistula repair. Finally, FC+ co-authored a commentary with WHO on the need for, and possible approaches to, strengthened measurement and estimation of the global and country-level fistula burden. This commentary has been accepted for publication in the *Bulletin of the WHO*. The topic of better measurement of fistula-related needs was also addressed, along with identification of key areas of research during meetings co-convened by FC+ and MHTF in July 2014 (see Objective 5). Bangladesh, Niger, Nigeria, and Uganda have all identified HMIS indicators related to fistula services and the latter three countries have begun active incorporation of these into HMIS training and/or data collection processes. The project will collect information on progress in HMIS indicators as part of its FC14/15 measurement and research activities.

Project staff have been exploring opportunities for collaboration with Johnson & Johnson (J&J). Mr. Denis Robson, Director for African Affairs of J&J Medical, has met with the project team and facilitated connections to several institutions and individuals with potential for collaboration.

We are discussing the potential to provide sutures for facilities supported by the project, and Mr. Robson has connected FC+ staff with Becton Dickinson (BD), which manufactures catheters. FC+ will be meeting with BD in FY14/15, and has prepared materials for proposed public-private partnerships with BD. FC+ global staff have also been working with a USAID-supported consultant to understand how to identify and approach providers of fistula-related commodities in FC+ countries for public-private partnerships (PPP). As described in the country reports below, three country-specific PPPs have been established in Niger, Nigeria, and Uganda.

The team has also been planning the next iteration of the FC+ website, to be finalized in the first quarter of FY14/15.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

Country-level activities to increase community understanding and practices on preventing fistula and the availability of fistula repair services have been undertaken in DRC, Niger, Nigeria and Uganda during the fiscal year. EngenderHealth's Senior Technical Advisor for community engagement traveled to Niger to orient new FC+ staff from Niger and Nigeria to this topic, including providing an overview of EngenderHealth experience, approaches and tools. (Both countries serve a Hausa speaking population, and at the border between the two countries, women often cross from one country into the other in search of services. The project will focus on how to support south-south initiatives for improved quality of care and access to services.) This provided an excellent opportunity to bring staff from different country programs together to foster opportunities for cross-country collaboration.

The Senior Technical Advisor also supported FC+ Niger staff in conducting exploratory consultations with regional and district partners in Maradi about planned community-level fistula prevention activities. Outcomes of this work included the introduction of staff and partners to planned community engagement approaches and selection of priority sites for interventions selected in Maradi Region. The Senior Technical Advisor also carried out a similar trip to Uganda during which she supported the FC+ Uganda team in planning community engagement activities to be conducted during the remainder of FY13/14 and during FY14/15.

As mentioned earlier, training and outreach activities for FY13/14 did not achieve projected targets due to delays in funding and sub-award approvals. However, FC+ Uganda was able to implement two community volunteer and educator trainings (see Tables 5 and 6) during the fiscal year, targeting village health teams and clerics from the Anglican Church. The trainings included topics such as promoting healthy practices during and after pregnancy and childbirth, male involvement in maternal health, FP, and dispelling myths that contribute to poor maternal and infant outcomes in their communities.

Table 6: Community Volunteer/Educator Training, by Country, FY13/14

Type of Training	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Total FY13/14
Uganda	0	27	87	114
Total	0	27	87	114

FC+ conducted community outreach and education events in Nigeria and Uganda. Nigeria staff worked with local religious leaders to reach out to the community with messaging on safe birth practices and fistula prevention, treatment and reintegration. This approach builds on successful work initiated under the previous FC project with religious leader action committees. These events reached over 10,500 people (see Table 7). Following the aforementioned community engagement planning in Uganda, a site walk-through event was conducted at Bururu HC III in which 63 community representatives participated in a guided tour of the health facility to learn about services provided. Representatives also participated in discussions on how to improve the quality of services, mobilizing clients for services, and mobilizing resources for the facility.

Table 7: Community Outreach/Education Events, by Country, FY13/14

Country	Jan-Mar 2014		Apr-Jun 2014		Jul-Sept 2014		Total FY13/14	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Nigeria	0	0	0	0	11	10,682	11	10,682
Uganda	0	0	0	0	1	63	1	63
Total	0	0	0	0	1	63	12	10,745

As noted above, global staff provided technical and management input to the sub-awards development process for all countries; this includes support to TERREWODE, a resource partner on the FC+ project, for the development of a scope of work specifically targeting WDI. This sub-award is awaiting USAID approval and projected to begin early in FY14/15.

Although not a part of the approved workplan, in April 2014, the project was asked by the USAID Nigeria Mission to provide support to addressing the health needs of the girls who were abducted from their school in Chibok, Borno State. Global staff have supported the Nigeria staff in conducting an assessment of needs and of resources for support, preparing an algorithm for the health and psychosocial support that the girls will require, considering how to address the potential sexual and gender-based violence (SGBV) that may have occurred, developing a mapping process for resources, and participating in coordination meetings with the various state and non-state actors involved in this process.

Objective 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

The Population Council, implementing partner in FC+, initiated a desk review to guide the development of interventions that will be tested in one to three countries, starting in Year 2. They have completed the first phase of the review (structured searches of target databases and

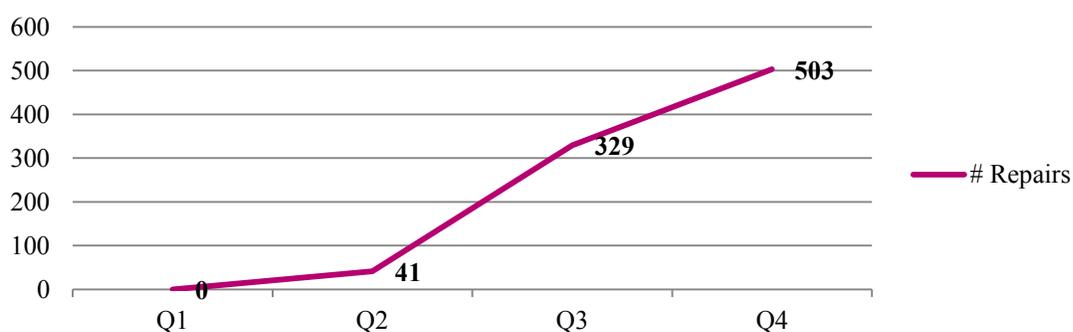
identification of resources for abstract review) and will soon be initiating the second phase (review of abstracts for selection and synthesis of full-text resources). Progress on this sub-award was delayed due to delays in field support funding and concerns expressed by the Bangladesh USAID mission late in the fiscal year (described above in Section I, Funding). While awaiting resolution on the Population Council sub-award, FC+ also conducted an analysis of media reporting of barriers to fistula treatment, to identify barriers that could be further explored through planned formative research by the Population Council. The analysis found 85 articles that described barriers to fistula treatment, including 19 from FC+ priority countries. These articles described 11 distinct barriers experienced by women. A summary of this media analysis is provided in Appendix C.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Site assessments were carried out during FY13/14 by global and country clinical and program staff in all five FC+ countries: Bangladesh, DRC, Niger, Nigeria, and Uganda. These assessments are an opportunity to gather baseline information on site capacity and programmatic needs, for both fistula repair and prevention services, including EmOC and FP. Findings from the site assessments inform planning for future programmatic activity.

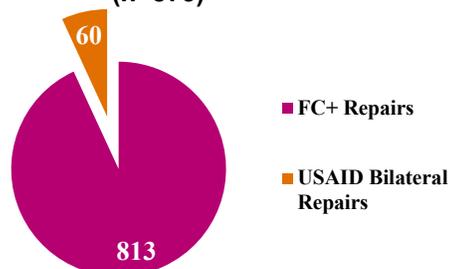
Support for fistula surgeries was lower than projected across countries because of the hiatus between projects, delays in receipt of field support funding, and in the case of Nigeria, a nationwide strike by doctors for two months. However, with obligation of funding completed by the third quarter, FC+ was able to significantly increase the number of surgeries supported in the third and fourth quarters (see Figure 2).

Figure 2: USAID-Supported Fistula Repairs, by Quarter, FY13/14 (n=873)



A total of 873 repairs were supported by USAID in five countries (Bangladesh, DRC, Niger, Nigeria and Uganda) during FY13/14, of which 813 were supported through FC+ (see Figure 3 and Table 8 for detail). The remainder of repairs was supported by the PROSANI project in DRC. FC+ is currently awaiting completion and approval for sub-awards to several supported facilities, at which time the number of supported repairs is expected to further increase.

Figure 3: Source of USAID-Supported Repairs, FY13/14 (n=873)



FC+ has finalized its data collection forms and developed a new M&E system using DHIS2. This system will be implemented with the first quarter of FY14/15. At that time, all back data for the first year of the project will be entered, and we will be able to report in greater detail on fistula repairs supported by USAID from the start of the project, including outcomes and complication rates (see Objective 5 for details).

Table 8: Number of USAID-Supported Fistula Repairs, by Country, FY13/14³

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Total FY13/14
Bangladesh	41	57	27	125
DRC (PROSANI)	NA ⁴	NA	60	60
Niger	0	50	77	127
Nigeria	0	222	276	498
Uganda	0	0	63	63
Total	41	329	503	873

To strengthen provider capacity for fistula repair, FC+ has trained seven surgeons in two countries (Bangladesh and Uganda) using the FIGO training curriculum, during FY13/14. Two surgeons participated in their first training in fistula surgical repair, while five took part in continuing trainings (see Table 9). Delays in funding and sub-awards hampered efforts to initiate surgeon training in other FC+ countries, but trainings are expected to begin in FY14/15.

Table 9: Training in Surgical Fistula Repair, by Quarter, FY13/14

Type of Training	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Total FY13/14
First Training in Surgical Fistula Repair	1	1	1	2⁵
Continuing Training in Surgical Fistula Repair	0	5	0	5
Total	1	6	1	7

A total of 154 health system personnel in three countries (Bangladesh, Niger, and Uganda) participated in training in non-surgical topics during FY13/14, including infection prevention, fistula counseling, FP methods and quality assurance approaches such as COPE and facilitative supervision (see Table 10).

³ The number of repairs for Nigeria has been amended from the third quarter report to reflect additional data verified in the fourth quarter.

⁴ NA means data was not available.

⁵ One surgeon from Bangladesh (Ad-Din Dhaka Hospital) participated in an initial training session that spanned both the second and third quarters. Though reported for each quarter, he is only counted once in the FY total.

Table 10: Non-Surgical Training for Health System Personnel, by Quarter, FY13/14

Type of Training	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Total FY13/14
FP Methods	0	0	30	30
Fistula Counseling	0	0	64	64
Infection Prevention	0	0	18	18
Pre- and Post-Operative Care	0	0	17	17
Quality Assurance	0	0	25	25
Total	0	0	154	154

As an initial part of efforts to establish support for reintegration of women who have undergone fistula repair, FC+ participated in the inauguration of Panzi Hospital’s Dorcas House 3 in DRC for survivors of violence or those under care for fistula and incontinence healing (see Section III, DRC for additional detail).

In the beginning of May 2014, EngenderHealth staff, including FC+ country program staff, gathered in Lomé, Togo to learn about and discuss a new conceptual framework developed by the Futures Group and EngenderHealth: Voluntary FP Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework. This rights and choice framework provides practical programming guidance on integrating sexual and reproductive rights into FP programs. The framework can help institutions consider how policy language pertaining to rights can be successfully operationalized. The meeting costs were paid with private funding.

Objective 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

On July 8-9, FC+ convened the first meeting of its IRAG and key project partners, to discuss research conducted by the previous FC project and examine future research needs across four categories: 1) clinical/biomedical research, 2) epidemiological research, 3) service delivery improvement research, and 4) community-based/other programmatic research.

The group’s goal was to propose and prioritize potential research topics for FC+, for consideration by project management in consultation with USAID. Applying structured criteria, participants rated and ranked topics within each of the four research categories individually, in small groups, and in plenary. Of the 28 meeting participants, 17 completed individual surveys rating research topics. While complete consensus on priorities was not achieved, there was broad agreement on important issues within each research category. Illustrative research questions within emerging priority topics were also identified in plenary discussions.

On July 10-11, FC+ convened an in-depth consultation regarding the quantification of the burden of fistula. Participants included epidemiologists, demographers, midwives, and other experts from around the world; several IRAG members were also invited to this consultation. This group’s goal was to build a consensus regarding FC+ priorities related to the measurement and estimation of the prevalence and incidence of obstetric fistula. Presenters summarized available

approaches to measurement and estimation (e.g., household surveys) and participants discussed the merits and challenges of each in small groups, identifying implementation and research priorities. Specific research questions and studies were also identified in plenary discussions. The discussions and materials presented at this meeting were used to develop a set of FC+ talking points about the measurement of the global fistula burden (see Appendix I). These talking points have been circulated to field staff and are shared with partners as needed.

Reports from both meetings were circulated to meeting participants. Key recommendations and research priorities from these meetings were discussed with USAID; based on these discussions FC+ has incorporated selected research activities into its Y2 core workplan.

FC+ received PMP approval from USAID during the third quarter of FY13/14. Beginning in FY14/15, FC+ also expects to report on all USAID-supported fistula treatment activities, including through bilateral agreements. All back data from FY13/14 will be gathered and entered into the DHIS2 database to provide a comprehensive repository for program activities.

To operationalize this PMP, a key activity in FY13/14 has been the updating of FC+ M&E and data management systems. After extensive review of possibilities for upgrading the database used by the previous FC project, FC+ made the decision to build a new global M&E database for the current project. FC+ selected the DHIS2 platform, which has been endorsed by PEPFAR and the Global Fund for AIDS, Tuberculosis, and Malaria, and is being used by an increasing number of country programs and implementing organizations. It has also been applied by EngenderHealth in Tanzania, and is being considered for organization-wide use in the future. FC+ identified DHIS2-capable organizations and consultants and developed scopes of work and service agreements to host the new database servers, develop the new database, and train FC+ staff in its use. Training and database construction have taken place at the end of FY13/14 and the production server is expected to ‘go live’ for use in reporting activities in the second fiscal year. FC+ will be creating dashboards that will enable USAID and project partners to log in and see data visualizations for a selection of current project data. A sample data collection screen from the DHIS2 platform is included in Appendix J, and a sample dashboard collection is included in Appendix K. This dashboard is illustrative and will be customized to the individual user.

FC+ clinical and project activity reporting forms to structure quarterly reporting into this database have been updated (and drafted, in the case of new activity areas such as genital prolapse (GP)) and finalized following consultation with global and country staff. During FY13/14, FC+ has developed and field tested new program tools for conducting needs assessments, environmental mitigation and facilitative supervision.

FC+ has initiated several efforts to disseminate evidence from program and research activities to the broader maternal health/FP/reproductive health community. These have included participation and presentations at multiple international meetings (see Table 3). Highlights include presenting on integrating FP into fistula services at the Global Health Mini-University; a panel presentation at the 2014 International Confederation of Midwives (ICM), discussing the role of midwives in catheterization to prevent and support treatment of obstetric fistula;

participation in an MCHIP-sponsored ICM workshop on the partograph, at which results from an FC+/University of Manchester realist review of evidence on the partograph were presented along with findings from a survey of midwives on partograph use; and a day-long workshop with FIGO stakeholders to discuss the clinical implications of the FC project RCT on the non-inferiority of shortened duration of catheterization after surgical repair. Next steps for acting on the RCT findings were discussed at the FIGO meeting, including further disseminating RCT results at multiple forums and health system levels; updating training guidelines; and supporting health facilities with clinical algorithms, job aids, and training materials. The publication of the pending *Lancet* paper on the RCT, expected in FY14/15, will be a significant aid to these efforts.

Six abstracts were submitted and accepted for the upcoming October 2014 ISOFS meeting in Uganda by FC+ staff and supported partners, in addition to a panel presentation on the findings of the RCT on catheterization and a presentation on outcomes from the FC+ research and measurement consultations in July 2014. Appendix H summarizes the planned FC+ presence at ISOFS.

The digital archive established under the Fistula Care project continues to receive a high number of visitors and page views per month, indicating it remains a valuable resource as the largest known repository of fistula-related programmatic and research documentation. The number of pages viewed has averaged just above 3,000/month, and we have tracked approximately 1,250 visitors/month over the last 12 months.

During FY13/14, several articles were accepted or published in peer-reviewed journals (see Table 11). Highlights include: an article presenting the findings from an FC project study on birth preparedness and women’s care-seeking in Guinea in the journal *Health Care for Women International*; an article on iatrogenic fistula in the *International Journal of Urogynecology*; and an article on mortality among surgical fistula repair clients in the *International Journal of Gynecology and Obstetrics*. See Appendix E for a complete list of FC/FC+ peer-reviewed journal publications and Appendix G for readership of articles published by FC/FC+. While metrics are only available for some FC/FC+ articles, these have been viewed more than 12,600 times. As noted in Section II, Objective 1, several FC+ publications have been highlighted in the MHTF Buzz and Blog (see Appendix F for detail).

Table 11: Peer-Reviewed Articles Published, FY13/14⁶

Authors	Title	Journal
Brazier E, Fiorentino R, Barry MS, Diallo M.	The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea.	Health Policy and Planning. 2014 Aug 22. [Epub ahead of print] http://heapol.oxfordjournals.org/content/early/2014/08/22/heapol.czu089.long
Brazier E, Fiorentino R, Barry MS, Kassé Y, Millimono S.	Rethinking How to Promote Maternity Care-Seeking: Factors Associated With Institutional Delivery in Guinea	Health Care for Women International. 2014, 35(7-9).
Landry E, Pett C, Fiorentino R,	Assessing the quality of record keeping for cesarean deliveries: results from a	BMC Pregnancy and Childbirth. 2014,

⁶ This table includes updates (e.g., print publication) for articles that were accepted prior to FY 2013/2014

Authors	Title	Journal
Ruminjo R and Mattison C	multicenter retrospective record review in five low-income countries.	14:139
Raassen TJ, Ngongo CJ, Mahendeka MM.	Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries.	International Journal of Urogynecology. 2014 Jul 26. [Epub ahead of print] http://link.springer.com/article/10.1007%2Fs00192-014-2445-3
Ruminjo JK, Frajzyngier V, Bashir Abdullahi M, Asiimwe F, et al.	Clinical procedures and practices used in the perioperative treatment of female genital fistula during a prospective cohort study.	BMC Pregnancy and Childbirth. 2014, 14:220
Ruminjo R, Landry E, Beattie K, Adamu I, Faisal AJ, Millimono S.	Mortality risk associated with surgical treatment of female genital fistula.	International Journal of Gynecology and Obstetrics. 2014 Apr 18. pii: S0020-7292(14)00194-5.
Tuncalp O, Isah A, Landry E, Stanton CK.	Community-based screening for obstetric fistula in Nigeria: a novel approach.	BMC Pregnancy and Childbirth. 2014, 14:44

In addition to the peer-reviewed publications in Table 11, FC+ staff co-authored the “Algorithm for Sexual and Gender-Based Violence” through the Chibok Girls Support Group in Nigeria.

FC+ Deputy Director Vandana Tripathi co-authored a commentary on measurement and estimation of the prevalence and incidence of fistula with co-authors at the World Health Organization and the Johns Hopkins Bloomberg School of Public Health, among others. This commentary, which was reviewed and approved by USAID, has been accepted for publication in the *Bulletin of the World Health Organization*.

A manuscript submitted to the *Lancet* on the results of the FC project RCT on the non-inferiority of shortened duration of catheterization after surgical repair is under revision. Authors responded to initial reviewer comments in May 2014, and received a second round of comments in September 2014 from an additional reviewer. Those comments were minor and the final reviewer suggested that the *Lancet* publish the manuscript. Revisions were made and responses sent in September 2014. A final decision is expected in the first quarter of FY14/15.

SECTION III: COUNTRY REPORTS

Please note: Updates are provided only for Objectives that countries actively addressed in FY 13/14.

Bangladesh

The first two quarters of the fiscal year focused on start-up activities, including the recruitment and orientation of four staff: a project manager and three project officers (see Table 1). In addition, sub-awards were developed for supported sites and are awaiting review and approval.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+ Bangladesh has been working closely with the Directorate General of Health Services (DGHS), UNFPA and the Obstetric and Gynecological Society of Bangladesh (OGSB) in the development and implementation of the National Strategy on Obstetric Fistula for 2013-2016. It was endorsed by the Ministry of Health and Family Welfare in January 2014. The first consultative meeting to develop the “Action Plan of National Strategy on Obstetric Fistula” was held in April 2014 at DGHS; a committee was formed for action plan development. A draft action plan was developed at the second consultative meeting later in April. The committee met a third time in July 2014 and the action plan is expected to be finalized at the next meeting.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Site assessments were carried out at five supported sites to gather baseline information and assess site capacity and programmatic needs, including integration of FP services with fistula care services: Ad-Din Dhaka, Ad-Din Jessore, Kumudini, LAMB, and Bangabandhu Sheikh Mujib Medical University (BSMMU).

During FY13/14, a total of 125 fistula repair surgeries were supported by the project at three private hospitals: Ad-Din Dhaka, Kumudini and LAMB (see Table BGD1 for detail by quarter). Repairs took place both through routine service provision and three concentrated repair efforts for complicated cases held at LAMB Hospital (2nd and 4th quarters) and Kumudini (4th quarter). Through efforts targeting corporate donors, the project has secured donations of drugs needed for repair surgeries from Nuvista Pharmaceuticals.

Table BGD1: Bangladesh USAID-Supported Fistula Repairs, by Site, FY 13/14.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
Ad-din Dhaka	3	9	3	15
Kumudini	13	8	7	28
LAMB	25	40	17	82
TOTAL	41	57	27	125

Six surgeons received training in fistula surgical repair during this fiscal year. One surgeon received initial training across the January-March and April-June quarters, and the remaining five received continuing training in advanced repair (see Table BGD2 for detail, by site).

Table BGD2: Bangladesh Surgical Fistula Repair Training, by Site, FY 13/14.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
LAMB	0	2	0	2
BSMMU/Kumudini	0	3	0	3
Ad-Din Dhaka	1	1	0	1 ⁷
TOTAL	1	6	0	6

As part of fistula prevention efforts, FC+ Bangladesh has provided training to 59 health care providers during the fiscal year. Trainings covered fistula patient identification and counseling and provision of long-acting and permanent contraception, including postpartum FP (see Table BGD3 for detail, by site).

Table BGD3: Bangladesh Non-Surgical Health System Personnel Training, by Site, FY 13/14.

Topic	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
Fistula counseling (Ad-Din Jessore)	0	0	52	52
FP (Mohammadpur Fertility Services & Training Centre)	0	0	7	7
TOTAL	0	0	59	59

Democratic Republic of Congo

Activity in the Democratic Republic of Congo (DRC) during FY13/14 to date has focused on negotiation and development of five sub-awards and their approval by the local USAID mission. The bulk of funds available for work in DRC are applied through sub-awards. Multiple meetings have been held with the PROSANI project, UNFPA, the MOH, and partner sites to ensure effective coordination and further this process.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

To promote policy level support for the national fistula strategy and coordination of activities that can support fistula prevention, DRC FC+ representative Michel Mpunga has attended all MoH Task Force meetings on maternal and neonatal health.

⁷ One surgeon from Ad-Din Dhaka participated in an initial training session that spanned the second and third quarters. While reported for each quarter, the surgeon is only counted once in the FY total.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

To increase public awareness of fistula prevention and treatment, FC+ worked with St. Joseph's Hospital in Kinshasa to organize a televised conference and debate on obstetric fistula. The interview featured Dr. Dolorès Nembunzu and was aired in May 2014, on the International Day to End Obstetric Fistula. In collaboration with the MOH, the National Sexual and Reproductive Health Department, USAID, and UNFPA, an event was held at St. Joseph's Hospital to listen to the radio broadcast and celebrate the work of Dr. Nembunzu and her team. The theme for the day as established by UNFPA was "Detect Fistula Cases and Transform Lives."

In early May, while in DRC, U.S. Secretary of State John Kerry visited St. Joseph's Hospital, an FC+-supported facility. During his remarks, Secretary Kerry stated,

"Fistula is a very debilitating, degrading, and unbelievably painful, horrible condition that seals the future of these young women. Many of these young women, unfortunately, are ostracized by their community, abandoned by their families and their husbands, and they are left to their own devices. And but for the extraordinary care that is provided in a place like St. Joseph's, these women would be lost."

The full transcript of Secretary Kerry's remarks about how fistula and the impact of FC+-supported activities in DRC is available here:

<http://www.state.gov/secretary/remarks/2014/05/225590.htm>.



(Left) U.S. Secretary of State John Kerry speaking at St. Joseph's Hospital in DRC, with fistula surgeon Dr. Dolorès Nembunzu.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

At the close of FY13/14, funds were not yet available through FC+ for support of fistula repairs

in DRC. In the fourth quarter, USAID supported 60 repairs through the PROSANI project in Kaziba.

FC+ has worked closely with Panzi Hospital and Panzi Foundation throughout the year. In addition to administrative and planning meetings, a meeting on “Behavior Change: Myth or Reality” took place in September 2014. FC+ also participated in the inauguration of Panzi Hospital’s Dorcas House 3 in the village of Bukavu. Dorcas House 3 will function as a transit and safety house for survivors of violence or those under long-or medium-term care for fistula and incontinence healing. While there, women receive literacy training and skills including small business management aimed at improving their livelihood. Women also receive continuous psychosocial and medical care, including group and individual therapy.

In addition to FC+ activities in DRC, EngenderHealth has embarked on a two year, \$3 million Bill and Melinda Gates Foundation (BMGF) grant project, Scaling Up Access and Use of Quality Implant Services. This FP project focuses on increasing access to quality hormonal implant services in a context of informed choice and volunteerism in Tanzania, DRC, and Uganda with a focus on training and support for providers.

West Africa/Niger

At the beginning of the project, the FC+ liaison at the USAID West Africa Mission, informed the project staff that it would continue to support activities in Niger, but no longer in Sierra Leone. In addition, he requested that the project consider how it might focus efforts on regional activities which is the mandate of the West Africa region. We have been discussing with EngenderHealth’s other USAID/West Africa supported initiative, Agir PF, how we might collaborate.

FC+ global staff supported the development of workplans and initial project activities in Niger while we recruited for staff members. A fulltime FC+ Project Officer was hired and began in the final quarter of FY13/14. Recruitment for an administrative assistant and an M&E Advisor are ongoing and these positions are expected to be filled in early FY14/15.

Over the course of FY13/14, project staff met regularly with MOH officials to identify priorities and plan activities. In-country partner Réseau pour l’Eradication des Fistules (REF) has planned quarterly coordination meetings, held at the Centre National de Reference pour la Fistule Obstétricale (CNRFO). Fistula-related questions adapted from project data collection tools and the DHS Fistula Module were incorporated into the AgirPF project baseline assessment survey, so that both projects will be able to benefit from baseline data in Niger. The EngenderHealth Niger Country Manager and FC+ global staff have held meetings in the Maradi and Tahoua regions to introduce the FC+ project to regional administrative and health authorities. This also provided opportunity to discuss, with local authorities and service delivery staff, needs for improving health system function and building capacity for fistula treatment and prevention.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+ has partnered with REF, particularly Dr. Souley who serves as its president and the General Director of Reproductive Health (DGSR), to move forward on updating the 2005-2009 National Strategy for Fistula Elimination. A subcommittee was formed in May 2014 to work on this topic. Meetings have been held under the direction of the DGSR to plan a FY 14/15 strategy revision workshop, with participation from FC+, UNFPA, CNRFO, the Division of Maternal and Child Health (DSME), and REF staff. The workshop will include national professional associations such as Société Africaine de Gynécologie et Obstétrique (SAGO) and Association des Sages-Femmes du Niger (ASFN).

FC+ and AgirPF staff have participated in activities working towards the institutionalization of fistula prevention, treatment, and reintegration services in Niger during FY13/14, including the launch of the national campaign to reduce maternal mortality in Tahoua in June 2014 and a celebration of Niger's National Women's Day in May 2014. In May 2014, the MOH and CNRFO organized a ceremony to commemorate the UNFPA International Day to End Obstetric Fistula; this was attended by the First Lady, Minister of Population, and representatives from local and international organizations.

FC+ is also working with REF and AgirPF to plan for a discussion of regional policy questions related to fistula services at the West African Health Organization (WAHO) meeting during FY14/15. REF will lead that meeting with the support of EngenderHealth and the FC+ project.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+ has begun working on a community engagement strategy that builds on the success of the FC project's work with community committees. As described in Section II, Objective 2, the FC+ Senior Technical Advisor for community engagement visited Niger in September 2014 to provide guidance and help carry out consultative discussions with regional and district partners in Maradi about planned community-level fistula prevention activities. FC+ has developed several tools on this topic including one that will help to select health facilities and communities for participation in fistula prevention activities in Madarounfa and Guidan Roumji. A total of 10 Centres de Santé Intégré (CSIs) and 25 communities have been selected. Other community engagement tools, including training for community cadres and the "Site Walk-Through" approach, have been adapted for the context of Maradi, based on partner consultations and findings from visits to Madarounfa and Guidan Roumji districts. The identification and training of community committee members is planned for the first quarter of FY14/15.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Site assessments were carried out by FC+ and REF at three supported facilities: Maradi, Tahoua and CNRFO. Findings from the assessments are to be finalized and distributed in the first quarter

of FY14/15. These assessments also provided the opportunity to present FC+ project objectives and expected results to regional health authorities and service delivery agents.

127 fistula repairs were carried out with FC+ support at two sites during FY13/14: CNRFO and Tahoua (see Table NGR1 for detail). UNFPA also provides support to some of the sites supported by FC+; therefore, REF coordinates which fistula repairs are reimbursed by each donor to ensure transparency and avoid double-counting. Dimol, a local NGO working on obstetric fistula identification and integration, has been a helpful partner in referring cases to CNRFO for repair.

Table NGR1: Niger USAID-Supported Fistula Repairs, by Site, FY 13/14.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
CNRFO	0	45	60	105
Tahoua	0	5	17	22
TOTAL	0	50	77	127

A training of trainers (ToT) in COPE for EmOC was conducted in with 14 trainers from Maradi, Tahoua and Niamey in the fourth quarter of FY13/14, This training, designed to strengthen fistula prevention, included gynecologists, midwives, registered nurses and a surgical assistant (see Table NGR2). In partnership with AgirPF, a ToT in facilitative supervision was conducted for 11 individuals from Tahoua, Maradi and Niamey which included doctors and a surgical assistant. TOTs for the district hospitals of Madarounfa and Guidan Roumji are planned for November 2014.

Table NGR2: Niger Non-Surgical Health System Personnel Training, by Topic, FY 13/14.

Topic	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
COPE for EmOC TOT (Maradi, CNRFO, Tahoua)	0	0	14	14
Facilitative Supervision TOT (Maradi, CNRFO, Tahoua)	0	0	11	11
TOTAL	0	0	25	25

AgirPF and FC+ are partnering to work with 10 selected health centers in Madarounfa and Guidan Roumji Health districts to ensure quality provision of FP services. Training of contraceptive technology trainers will begin in the first quarter of FY14/15 at the CNRFO, CME Tahoua, HD Guidan Roumji, and HD Madarounfa.

Nigeria

In Nigeria, FC+ supports activities in Bauchi, Cross River, Ebonyi, Jigawa, Kano, Katsina, Kebbi, Kwara, Oyo, Sokoto and Zamfara States. The first part of the fiscal year was focused on project start-up, including staff recruitment, preparation of the Abuja and Sokoto offices as well

as communication with relevant partners at federal and state levels on the new project. The Sokoto State Government has contributed office space in Sokoto free of charge (documented as FC+ cost share). Meetings have been ongoing with the USAID/Nigeria Mission to discuss and plan project activities, as well as develop workplans.

With the majority of project staff in place in the fourth quarter of FY 13/14, FC+ Nigeria began program implementation activities in earnest during the last quarter. There were several challenges to implementation in Nigeria during FY13/14. These included ongoing security issues in northeast regions, Ebola concerns (which were quickly contained), labor strikes by health workers, and the identification through site assessments of inadequate resources (human and material) at some planned supported facilities. While some of these are outside of the project's scope, FC+ is working to address the latter challenges through support to sites to ensure capacity building, develop stronger supply networks, and ensure adequate feeding for clients through advocacy and partnership with NGOs and philanthropists.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

On March 25, 2014, after several months of planning, the Ningi Fistula Center in Bauchi State was handed over from state to federal oversight and became an officially designated National Fistula Center. This was aided by extensive efforts of Bauchi State government, USAID/Nigeria and the previous FC project to expand fistula treatment and prevention services in Bauchi State through advocacy, training and facility upgrades. The project has repeatedly expressed its concern, however, that currently there is no resident fistula surgeon at the "Federal Center" and the center is reliant on pooled efforts by surgeons from other states. In addition, because federal funds have yet to be released to the center, the center is reliant upon donor funds to support fistula services. Project staff are negotiating with both federal and state ministries to ameliorate this situation.

FC+ Nigeria has been working with stakeholders at the national, state and local levels to advocate for more attention and provision of resources towards fistula prevention, treatment and reintegration efforts. The project has worked with the Federal Ministry of Health (FMOH), the National Obstetric Fistula Working Group (NOFWG), UNFPA and others to convene a meeting of the NOFWG. The meeting was attended by the Chairperson of the NOFWG, Mrs. Josephine Elechi (First Lady of Ebonyi State); representatives of the MOH; other development partners including UNFPA; facility managers from national fistula centers; and other stakeholders.

During this meeting, presentations included updates on the G-WINN project, activities carried out by development partners, and service data statistics from facility managers. FC+ updated the working group members on recommendations made at the 2013 international consultative forum on the use of catheter for prevention and treatment of fistula convened in Nigeria by the previous

FC project.⁸ FC+ has advocated for the adoption these recommendations, while recognizing that further research and careful M&E is needed to understand the effect of changed practices in real-world settings. In his closing remarks, Dr Wapada Balami, the Director of the Family Health (FHD) division of FMOH, assured participants that the treatment and prevention recommendations of the 2013 consultative forum were included in the new national guidelines for basic obstetric care and EmOC. Once FC+ Nigeria receives approval from the FMOH, the project will print copies of catheterization guidelines for distribution and use by health facilities. FC+ is also advocating for the review of the National Strategic Framework for Elimination of Obstetric Fistula in Nigeria 2011 – 2015 which will soon expire.

FC+ has also made visits to Jigawa and Bauchi states to visit state level health officials including the Honorable Commissioners for Health and for Health and Women's Affairs, representatives of hospital services management boards, primary health care directorates, and local directors of government affairs. In Jigawa state, agreement was reached on a memorandum of understanding to be drafted and signed regarding FC+ activities, and the Women Affairs Commissioner discussed a well-established and impressive grass roots structure: the Safe Motherhood Initiative for Demand Creation (SMDI), with which FC+ could effectively collaborate for community mobilization. In Bauchi, discussions included collaboration to support the newly established National Obstetric Fistula Center at Ningi, and advocacy for increased support from the state to ensure feeding of fistula clients at the center before and after fistula surgery.

FC+ has also reached out to other implementing partners in country to ensure that strategies are aligned and maximize collaboration opportunities. Efforts have included participation in a meeting of partners in Sokoto state to create a coordination platform for all USAID projects in the state to avoid duplication of efforts. Because FC+ plans to expand support for fistula services to Jahun Vesico Vaginal Fistula (VVF) center in Jigawa State, project staff arranged discussions with Médecins Sans Frontières (MSF) who currently have an agreement with the state to run the center and provide EmoC services. Agreement was reached in identifying areas where FC+ could provide needed support for which MSF lacks capacity, including training specific to fistula repair, provision of FP in and around the communities of Jahun, and rehabilitation/reintegration of fistula repair clients. Collaboration and discussions will continue.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+ Nigeria commenced consultations with community-based partners in order to understand how they fared during the transitional period between the previous FC project and FC+. Nigeria staff have also worked closely with the global team to develop and improve community engagement strategies. To this end, the FC+ community mobilization officer in Nigeria visited Niger to meet with the global FC+ Senior Technical Advisor for community engagement as well as discuss potentially beneficial exchange between the two countries. An orientation was

⁸ The full report of this meeting is available at: <http://www.fistulacare.org/pages/da/files/1/1.2/Catheterization-Fistula-Prevention-Meeting-Report-Nigeria.pdf>.

provided on community engagement and various community engagement tools and approaches. In particular, the site-walk-through approach was discussed in detail. FC+ Nigeria is currently reviewing the feasibility of adopting this approach in supported states.

Under the previous FC project, support was provided to various community mobilization and awareness activities through religious leaders from Sokoto, Kebbi and Zamfara states. The religious leaders acted as agents for change through community outreach events and played a key role in both mobilization of clients and reintegration of repaired clients back to their communities. FC+ Nigeria staff met with religious leaders from Sokoto and Kebbi states to discuss rejuvenating these religious leaders' community mobilization activities. Meetings indicated that the capacity building efforts of the FC project had successfully led to ownership of the activities by the religious leaders, and many of the activities had continued after the close out of the project. FC+ is now providing capacity-building support to the religious leaders as they collect and review their data to improve programmatic focus. FC+ also provides support to strengthen the informational content of their messaging for fistula and reproductive health education, preaching, and reconciliation activities. During the last quarter of FY13/14, eleven events reached over 10,500 people (see Table NGA1). FC+ will continue to engage the religious leaders to support and monitor their activities.

Table NGA1: Nigeria Community Outreach/Education Events, FY13/14

Type of Event	Jan-Mar 2014		Apr-Jun 2014		Jul-Sept 2014		Total FY13/14	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
RLAC Activities	0	0	0	0	11	10,682	11	10,682
Total	0	0	0	0	11	10,682	11	10,682

In addition to working directly with local communities, FC+ is focusing attention on collaborations with media outlets in order to maximize the reach of educational messaging throughout Nigeria. The project has held a meeting with Radio Nigeria (FRCN) Abuja to continue the fruitful collaboration initiated during the previous FC project. Together, FC+ and FRCN have agreed on allocations of time for the Health Watch Program, a weekly half hour radio program on health and fitness. FRCN Abuja has agreed to share 20% of the cost of airtime of any FC+ sponsored radio programs.

The project also organized a press release and press conference to coincide with the Providers Network Meeting (see Objective 4). As a result, three major newspapers featured four stories on fistula between August and September 2014, while the Nigerian Television Authority (NTA) aired the Providers Network Meeting.

In April 2014, the USAID Nigeria Mission requested that FC+ propose ways of alleviating the suffering of girls abducted by Boko Haram insurgents in Borno State, Northeast Nigeria. Global and country FC+ staff conducted exploratory visits and consulted with various experts in the areas of SGBV, producing a report for USAID/Nigeria. Among other things, FC+ proposed development of tools that would guide the management of victims of SGBV in Nigeria, plans to

support transport and treatment of women with genital injuries including fistula, and review of the current national protocol for managing SGBV in Nigeria. In May 2014, FC+ participated in a coalition of partners (called the Chibok Support Group) that expressed interest in supporting the girls abducted by Boko Haram. Some of these partners include UNFPA, FHI360, IPAS, WHO, UNICEF, UN WOMEN, Save the Children, PATHS 2, and NURHI. The coalition has held multiple meetings between May and September 2014. FC+ has developed and shared an algorithm for the provision of care, treatment and referral for survivors of SGBV. Partners are expected to make inputs and the final product will be adopted for use in Nigeria, with EngenderHealth providing training and printing posters of the algorithm for distribution to health facilities. FC+ will continue to participate in the Chibok Support Group meetings.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Site assessments were carried out in Sokoto, Kebbi, Jigawa and Bauchi states to assess human and material resources and facility conditions. Key findings included:

- Inadequate number of fistula surgical repair sets
 - Inadequate or erratic supply of essential medical supplies to support routine fistula repairs
 - Inadequate and broken instruments and equipment
 - Inadequate infrastructural upgrades
 - Inadequate number of health care workers, including doctors and nurses, in facilities
 - Inadequate monitoring, facilitative supervision, and service documentation
 - Knowledge gaps among providers in basic and comprehensive EmOC
 - Health care workers lack skills to diagnose urinary incontinence
- Eight of the 11 assessed facilities have skilled staff for routine repairs, while three (Ningi, Ogoja, and Jahun), rely entirely on pooled efforts to manage the backlog of fistula clients.

Key findings specifically related to FP include:

- All assessed facilities provide FP information to clients accessing fistula services.
- A variety of FP methods were readily and continuously available in all the facilities over the last two quarters.
- Facilities have a reasonable number of staff offering FP counseling and services, but most require formal training and knowledge updates. In particular, training is needed for counseling and infection prevention.
- None of the facilities had FP referral records available, indicating lack of functioning referral systems.
- Most facilities lack job aids and clear protocols for counseling, service provision and infection prevention.
- Data tools and collection are a source of frustration. Data collection is poorly harmonized, resulting in inadequate and inconsistent collection.
- There is a general lack of monitoring and supervision at facilities, resulting in serious concerns about poor standard of practice for both counseling and service delivery.

FC+ intends to address these gaps directly and through collaboration with state governments and partners. FC+ activities to address these findings at supported sites will include provision of training, including on facilitative supervision; establishment of clear protocols; and improvement of data capture. Additional assessments are planned for the first quarter of FY14/15.

Following the obligation and release of MCH funds in May 2014, FC+ commenced support for fistula repairs in some supported states. FC+ Nigeria supported 498 surgeries in 8 sites during FY13/14 (see Table NGA2 for details). These repairs were carried out through a mixture of routine services, outreach services, and pooled efforts.

Table NGA2: Nigeria USAID-Supported Fistula Repairs, by Site, FY 13/14⁹.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
Maryam Abatcha Women and Children's Hospital, Sokoto State	0	23	70	93
Gesse VVF Center, Birnin Kebbi, Kebbi State	0	25	30	55
University College Hospital, Ibadan State	0	15	0	15
National Obstetric Fistula Center, Abakaliki, Ebonyi State	0	47	24	71
Ogoja General Hospital, Cross River State	0	0	14	14
Laure VVF Center, Kano State	0	79	43	122
Faridat General Hospital, Gusau, Zamfara State	0	8	13	21
National Obstetric Fistula Center, Babbar Rugar, Katsina State	0	25	82	107
TOTAL	0	222	276	498

During the previous FC project, the Nigeria program had great success with pooled effort campaigns and the practice is continuing under FC+. This approach enables sites to provide a larger number of repairs by pooling together the efforts of multiple surgeons during a specific period of time. It also allows sites to provide access to surgeons with more advanced surgical repair skills. In the third quarter of FY13/14, FC+ met with the FMOH FHD Director and other staff to reach a common understanding regarding coordination of pooled effort fistula repairs initiated by FC+ and those initiated by the Fistula Desk through the federal government's Girls and Women in Nigeria (G-WINN) initiative. FC+ and FHD agreed to jointly plan these activities, inform each other about the time and venue of pooled efforts and supervision of the facilities. In addition, FC+ and FHD agreed to share work plans and to organize the next National Fistula Working Group meeting together.

FC+ had been proceeding with plans to support a pooled fistula repair effort initiated by the wife of the Gombe State Governor and Stephanie Okereke (a Nollywood actress and fistula advocate). However, these plans were postponed due to the deteriorating security situation in Gombe State. FC+ will restart these efforts when the security situation improves.

During the fourth quarter, a pooled effort took place at the request of Ogoja General Hospital during which four surgeons provided 14 repairs, with an additional four women receiving

⁹ Numbers of reported repairs for Nigeria have been amended from the third quarter report, based on updated field information.

conservative catheter treatment. FC+ had planned to support a pooled effort at Maryam Abacha during this period as well, but learned that UNFPA was already supporting a large fistula repair effort during this time. To avoid duplication of efforts, FC+ instead supported the facility with surgical supplies. Four surgeons (two visiting and two local) provided 56 repairs. A third pooled effort was planned for Ningi National Obstetric Fistula Center, however FC+ was unable to receive assurance that all clients would receive regular feeding during the pre and post-operative periods. These plans were postponed while FC+ engaged in advocacy to relevant stakeholders at local and state levels, as described above. FC+ expects to conduct the Ningi pooled effort in the first quarter of FY14/15.

FC+ has resumed convening annual Providers Network Meetings, as initiated under the previous FC project. These meetings have provided a forum where fistula professionals can come together to share experiences, learn new techniques, discuss challenges, and strategize on the way forward to ensure quality service delivery and coordination of activities to reduce both incidence and backlog of fistula cases. A Providers Network Meeting was held in September 2014 in Abuja, with participants from all supported sites, as well as representatives from state ministries of Health and Women Affairs, FMOH, FMWA, religious leaders, fistula advocates, media, and other implementing partners. This meeting also marked the official launch of FC+ in Nigeria.

In discussions with the USAID/Nigeria mission, FC+ has been asked to focus FP and maternal and child health efforts through support to selected sites in five priority states: Bauchi, Sokoto, Kogi, Ebonyi and Cross River. The project may also consider providing support state-wide, to all facilities providing FP services, in Cross River and Ebonyi states. In February 2014, FC+ participated in a Nigeria Family Planning Stakeholders Meeting held in Abuja and organized by the Health Policy Project. This meeting served to facilitate national coordination between stakeholders to invigorate FP advocacy in Nigeria and included providers and donor agencies. Outcomes included plans to scale up national task-shifting policy allowing Community Health Extension Workers (CHEWs) to provide injectables and involving health economists and the private sector to address cost issues.

During the fourth quarter, FC+ Nigeria's Family Planning Advisor participated at a stakeholders' consultation on Voluntary Family Planning, Rights and Choice in Uganda. The goal of this activity was to strengthen the focus of FP programs on clients' rights and choices and strengthen overall provision of services. FC+'s FY14/15 work plan incorporates the rights and choice concept and includes convening a workshop with federal and state-level stakeholders to introduce the EngenderHealth rights and choice framework and its operationalization.

Uganda

The FC+ Uganda team has focused on project start-up in FY 13/14, with orientation of new staff members, office relocation in July 2014 and the development of sub-awards with partners. MCH funds were received in May 2014. A sub-award with Kitovu Hospital was approved in the fourth

quarter. Planning meetings will be held among partners supporting fistula activities at Kitovu in the first quarter of FY14/15.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

On a policy level, FC+ Uganda has worked closely with the MOH to support meetings of the National Technical Working Group as it prepares to host the International Society of Obstetric Fistula Surgeons (ISOFS) and International Obstetric Fistula Working Group (IOFWG) meetings in October 2014.

In Uganda's FY14/15 (starting July 2014, during the first FC+ project year), the national government allocated funds specifically for fistula services for the first time; this support of \$50,000 USD targeted fistula repairs through camps at large hospitals.

FC+ also held a two-day stakeholders meeting in Hoima in March 2014. Participants reviewed health programs and collaborated to identify targets and activities for the fiscal year. The meeting was attended by all in-country implementing partners in the areas of maternal health and HIV/AIDS, the local council, district health teams, media representatives, and religious leaders.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

As part of initial efforts to develop and implement an effective community engagement strategy, an assessment was carried out in five FC+ supported sites in Masaka, Kalungu, and Hoima districts. The assessment was intended to determine their capacity and suitability to host community engagement interventions including the site walk-through and village health worker/team (VHT) approaches. At each site, a standard tool was used to collect basic data on the site's maternal health and FP services and caseloads, as well as to solicit feedback from the site staff on the level of collaboration with community leaders and VHTs in the catchment area. Information was also collected on the number of VHTs in the catchment area, their previous training, and their level of activity in health promotion. Data were also collected at the district level. The team explored perspectives and priorities with District Health Officers and available members of the district health management team. Based on the assessment, Buraru Health Centre IV has emerged as the best choice for initial activities.

Following the assessment, FC+ Uganda supported Hoima District Health Office to train 87 VHTs selected from 18 villages around Buraru HC III (see Table UGA1). The purpose of the training was to equip participants with knowledge and skills in promoting healthy practices during and after pregnancy and childbirth and to monitor maternal health care seeking behaviors and pregnancy outcomes in their communities. The VHTs will conduct community mobilization and home visiting activities to sensitize community members about a range of maternal health issues. They will also collect routine data on the number of people reached with maternal health messages and those referred to health facilities for services.

Through a new PPP, three radio stations agreed to donate air time for communications related to fistula services in Uganda.

Table UGA1: Uganda Community Volunteer/Educator Training, FY13/14

Type of Training	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Total FY13/14
Religious Leaders (Hoima)	0	27	0	27
VHT training (Bururu)	0	0	87	87
Total	0	27	87	114

A site walk-through event was also conducted at Bururu HC III (see Table UGA2) in which 63 community representatives participated in a guided tour of the health facility to learn about the health services provided and held discussions on quality improvement and mobilization of both resources and clients. Participants included district officials, health workers, local politicians, VHTs and satisfied clients.

Table UGA2: Uganda Community Outreach/Education Events, FY13/14

Type of Event	Jan-Mar 2014		Apr-Jun 2014		Jul-Sept 2014		Total FY13/14	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Site Walk-through (Bururu HCIII)	0	0	0	0	1	63	1	63
Total	0	0	0	0	1	63	1	63

FC+ also continued work with religious leaders doing community outreach initiated during the previous FC project. A refresher training was held for 27 clerics from the Anglican Church in Hoima and surrounding districts in June 2014 (see Table UGA1). This training addressed male involvement in maternal health, birth preparedness, attending antenatal care (ANC) at least four times during pregnancy, delivering at a health care facility, attending postnatal health care services, FP, avoiding the three delays that contribute to maternal mortality, and dispelling myths that contribute to poor maternal and infant outcomes. Participants were also able to share updates on progress made in implementing the action plans they developed at the end of the first training.

With private funds (cost share), in August 2014, EngenderHealth hosted a workshop entitled “Voluntary Family Planning: A Matter of Choice and Rights in Uganda. Participants included representatives from the Ministry of Health at national and district levels, as well as staff from FC+ (Uganda and Nigeria) and EngenderHealth’s BMGF-funded implants project. The objective of the workshop was to field test a contraceptive choice and human rights materials for which partial support had been provided through USAID’s global RESPOND project, also managed by EngenderHealth. The purpose was to promote universal access to voluntary FP by increasing awareness, understanding and action related to human rights and full, free and informed choice in FP programs. Two new tools were field-tested during this meeting: *Checkpoints for Choice: Orientation and Resource package* and *Voluntary Rights-based Family Planning Framework: Preliminary Users’ Guide*. The workshop was timely as it followed soon after Uganda’s first national FP conference (July 28-30, 2014) during which President Museveni announced a change in stance and endorsed planning as a key pillar to accelerating national social and economic transformation. Dr. Zainab Akol, the Principal Medical Officer for FP and RH in the Ministry of Health

actively participated in the EngenderHealth workshop. She said, “It is very vital to me as the lead person for FP in Uganda: we will review all national standards including training materials. I will be an advocate and train other advocates in choice and rights issues in health.” FC+ plans to implement action plans developed during the meeting in the next fiscal year.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Site assessments were conducted with technical support from an FC+ Senior Clinical Associate at Kamuli, Kagando, and Kitovu Mission Hospitals; Bwera Hospital; and Jinja, Masaka and Hoima Regional Referral Hospitals. At each of the hospitals, interviews were conducted with selected health managers and departmental heads and data were collected on fistula, FP, and maternal health services. The data collected are currently being analyzed and results will be used by FC+, the MOH and other partners to inform programmatic planning.

A total of 63 fistula repair surgeries were supported during FY13/14, all carried out at Hoima Hospital during the fourth quarter (Table UGA3). Additionally, one surgeon from Hoima initiated training in surgical fistula repair (Table UGA4). An individual donated commodities (soap) to support fistula repairs in Uganda.

Table UGA3: Uganda USAID-Supported Fistula Repairs, by Site, FY 13/14.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 3/14
Hoima	0	0	63	63
TOTAL	0	0	63	63

Table UGA4: Uganda Surgical Fistula Repair Training, by Site, FY 13/14.

Site	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
Hoima	0	0	1	1
TOTAL	0	0	1	1

FC+ Uganda has carried out several other trainings as part of efforts to increase site capacity to provide quality fistula prevention and treatment services. These trainings have reached 70 health care workers including nurses, midwives, counselors and laboratory workers and have focused on pre- and post-operative care, fistula counseling, infection prevention and FP integration (see Table UGA5). Pre- and post-operative care training covers a number of key issues including preparing the client for fistula surgery, catheter care, fluid intake, feeding, and pre-discharge counseling among others.

Table UGA5: Uganda Non-Surgical Health System Personnel Training, by Topic, FY 13/14.

Topic	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Total FY 13/14
Family Planning Integration (Kikube HC IV)	0	0	23	23
Fistula Counseling (Hoima)	0	0	12	12
Infection Prevention (Hoima)	0	0	18	18
Pre- and Post-Operative Care (Hoima)	0	0	17	17
TOTAL	0	0	70	70

In addition to FC+ activities, EngenderHealth conducted two additional notable efforts in Uganda in FY13/14: In collaboration with the Uganda MOH and with support from the William and Flora Hewlett Foundation and USAID, EngenderHealth convened a three and a half day workshop in August 2014 in Kampala under the theme “Voluntary Family Planning: A Matter of Choice and Rights. The purpose of the workshop was to promote universal access to voluntary FP in Uganda by increasing awareness, understanding and action related to human rights and full, free and informed choice in FP programs. A diverse group of government and non-government stakeholders from the FP and human rights communities attended, including FC+ staff. As noted above, EngenderHealth has also embarked on a BMGF project, Scaling Up Access and Use of Quality Implant Services. This project is working in Tanzania, DRC, and Uganda with a focus on training and support for providers.

APPENDIX A: FC+ PLANNED AND ACTUAL SUPPORTED TREATMENT AND PREVENTION SITES, BY COUNTRY

Country/Site	Sector	Planned FY13/14 T: Treatment & Prevention P: Prevention-only	Actual FY13/14
Bangladesh: 10 sites		7T, 3P	5T
Ad-Din Dhaka	Private	T	T
Ad-Din Jessore	Private	T	T
Kumudini Hospital	Private	T	T
LAMB Hospital	FBO	T	T
Bangabandhu Sheikh Mujib Medical University	Government	T	T
Noakhali Government Medical College Hospital	Government	T	
Kushtia Government Medical College Hospital	Government	T	
Moulvibazar District Hospital	Government	P	
Patuakhali District General Hospital	Government	P	
Cox's Bazar District Hospital	Government	P	
DRC: 5 sites		3T, 2P	3T, 2P
St. Joseph's Hospital/Satellite Maternity Kinshasa	FBO	T	T
Panzi Hospital	FBO	T	T
HEAL Africa	FBO	T	T
Imageri Des Grands-Lacs	Private	P	P
Maternité Sans Risque Kindu	Private	P	P
Niger: 5 sites		3T, 2P	3T, 2P
Centre Hospitalier Régional de Maradi	Government	T	T
Centre National de Référence des Fistules Obstétricales, Niamey	Government	T	T
Centre de la Sante de la Mère (CSME) et de l'Enfant de Tahoua	Government	T	T
Madarounfa District Hospital, Maradi	Government	P	P
Guidan Roumji District Hospital, Maradi	Government	P	P
Nigeria: 31 sites		12T, 19P	11T, 5P
General Hospital, Ningi	Government	T	
General Hospital, Ogoja	Government	T	T
MCH Ogoja	Government	P	
National Fistula Center, Abakaliki	Government	T	T
Ebonyi State University Teaching Hospital	Government	P	

Country/Site	Sector	Planned FY13/14 T: Treatment & Prevention P: Prevention-only	Actual FY13/14
Azuyiokwu PHC	Government	P	
Ezangbo Maternity Hospital	Government	P	
Mgbo PHC	Government	P	
Owutu Edda General Hospital	Government	P	
Agubia Cottage PHC	Government	P	
Laure VVF Center	Government	T	T
CHC Kumbotso	Government	P	
Taruani MCH	Government	P	
Takai MCH	Government	P	
Unguku MCH	Government	P	
Muhammadu Wase	Government	P	
National Fistula Center, Babbar Ruga, Katsina	Government	T	T
Gesse VVF Center, Birnin Kebbi	Government	T	T
General Hospital Argungu	Government	P	P
General Hospital Dakingari	Government	P	P
General Hospital Maiyama	Government	P	P
General Hospital Kamba	Government	P	P
General Hospital Jega	Government	P	P
Sobi Specialist Hospital, Ilorin	Government	T	T
Maryam Abatcha Women and Children's Hospital, Sokoto	Government	T	T
Faridat General Hospital, Gusau	Government	T	T
Bungudu General Hospital	Government	P	
Bakura General Hospital	Government	P	
University College Hospital, Ibadan	Government	T	T
Jahun VVF Center, Jigawa State	Government	T	T
Adeoyo General Hospital, Ibadan	Government	T	T
Uganda: 17 sites		3T, 14P	3T, 7P
Kitovu Mission Hospital	FBO	T	T
Kamuli Mission Hospital	FBO	T	T
Hoima Regional Referral Hospital	Government	T	T
Masaka Regional Referral Hospital	Government	P	P
Jinja Regional Referral Hospital	Government	P	P
Bwera General Hospital	Government	P	P
Kiyumba HC IV	Government	P	
Kyanamukaka HC IV	Government	P	

Country/Site	Sector	Planned FY13/14 T: Treatment & Prevention P: Prevention-only	Actual FY13/14
Kalungu HC III	Government	P	
Karambi HC IV	Government	P	
Nyabugando HC III	FBO	P	
Kigoroby HC IV	Government	P	
Azur HC III	FBO	P	
Bukoto HCIII	Government	P	P
Buseruka HCIII	Government	P	P
Kikuube HCIV	Government	P	P
Kagando Hospital	FBO	P	P
USAID Supported, Non Fistula Care Plus PROSANI (DRC) Kaziba HGR Katana HGR 13 periodic mobile outreach sites Hamlin Hospital (Ethiopia – TBD)	Government Government Government Private	16T (of which 13 periodic) T T T T	1T T
TOTAL FC+ = 5 Countries		28T, 40P = 68 sites	25T, 16P = 41 sites
TOTAL USAID supported, Non FC+ = 2 Countries		16T = 16 sites	1T = 1 site
TOTAL USAID supported, All sites = 6 countries		44T, 40P = 84 sites	26T, 16P = 42 sites

APPENDIX B: FC+ PRESENT AND PLANNED PARTNERSHIPS, BY COUNTRY

Country	Partners	Nature of Partnership
Bangladesh	Government of Bangladesh	
	Ministry of Health and Family Welfare (MOHFW)	Endorsement and dissemination of National Fistula Strategy and National Action Plan, Participation in National Task Force on Obstetric Fistula, Vouchers
	Directorate General of Health Services (DGHS)	National Task Force and Action Plan development, Government Medical College and District Hospitals, Partograph use, C-Section, Strengthening HMIS, Surgical training
	Directorate General of Family Planning (DGFP)	FP integration, Community outreach
	Ministry of Social Welfare (MOSW) and Ministry of Women and Children's Affairs (MCWC)	Reintegration, WDI
	Ministry of Local Government, Rural Development and Cooperatives (MOLGRD)	Community outreach
	Obstetrical and Gynecological Society of Bangladesh (OGSB)	Partograph use, C-Section
	UNFPA	National Task Force, Strengthening HMIS, policy
DRC	Bangladesh Rural Advancement Committee (BRAC) and NGO Health Delivery Service Program (NHSDP)	Community outreach
	Hope Foundation Hospital	Strengthening HMIS
	Grameen Phone	Public/Private partnerships
	Nuvista Pharmaceuticals	Public/Private partnerships
	Ministry of Health	Fistula prevention and treatment
	PROSANI	Fistula prevention and treatment
	Access to Primary Health Care Project (ASSP) (DFID)	Fistula treatment, Community outreach
Niger	UNFPA	Fistula prevention
	Ministry of Health	Coordination, strategy
	Centre National de Référence des Fistules Obstétricales (CRNFO)	Training, treatment and research
	Agir pour la Planification Familiale (AgirPF)	Fistula prevention, coordination
	UNFPA	Fistula prevention and treatment
Nigeria	Community committees	Community outreach
	Federal Ministry of Health	Coordination with G-WIN Initiative
	UNFPA	Coordination with ongoing activities

Country	Partners	Nature of Partnership
	Médecins Sans Frontières (MSF)	Referral and coordination
	Media, CBOs, Women's Groups, Ward Development Committees, Religious Leaders, Transport Unions. Traditional Rulers	Community outreach
	Population Council	Barriers to access
	National Obstetric Fistula Working Group	National fistula prevalence study
	Dimagi	mHealth application
	Radio Nigeria (FRCN)	Public-private partnerships
Uganda	Ministry of Health	Fistula prevention and treatment, National technical working groups
	Terrewode	Social reintegration, particularly with WDI
	AMREF	Fistula prevention and treatment
	Population Council	Barriers to access
	St. Mary's Hospital, Lacor	Fistula treatment
	Kitovu Mission Hospital	Fistula treatment
	Direct Relief International	Drugs and medical supplies
	UNFPA	Fistula prevention and treatment
	Village Health Teams, Religious groups, Women's groups	Community outreach
Radio stations	Public-private partnerships	

APPENDIX C: SUMMARY OF FC+ ANALYSIS OF MEDIA REPORTING OF BARRIERS TO FISTULA TREATMENT

Background Information

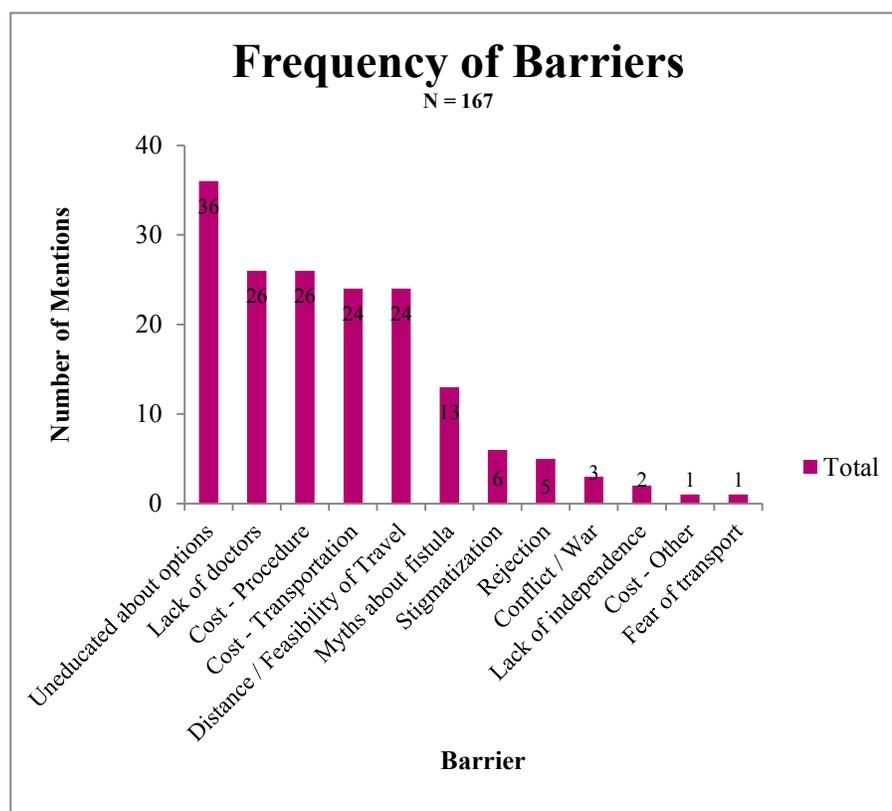
Database: LexisNexis Historical News Database

- Search terms
 - fistula treatment
 - fistula repair
 - fistula surgery
- Dates: 1/1/1990 – 7/22/2014
- Duplicate articles were excluded, as were press releases

Summary of Preliminary Findings

Total article count: 85 Total number of times a barrier was mentioned: 167 (some articles mentioned multiple barriers. The average was 2 barriers mentioned per article).

Country	# of articles
Ethiopia	12
Kenya	10
Uganda	10
Unspecified / Multiple	9
Tanzania	8
Pakistan	6
Nigeria	5
Liberia	3
Bangladesh	2
Madagascar	2
Mali	2
Nepal	2
Niger	2
Sierra Leone	2
South Sudan	2
Zambia	2
All other nations*	6
Grand Total	85



*Afghanistan, Cameroon, Cote d'Ivoire, Egypt, Rwanda and Senegal each had one article

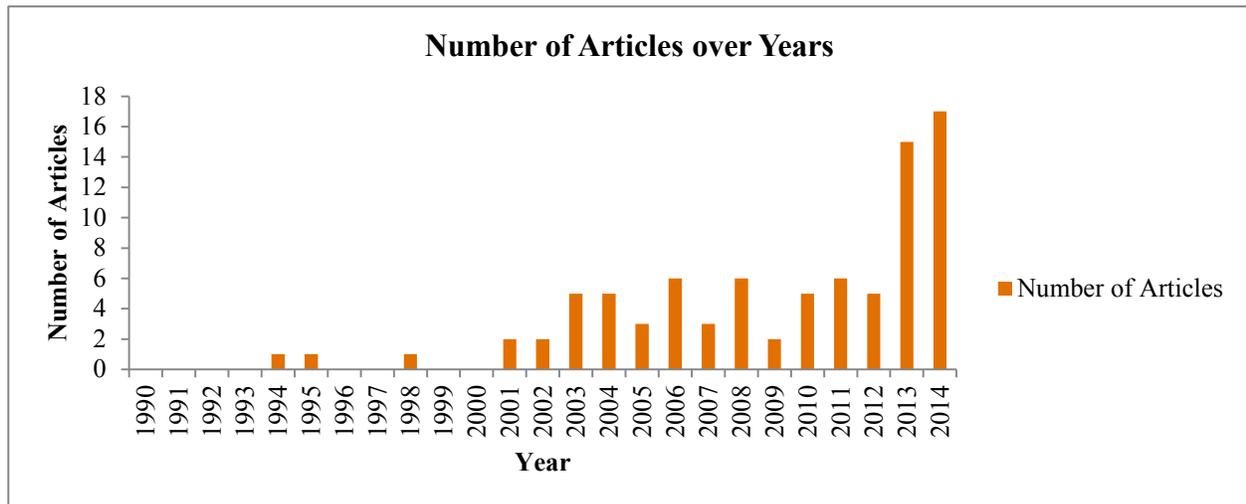
Barrier	Explanation
Uneducated about Options	Women were unaware that there was treatment for their condition or where to get treatment
Cost – Procedure	The cost of the actual surgery was prohibitive for women
Cost – Transportation	The cost of transport was prohibitive
Distance / Feasibility of Travel	Distance or logistical challenges (other than cost) prevented women from reaching treatment
Lack of Doctors	Lack of surgeons/facilities became a barrier once women arrived at a center
Myths about Fistula	Cultural myths about fistula dissuaded women from seeking treatment
Stigmatization	Used when the article specifically cited stigma as a barrier (did not include references to stigma being a quality of life issue, which was a much more common reference)
Rejection	Somewhat nebulous; used when the article described a woman being denied services (e.g., kicked off a bus or out of a medical center) because of her condition
Conflict / war	Conflict or war became a barrier to women seeking treatment
Lack of independence	Women could not seek treatment because, as women, they did not have the autonomy or independence to go decide to seek treatment
Cost – other	Some other type of indirect cost to the woman became a barrier (e.g., leaving her crops behind to die while she went to get treatment)
Fear of transport	Women were fearful of taking transit because of their incontinence

Examples of quotations:

- **Uneducated about options:** “I said, ‘why didn't you come before?’ She said ‘I thought I was not able to be cured’.” – Saving Women in Shame, Ethiopia, 1994
- **Cost – Transportation:** “It took us five months to get here because we have no money.” – Hospital a Beacon of Hope in a Ravaged Land, Ethiopia, 2002
- **Distance / Feasibility of Travel:** “One woman crawled almost 15km from her village to the hospital.” – From Despair to Dignity, Ethiopia, 2004
- **Cost –Procedure:** “Compounding the lack of resources is the \$353 price tag for surgery -- a grossly expensive amount for a country like Tanzania, where 60 per cent of the population survives on less than \$2.35 a day.” – An African Mother’s Agony, Tanzania, 2006
- **Lack of Doctors:** “Dr. Pollock says doctors there are unable to meet the demand for care. She cites one incident in Uganda, where a visiting doctor could only operate on 22 of the 200 women who had come for treatment before he had to leave” – UN Population Fund Draws Attention to Obstetric Fistula in African Women, Uganda, 2003
- **Myths about Fistula:** “They try to break down common myths, including that fistula is caused by witchcraft and cannot be treated medically,” said John Mulbah, lead surgeon with the LFP. Such beliefs have prevented many women from seeking treatment to date... They think the situation is due to a curse from their ancestors.” – Boost for Fistula Treatment in Liberia, Liberia, 2013

- **Rejection:** "She adds there are even some medical workers who tell patients that there are no doctors in Cameroon who can help and as such they should go and wait for death at home." – Many African Females at Risk of Obstetric Fistula, Cameroon, 2014
- **Stigmatization:** "Ms Ondeko cited stigmatization of fistula patients by society as one of the reasons most patients do not seek medical help " – Uganda Needs 100 Years to Clear Fistula Backlog, Uganda, 2014
- **Conflict / War:** "Destabilisation in the country has likely diminished access to the care needed to prevent fistula. Most of the patients at Man hospital came from areas formerly under control of the rebels, the Forces Nouvelles de Côte d'Ivoire. " – Growing Number of Women Presenting with Obstetric Fistula, Cote D'Ivoire, 2007
- **Lack of independence:** "[Women] lacked the resources and the autonomy to seek surgery." When Childbirth Leads to Disability and Despair, Kenya, 2013
- **Cost – Other:** "Recovering from her first fistula operation at the centre, Gounam Boukou Niafunke told IRIN her millet, gumbo and peanut crops died while she was in treatment." – When Surgery Cannot Heal Fistula Wounds, Mali, 2009
- **Fear of Transport:** "Most women with fistula require prior counselling and financial support because they fear to use public transport," says TERREWODE's Martha Ibeno." Hope for Fistula Sufferers, Uganda, 2006

Temporal Distribution of Articles



Fistula Type

- All 85 articles discussed Obstetric Fistula and prolonged/obstructed labor as the primary cause
- 5 articles (6% of all articles) mentioned Iatrogenic Fistulae
- 6 articles (7% of all articles) mentioned Traumatic Fistulae

Other notes:

- There were very few articles mentioning barriers between 1990 and 2001, with no articles at all found between 1990 and 1994; this may be due to LexisNexis's limitations or lack of interest/awareness about fistula among reporters

- “Myths about fistula” was surprisingly common, although it became hard at times to separate the “uneducated” category from “myths” category
- Many of the barriers were mentioned through anecdotes or quotes from women with fistula (i.e., all anecdotal evidence; no article quoted data or a study of the frequency of these barriers)
 - Some articles quoted staff from EngenderHealth, UNFPA, Fistula Foundation, and similar organizations when describing barriers (as would be expected)
- 2013 and 2014 had far more articles than any other year , likely due to the increased coverage of the International Day to End Obstetric Fistula, which began in 2013
- “Cost – Procedure” comments were often followed by information about aid groups, NGOs and government programs that were helping offset the cost of the procedure for women; this barrier is obviously already being alleviated more so than other barriers.

APPENDIX D: NUMBER OF USAID-SUPPORTED FISTULA REPAIR SURGERIES BY COUNTRY, SITE AND YEAR

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14
Africa Mercy															
Benin	NS	0	110	21	20	0	0	NS	NS	NS	NS	NS	151	NS	151
Ghana	63	0	0	0	0	0	0	NS	NS	NS	NS	NS	0	NS	63
Liberia	NS	59	0	0	0	0	0	NS	NS	NS	NS	NS	59	NS	59
Togo	NS	0	0	97	0	0	0	NS	NS	NS	NS	NS	97	NS	97
Total	63	59	110	118	20	0	0	NS	NS	NS	NS	NS	307	NS	370
Bangladesh															
Ad-Din Dhaka	NS	NS	NS	34	50	53	42	NS	3	9	3	15	179	15	194
Ad-Din Jessore	NS	NS	NS	2	1	25	48	NS	0	0	0	0	76	0	76
Kumudini Hospital	53	57	49	37	25	33	48	NS	13	8	7	28	249	28	330
Lamb Hospital	116	52	81	70	74	73	129	NS	25	40	17	82	479	82	677
Memorial Christian Hospital (MCH)	63	13	1	NS	0	0	NS	NS	NS	NS	NS	NS	14	NS	77
Total	232	122	131	143	150	184	267	NS	41	57	27	125	997	125	1,354
DRC															
HEAL Africa Hospital	268	200	214	210	163	288	264	NS	NS	NS	NS	NS	1339	NS	1,607

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14
Imagerie Des Grands-Lacs	NS	0	0	0	38	78	89	NS	NS	NS	NS	NS	205	0	205
Maternité Esengo de Kisenso	NS	NS	NS	NS	NS	NS	27	NS	NS	NS	NS	NS	27	NS	27
Maternite Sans Risque Kindu	NS	NS	NS	NS	35	151	82	NS	NS	NS	NS	NS	268	0	268
Mutombo	NS	NS	NS	NS	104	80	119	NS	NS	NS	NS	NS	303	NS	303
Panzi Hospital	371	134	268	262	180	500	567	NS	NS	NS	NS	NS	1911	0	2,282
St. Joseph	NS	NS	NS	NS	45	124	208	NS	NS	NS	NS	NS	377	0	377
DRC Bilaterals															
Project AXxes	NS	361	442	514	NS	NS	NS	NS	NS	NS	NS	NS	1317	NS	1,317
PS Kabongo	NS	NS	NS	NS	NS	50	0	NA	NA	NA	NA	NA	50	NA	50
PS Katako Kombe	NS	NS	NS	NS	NS	87	0	NA	NA	NA	NA	NA	87	NA	87
PS HGR Katana	NS	NS	NS	NS	NS	NS	50	NA	NA	NA	NA	NA	50	NA	50
PS Kaziba	NS	NS	NS	NS	NS	152	135	NA	NA	NA	60	60	287	60	347
PS Lodja	NS	NS	NS	NS	NS	82	0	NA	NA	NA	NA	NA	82	NA	82
PS Luiza	NS	NS	NS	NS	NS	28	0	NA	NA	NA	NA	NA	28	NA	28
PS Malemba Kulu	NS	NS	NS	NS	NS	60	0	NA	NA	NA	NA	NA	60	NA	60
PS Tshikaji	NS	NS	NS	NS	NS	49	0	NA	NA	NA	NA	NA	49	NA	49
PS Uvira	NS	NS	NS	NS	NS	13	37	NA	NA	NA	NA	NA	50	NA	50

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14
Total	639	695	924	986	565	1742	1,578	NS	NS	NS	60	60	6,490	60	7,189
Ethiopia¹⁰															
Arba Minch Hospital	NS	NS	NS	27	0	0	0	NA	NA	NA	NA	NA	27	NA	27
Bahir Dar Fistula Center	564	596	297	383	307	392	0	NA	NA	NA	NA	NA	1975	NA	2,539
Mekelle Center	NS	n/a	166	177	195	198	0	NA	NA	NA	NA	NA	736	NA	736
Total	564	596	463	587	502	590	0	NA	NA	NA	NA	NA	2,738	NA	3,302
Guinea															
Ignace Deen	193	63	49	20	NS	NS	0	NS	NS	NS	NS	NS	132	NS	325
Jean Paul II	NS	36	88	126	144	185	90	NS	NS	NS	NS	NS	669	NS	669
Kissidougou	298	130	148	132	193	189	173	NS	NS	NS	NS	NS	965	NS	1263
Labe	NS	NS	31	114	122	123	132	NS	NS	NS	NS	NS	522	NS	522
Mercy Ships training repairs	NS	NS	NS	NS	NS	NS	25	NS	NS	NS	NS	NS	25	NS	25
Total	491	229	316	392	459	497	420	NS	NS	NS	NS	NS	2,313	NS	2,804
Mali															
Gao Regional Hospital	NS	NS	46	40	91	53	0	NS	NS	NS	NS	NS	230	NS	230

¹⁰ Repairs in Ethiopia performed at Hamlin Fistula Hospitals with direct support from USAID/Ethiopia.

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14
Kayes Hospital	NS	NS	NS	NS	NS	NS	70	NS	NS	NS	NS	NS	70	NS	70
Mopti	NS	NS	NS	NS	NS	NS	20	NS	NS	NS	NS	NS	20	NS	20
Sikasso	NS	NS	NS	NS	NS	NS	140	NS	NS	NS	NS	NS	140	NS	140
Total	NS	0	46	40	91	53	230	NS	NS	NS	NS	NS	460	NS	460
Niger															
Dosso Regional Hospital	NS	17	15	22	41	21	13	NS	NS	NS	NS	NS	129	NS	129
Guidan Roumji District Hospital, Maradi	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	0	0	NS	0	0
Lamorde Hospital (Niamey)	27	70	84	129	173	110	92	NS	NS	NS	NS	NS	658	NS	685
Madarounfa District Hospital, Maradi	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	0	0	NS	0	0
Maradi Regional Hospital	NS	123	59	63	67	45	65	NS	NS	NS	0	0	422	0	422
National Maternity Center, Niamey	NS	NS	NS	NS	NS	NS	80	NS	NS	NS	NS	NS	80	NS	80
National Obstetric Fistula Center, Niamey	NS	NS	NS	NS	NS	NS	NS	NS	NS	45	60	105	NS	105	105
Tahoua	NS	NS	NS	6	52	33	44	NS	NS	5	17	22	135	22	157

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14
Tera District Hospital	NS	3	NS	NS	0	0	0	NS	NS	NS	NS	NS	3	NS	3
Zinder	NS	NS	NS	NS	NS	NS	79	NS	NS	NS	NS	NS	79	NS	79
Total	27	213	158	220	333	209	373	NS	NS	50	77	127	1,506	127	1,660
Nigeria															
National Obstetric Fistula Centre Abakaliki	NS	NS	189	330	268	277	316	NS	NS	47	24	71	1,380	71	1,451
Babbar Ruga Hospital (Katsina)	356	536	331	359	330	416	359	NS	NS	25	82	107	2,331	107	2,794
Faridat Yakubu General Hospital (Zamfara)	180	150	187	115	114	116	126	NS	NS	8	13	21	808	21	1,009
General Hospital Ogoja (Cross River State)	NS	0	0	0	NS	114	50	NS	NS	0	14	14	164	14	178
UTH Ibadan	NS	NS	NS	NS	NS	NS	37	NS	NS	15	0	15	37	15	52
Gesse VVF Center ¹¹ (Kebbi)	102	122	151	207	216	215	152	NS	NS	25	30	55	1,063	55	1,220
Laure Fistula Center at Murtala Mohammed	339	473	337	265	379	288	313	NS	NS	79	43	122	2,055	122	2,516

¹¹ Formerly known as the Kebbi Fistula Center.

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14						
Specialist Hospital (Kano)															
Maryam Abacha Women's and Children's Hospital (Sokoto)	104	156	152	200	137	138	132	NS	NS	23	70	93	915	93	1,112
Ningi General Hospital (Bauchi)	NS	0	0	0	63	78	74	NS	NS	NS	0	0	215	0	215
Other	NS	0	0	136	0	43	0	NS	NS	NS	NS	NS	179	NS	179
Sobi General Hospital (Kwara State)	NS	0	0	0	0	35	21	NS	NS	NS	0	0	56	0	56
Total	1,081	1,437	1,347	1,612	1,507	1,720	1,580	NS	NS	222	276	498	9,203	498	10,782
Rwanda															
CHUK	100	36	51	126	109	4	9	NS	NS	NS	NS	NS	335	NS	435
Kanombe Hospital	NS	NS	14	48	38	55	35	NS	NS	NS	NS	NS	190	NS	190
Kibogora	NS	NS	NS	NS	NS	21	0	NS	NS	NS	NS	NS	21	NS	21
Ruhengeri	192	47	102	85	131	34	4	NS	NS	NS	NS	NS	403	NS	595
Total	292	83	167	259	278	114	48	NS	NS	NS	NS	NS	949	NS	1,241
Sierra Leone															
Aberdeen	272	363	253	166	211	244	115	NS	NS	NS	NS	NS	1,352	NS	1,624

	Pre-FC	Fistula Care						Fistula Care Plus					TOTALS		
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14 Dec 13 - Sep 14					FC Total	FC+ Total	Grand Total
Country/Site	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY 08-13	FY 14-18	FY 05-14						
Total	272	363	253	166	211	244	115	NS	NS	NS	NS	NS	1,352	NS	1,624
Uganda															
Hoima	NS	NS	NS	NS	NS	184	102	NS	NS	NS	63	63	286	63	349
Kagando / Bwera	253	118	85	206	363	143	237	NS	NS	NS	NS	NS	1,152	NS	1,405
Kitovu / Masaka	604	192	183	243	248	190	183	NS	NS	NS	NS	NS	1,239	NS	1,843
Total	857	310	268	449	611	517	522	NS	NS	NS	63	63	2,677	63	3,597
Overall Total	4,518	4,107	4,183	4,972	4,727	5,870	5,133	NS	41	329	503	873	28,992	873	34,383
EngenderHealth	3,315	2,816	3,278	3,871	4,225	4,759	4,911	NS	41	329	443	813	23,860	813	27,988
Bilaterals	1,203	1,291	905	1,101	502	1,111	222	NA	NA	NA	60	60	5,132	60	6,395

NA= Data not available NS= Site not supported

APPENDIX E: FC/ FC+ PEER REVIEWED PUBLICATIONS¹²

I. Published

- Arrowsmith SD, Ruminjo J, Landry EG. Current practices in treatment of female genital fistula: a cross sectional study. *BMC Pregnancy Childbirth*. 2010 Nov 10;10:73.

BACKGROUND: Background: Maternal outcomes in most countries of the developed world are good. However, in many developing/resource-poor countries, maternal outcomes are bleaker: Every year, more than 500,000 women die in childbirth, mostly in resource-poor countries. Those who survive often suffer from severe and long-term morbidities. One of the most devastating injuries is obstetric fistula, occurring most often in south Asia and sub-Saharan Africa. Fistula treatment and care are available in many countries across Africa and Asia, but there is a lack of reliable data around clinical factors associated with the success of fistula repair surgery. Most published research has been retrospective. While these studies have provided useful information about the care and treatment of fistula, they are limited by the design. This study was designed to identify practices in care that could lead to the design of prospective and randomized controlled trials. **METHODS:** Self-administered questionnaires were completed by 40 surgeons known to provide fistula treatment services in Africa and Asia at private and government hospitals. The questionnaire was divided into three parts to address the following issues: prophylactic use of antibiotics before, during, and after fistula surgery; urethral catheter management; and management practices for patients with urinary incontinence following fistula repair. **RESULTS:** The results provide a glimpse into current practices in fistula treatment and care across a wide swath of geographic, economic, and organizational considerations. There is consensus in treatment in some areas (routine use of prophylactic antibiotics, limited bed rest until the catheter is removed, nonsurgical treatment for postsurgical incontinence), while there are wide variations in practice in other areas (duration of catheter use, surgical treatments for postsurgical incontinence). These findings are based on a small sample and do not allow for recommending changes in clinical care, but they point to issues for possible clinical trial research that would contribute to more efficient and effective fistula care. **CONCLUSIONS:** The findings from the survey allowed us to consider clinical practices most influential in the cost, efficacy, and safety of fistula treatment. These considerations led us to formulate recommendations for eight randomized controlled trials on the following subjects: 1) Efficacy/safety of short-term catheterization; 2) efficacy of surgical and nonsurgical therapies for urinary incontinence; 3) technical measures during fistula repair to reduce the incidence of post-surgery incontinence; 4) identification of predictive factors for "incurable fistula"; 5) usefulness of urodynamic studies in the management of urinary incontinence; 6) incidence and significance of multi-drug resistant bacteria in the fistula population; 7) primary management of small, new fistulas by catheter drainage; and 8) antibiotic prophylaxis in fistula repair.

- Arrowsmith SD, Barone MA, Ruminjo J. Outcomes in obstetric fistula care: a literature review. *Curr Opin Obstet Gynecol*. 2013 Oct;25(5):399-403.

PURPOSE OF REVIEW: To highlight the lack of consistency in the terminology and indicators related to obstetric fistula care and to put forward a call for consensus. **RECENT FINDINGS:** Recent studies show at least some degree of statistical correlation between outcome and the following clinical factors: degree of scarring/fibrosis, fistula location, fistula size, damage to the urethra, presence of circumferential fistula, bladder capacity, and prior attempt at fistula repair. **SUMMARY:** Consensus about basic definitions of clinical success does not yet exist. Opinions vary widely about the prognostic parameters for success or failure. Commonly agreed upon definitions and outcome measures will help ensure that site reviews are accurate and conducted fairly. To properly compare technical innovations with existing methods, agreement must be reached on definitions of success. Standardized indicators for mortality and morbidity associated with fistula repair will improve the evidence base and contribute to quality of care.

- Barone MA, Frajzyngier V, Arrowsmith S, Ruminjo J, Seuc A, Landry E, Beattie K, Barry TH, Lewis A, Muleta M, Nembunzu D, Olupot R, Sunday-Adeoye I, Wakasiaka WK, Widmer M, Gülmezoglu AM. Non-inferiority of short-term urethral catheterization following fistula repair surgery: study protocol for a randomized controlled trial. *BMC Womens Health*. 2012 Mar 20;12:5.

¹² This summarizes all peer-reviewed publications throughout the life of both the FC and FC+ projects.

BACKGROUND: A vaginal fistula is a devastating condition, affecting an estimated 2 million girls and women across Africa and Asia. There are numerous challenges associated with providing fistula repair services in developing countries, including limited availability of operating rooms, equipment, surgeons with specialized skills, and funding from local or international donors to support surgeries and subsequent post-operative care. Finding ways of providing services in a more efficient and cost-effective manner, without compromising surgical outcomes and the overall health of the patient, is paramount. Shortening the duration of urethral catheterization following fistula repair surgery would increase treatment capacity, lower costs of services, and potentially lower risk of healthcare-associated infections among fistula patients. There is a lack of empirical evidence supporting any particular length of time for urethral catheterization following fistula repair surgery. This study will examine whether short-term (7 day) urethral catheterization is not worse by more than a minimal relevant difference to longer-term (14 day) urethral catheterization in terms of incidence of fistula repair breakdown among women with simple fistula presenting at study sites for fistula repair service. **METHODS/DESIGN:** This study is a facility-based, multicenter, non-inferiority randomized controlled trial (RCT) comparing the new proposed short-term (7 day) urethral catheterization to longer-term (14 day) urethral catheterization in terms of predicting fistula repair breakdown. The primary outcome is fistula repair breakdown up to three months following fistula repair surgery as assessed by a urinary dye test. Secondary outcomes will include repair breakdown one week following catheter removal, intermittent catheterization due to urinary retention and the occurrence of septic or febrile episodes, prolonged hospitalization for medical reasons, catheter blockage, and self-reported residual incontinence. This trial will be conducted among 512 women with simple fistula presenting at 8 study sites for fistula repair surgery over the course of 24 months at each site. **DISCUSSION:** If no major safety issues are identified, the data from this trial may facilitate adoption of short-term urethral catheterization following repair of simple fistula in sub-Saharan Africa and Asia. **TRIAL REGISTRATION:** ClinicalTrials.gov Identifier NCT01428830.

- Barone MA, Frajzyngier V, Ruminjo J, Asiimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Lynch M, Mussell F, Podder DC. Determinants of postoperative outcomes of female genital fistula repair surgery. *Obstetrics and Gynecology*. 2012 Sep;120(3):524-31.

OBJECTIVE: To determine predictors of fistula repair outcomes 3 months postsurgery. **METHODS:** We conducted a multicountry prospective cohort study between 2007 and 2010. Outcomes, measured 3 months postsurgery, included fistula closure and residual incontinence in women with a closed fistula. Potential predictors included patient and fistula characteristics and context of repair. Multivariable generalized estimating equation models were used to generate adjusted risk ratios (RRs) and 95% confidence intervals (CIs). **RESULTS:** Women who returned for follow-up 3-month postsurgery were included in predictors of closure analyses (n=1,274). Small bladder size (adjusted RR 1.57, 95% CI 1.39-1.79), prior repair (adjusted RR 1.40, 95% CI 1.11-1.76), severe vaginal scarring (adjusted RR 1.56, 95% CI 1.20-2.04), partial urethral involvement (adjusted RR 1.36, 95% CI 1.11-1.66), and complete urethral destruction or circumferential defect (adjusted RR 1.72, 95% CI 1.33-2.23) predicted failed fistula closure. Women with a closed fistula at 3-month follow-up were included in predictors of residual incontinence analyses (n=1,041). Prior repair (adjusted RR 1.37, 95% CI 1.13-1.65), severe vaginal scarring (adjusted RR 1.35, 95% CI 1.10-1.67), partial urethral involvement (adjusted RR 1.78, 95% CI 1.27-2.48), and complete urethral destruction or circumferential defect (adjusted RR 2.06, 95% CI 1.51-2.81) were significantly associated with residual incontinence. **CONCLUSION:** The prognosis for genital fistula closure is related to preoperative bladder size, previous repair, vaginal scarring, and urethral involvement.

- Brazier E, Fiorentino R, Barry MS, Diallo M. The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea. *Health Policy and Planning Health Policy Plan*. 2014 Aug 22. pii: czu089. [Epub ahead of print]

BACKGROUND: This paper presents results from a community-level intervention that promoted use of maternal health services as a means of preventing obstetric fistula. Implemented in the Republic of Guinea, the intervention aimed to build the capacity of community-level committees to heighten awareness about maternal health risks and to promote use of professional maternal health services. **METHODS:** Data were collected through a population-based survey. A total of 2,335 women of reproductive age were interviewed, including 878 with a live birth or stillbirth since the launch of the intervention. An index of community capacity was created to explore the effect of living in a community with strong community-level resources and support for maternal health. Other composite variables were created to measure the content of women's antenatal counseling and their individual exposure to maternal health

promotion activities at the community level. Multivariate logistic regression was used to explore the effect of community capacity and individual exposure variables on women's use of antenatal care (≥ 4 visits), institutional delivery, and care for complications. RESULTS: Women living in communities with a high score on the community capacity index were more than twice as likely as women in communities with low score to attend at least four ANC visits, to deliver in a health facility, and to seek care for perceived complications. CONCLUSIONS: Building the capacity of community-level cadres to promote maternity care-seeking by women in their villages is an important complement to facility-level interventions to increase the availability, quality, and utilization of essential health services.

- Brazier E, Fiorentino R, Barry S, Kasse Y, Millimono S. Rethinking how to promote maternity care-seeking: factors associated with institutional delivery in Guinea. *Health Care Women Int.* 2014 Sep;35(7-9):878-95.

This paper presents findings from a study on women's delivery care-seeking in two regions of Guinea. We explored exposure to interventions promoting birth preparedness and complication readiness among women with recent live births and stillbirths. Using multivariate regression models, we identified factors associated with women's knowledge and practices related to birth preparedness, as well as their use of health facilities during childbirth. We found that women's knowledge about preparations for any birth (normal or complicated) was positively associated with increased preparation for birth, which itself was associated with institutional delivery. Knowledge about obstetric risks and danger signs, was not associated with birth preparation or with institutional delivery. The study findings highlight the importance of focusing on preparation for all births—and not simply obstetric emergencies—in interventions aimed at increasing women's use of skilled maternity care.

- Frajzyngier V, Ruminjo J, Asimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Lynch M, Mussell F, Podder DC, Barone MA. Factors influencing choice of surgical route of repair of genitourinary fistula, and the influence of route of repair on surgical outcomes: findings from a prospective cohort study. *BJOG.* 2012 Oct;119(11):1344-53.

OBJECTIVE: The abdominal route of genitourinary fistula repair may be associated with longer-term hospitalisation, hospital-associated infection and increased resource requirements. We examined: (1) the factors influencing the route of repair; (2) the influence of the route of repair on fistula closure 3 months following surgery; and (3) whether the influence of the route of repair on repair outcome varied by whether or not women met the published indications for abdominal repair. DESIGN: Prospective cohort study. SETTING: Eleven health facilities in sub-Saharan Africa and Asia. POPULATION: The 1274 women with genitourinary fistula presenting for surgical repair services. METHODS: Risk ratios (RRs) and 95% confidence intervals (95% CIs) were generated using log-binomial and Poisson (log-link) regression. Multivariable regression and propensity score matching were employed to adjust for confounding. MAIN OUTCOME MEASURES: Abdominal route of repair and fistula closure at 3 months following fistula repair surgery. RESULTS: Published indications for abdominal route of repair (extensive scarring or tissue loss, genital infibulation, ureteric involvement, trigonal, supratrigonal, vesico-uterine or intracervical location or other abdominal pathology) predicted the abdominal route [adjusted risk ratio (ARR), 15.56; 95% CI, 2.12-114.00]. A vaginal route of repair was associated with increased risk of failed closure (ARR, 1.41; 95% CI, 1.05-1.88); stratified analyses suggested elevated risk among women meeting indications for the abdominal route. CONCLUSIONS: Additional studies powered to test effect modification hypotheses are warranted to confirm whether the abdominal route of repair is beneficial for certain women.

- Frajzyngier V, Ruminjo J, Barone MA. Factors influencing urinary fistula repair outcomes in developing countries: a systematic review. *Am J Obstet Gynecol.* 2012 Oct;207(4):248-58.

We reviewed literature examining predictors of urinary fistula repair outcomes in developing country settings, including fistula and patient characteristics, and perioperative factors. We searched Medline for articles published between January 1970 and December 2010, excluding articles that were (1) case reports, cases series or contained 20 or fewer subjects; (2) focused on fistula in developed countries; and (3) did not include a statistical analysis of the association between facility or individual-level factors and surgical outcomes. Twenty articles were included; 17 were observational studies. Surgical outcomes included fistula closure, residual incontinence after closure, and any incontinence (dry vs wet). Scarring and urethral involvement were associated with poor prognosis across all outcomes. Results from randomized controlled trials examining prophylactic antibiotic use and repair outcomes

were inconclusive. Few observational studies examining perioperative interventions accounted for confounding by fistula severity. We conclude that a unified, standardized evidence-base for informing clinical practice is lacking.

- Frajzyngier V, Li G, Larson E, Ruminjo J, Barone MA. Development and comparison of prognostic scoring systems for surgical closure of genitourinary fistula. *Am J Obstet Gynecol*. 2013 Feb;208(2):112.e1-11.

OBJECTIVE: The purpose of this study was to test the diagnostic performance of 5 existing classification systems (developed by Lawson, Tafesse, Goh, Waaldijk, and the World Health Organization) and a prognostic scoring system that was derived empirically from our data to predict fistula closure 3 months after surgery. **STUDY DESIGN:** Women with genitourinary fistula (n = 1274) who received surgical repair services at 11 health facilities in sub-Saharan Africa and Asia were enrolled in a prospective cohort study. Using one-half of the sample, we created multivariate generalized estimating equation models to obtain weighted prognostic scores for components of each existing classification system and the empirically derived scoring system. With the second one-half, we developed receiver operating characteristic curves using the prognostic scores and calculated areas under the curves (AUCs) and 95% confidence intervals (CIs) for each system. **RESULTS:** Among existing systems, the scoring systems that represented the World Health Organization, Goh, and Tafesse classifications had the highest predictive accuracy: AUC, 0.63 (95% CI, 0.57-0.68); AUC, 0.62 (95% CI, 0.57-0.68), and AUC, 0.60 (95% CI, 0.55-0.65), respectively. The empirically derived prognostic score achieved similar predictive accuracy (AUC, 0.62; 95% CI, 0.56-0.67); it included significant predictors of closure that are found in the other classification systems, but contained fewer, nonoverlapping components. The differences in AUCs were not statistically significant. **CONCLUSION:** The prognostic values of existing urinary fistula classification systems and the empirically derived score were poor to fair. Further evaluation of the validity and reliability of existing classification systems to predict fistula closure is warranted; consideration should be given to a prognostic score that is evidence-based, simple, and easy to use.

- Landry E, Pett C, Forentino R, Ruminjo J, Mattison C. Assessing the quality of record keeping for cesarean deliveries: results from a multicenter retrospective record review in five low-income countries. *BMC Pregnancy and Childbirth*. Under review. Requested revisions submitted.

BACKGROUND: Reliable, timely information is the foundation of decision making for functioning health systems; the quality of decision making rests on quality data. Routine monitoring, reporting, and review of cesarean section (CS) indications, decision-to-delivery intervals, and partograph use are important elements of quality improvement for maternity services. **METHODS:** In 2009 and 2010, a sample of CS delivery records from calendar year 2008 was reviewed at nine facilities in Bangladesh, Guinea, Mali, Niger, and Uganda. Data from patient records and hospital registers were collected on key aspects of care (e.g., timing of key events, indications, partograph use, maternal and fetal outcomes). Qualitative interviews were conducted with key informants at all study sites. **RESULTS:** A total of 2,941 records were reviewed. Fifty-seven key informant interviews were conducted to learn about record-keeping practices. Patient record-keeping systems were of varying quality across study sites: at five sites, more than 20% of records could not be located. Across all sites, patient files were missing key aspects of CS delivery care: timing of key events (e.g., examination, decision to perform CS), administration of prophylactic antibiotics, maternal complications, and maternal and fetal outcomes. Rates of partograph use were disappointingly low at six sites: 0 to 23.9% of patient files at these sites had a completed partograph on file, and among those found, 2.1% to 65.1% were completed correctly. Information on fetal outcomes was missing in up to 40% of patient files. **CONCLUSIONS:** Deficits in CS patient record data quality across a broad range of health facilities in low-resource settings in four sub-Saharan Africa countries and Bangladesh indicate an urgent need to improve record keeping.

- Landry E, Frajzyngier V, Ruminjo J, Asiimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Kanoma B, Lynch M, Mussell F, Podder DC, Wali A, Mielke E, Barone MA. Profiles and experiences of women undergoing genital fistula repair: findings from five countries. *Glob Public Health*. 2013;8(8):926-42.

This article presents data from 1354 women from five countries who participated in a prospective cohort study conducted between 2007 and 2010. Women undergoing surgery for fistula repair were interviewed at the time of admission, discharge, and at a 3-month follow-up visit. While women's experiences differed across countries, a similar picture emerges across countries: women married young, most were married at the time of admission, had little education, and for many, the fistula occurred after the first pregnancy. Median age at the time of fistula occurrence was 20.0 years (interquartile range 17.3-26.8). Half of the women attended some antenatal care (ANC);

among those who attended ANC, less than 50% recalled being told about signs of pregnancy complications. At follow-up, most women (even those who were not dry) reported improvements in many aspects of social life, however, reported improvements varied by repair outcome. Prevention and treatment programmes need to recognise the supportive role that husbands, partners, and families play as women prepare for safe delivery. Effective treatment and support programmes are needed for women who remain incontinent after surgery.

- Longombe AO, Claude KM, Ruminjo J. Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies. *Reprod Health Matters*. 2008 May;16(31):132-41.

The Eastern region of the Democratic Republic of Congo (DRC) is currently undergoing a brutal war. Armed groups from DRC and neighbouring countries are committing atrocities and systematically using sexual violence as a weapon of war to humiliate, intimidate and dominate women, girls, their men and communities. Armed combatants take advantage with impunity, knowing they will not be held to account or pursued by police or judicial authorities. A particularly inhumane public health problem has emerged: traumatic gynaecological fistula and genital injury from brutal sexual violence and gang-rape, along with enormous psychosocial and emotional burdens. Many of the women who survive find themselves pregnant or infected with STIs/HIV with no access to treatment. This report was compiled at the Doctors on Call for Service/Heal Africa Hospital in Goma, Eastern Congo, from the cases of 4,715 women and girls who suffered sexual violence between April 2003 and June 2006, of whom 702 had genital fistula. It presents the personal experiences of seven survivors whose injuries were severe and long-term, with life-changing effects. The paper recommends a coordinated effort amongst key stakeholders to secure peace and stability, an increase in humanitarian assistance and the rebuilding of the infrastructure, human and physical resources, and medical, educational and judicial systems.

- Ngongo C, Christie K, Holden J, Ford C, Pett C. Striving for excellence: nurturing midwives' skills in Freetown, Sierra Leone. *Midwifery*. 2013 Oct;29(10):1230-4.

Midwives provide critical, life-saving care to women and babies. Effective midwives must be clinically competent, with the required knowledge, skills, and attitudes to provide quality care. Their success depends on an environment of supportive supervision, continuing education, enabling policies, and access to equipment and referral facilities. In Freetown, Sierra Leone, the Aberdeen Women's Centre launched a maternity unit with an emphasis on striving for excellence and providing ongoing professional development to its staff midwives. Its success was built upon fostering a sense of responsibility and teamwork, providing necessary resources, conforming to evidence-based standards, and building partnerships. An explicit philosophy of care was crucial for guiding clinical decision making. In its first two years of operation, the Aberdeen Women's Centre assisted 2076 births with two maternal deaths and 92 perinatal deaths. In-service education and supportive supervision facilitated the midwives' professional growth, leading to capable future leaders who are providing exemplary care to delivering mothers and their newborns in Freetown.

- Raassen TJ, Ngongo CJ, Mahendeka MM. Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries. *Int Urogynecol J*. 2014 Jul 26. [Epub ahead of print]

INTRODUCTION: Genitourinary fistula poses a public health challenge in areas where women have inadequate access to quality emergency obstetric care. Fistulas typically develop during prolonged, obstructed labor, but providers can also inadvertently cause a fistula when performing obstetric or gynecological surgery. **METHODS:** This retrospective study analyzes 805 iatrogenic fistulas from a series of 5,959 women undergoing genitourinary fistula repair in 11 countries between 1994 and 2012. Injuries fall into three categories: ureteric, vault, and vesico-[utero]/-cervico-vaginal. This analysis considers the frequency and characteristics of each type of fistula and the risk factors associated with iatrogenic fistula development. **RESULTS:** In this large series, 13.2% of genitourinary fistula repairs were for injuries caused by provider error. A range of cadres conducted procedures resulting in iatrogenic fistula. Four out of five iatrogenic fistulas developed following surgery for obstetric complications: cesarean section, ruptured uterus repair, or hysterectomy for ruptured uterus. Others developed during gynecological procedures, most commonly hysterectomy. Vesico-[utero]/-cervico-vaginal fistulas were the most common (43.6%), followed by ureteric injuries (33.9%) and vault fistulas (22.5%). One quarter of women with iatrogenic fistulas had previously undergone a laparotomy, nearly always a cesarean section. Among these women, one quarter had undergone more than one previous cesarean section. **CONCLUSIONS:** Women with previous cesarean sections are at increased risk

for iatrogenic injury. Work environments must be adequate to reduce surgical error. Training must emphasize the importance of optimal surgical techniques, obstetric decision-making, and alternative ways to deliver dead babies. Iatrogenic fistulas should be recognized as a distinct genitourinary fistula category.

- Ruminjo JK, Frajzyngier V, Bashir Abdullahi M, Asiimwe F, Hamidou Barry T, Bello A, Danladi D, Oumarou Ganda S, Idris S, Inoussa M, Lynch M, Mussell F, Chandra Podder D, Wali A, Barone MA. Clinical procedures and practices used in the perioperative treatment of female genital fistula during a prospective cohort study. *BMC Pregnancy Childbirth*. 2014 Jul 5;14:220.

BACKGROUND: Treatment and care for female genital fistula have become increasingly available over the last decade in countries across Africa and South Asia. Before the International Federation of Gynaecology and Obstetrics (FIGO) and partners published a global fistula training manual in 2011 there was no internationally recognized, standardized training curriculum, including perioperative care. The community of fistula care practitioners and advocates lacks data about the prevalence of various perioperative clinical procedures and practices and their potential programmatic implications are lacking. **METHODS:** Data presented here are from a prospective cohort study conducted between September 2007 and September 2010 at 11 fistula repair facilities supported by Fistula Care in five countries. Clinical procedures and practices used in the routine perioperative management of over 1300 women are described. **RESULTS:** More than two dozen clinical procedures and practices were tabulated. Some of them were commonly used at all sites (e.g., vaginal route of repair, 95.3% of cases); others were rare (e.g., flaps/grafts, 3.4%) or varied widely depending on site (e.g. for women with urinary fistula, the inter-quartile range for median duration of post-repair bladder catheterization was 14 to 29 days). **CONCLUSIONS:** These findings show a wide range of clinical procedures and practices with different program implications for safety, efficacy, and cost-effectiveness. The variability indicates the need for further research so as to strengthen the evidence base for fistula treatment in developing countries.

- Ruminjo R, Landry E, Beattie K, Isah A, Faisal AJ, Millimono S. Mortality risk associated with surgical treatment of female genital fistula. *International Journal of Gynecology and Obstetrics*. 2014 Apr 18. pii: S0020-7292(14)00194-5.

OBJECTIVE: Most surgeries proceed without incident, but all major surgeries have inherent risks for adverse events, including death. Some deaths are attributable to the condition requiring surgery, concurrent morbidity, or the surgery itself. For fistula treatment, published literature on mortality risk is extremely limited. This article describes the mortality risk associated with surgical treatment of female genital fistula and the contributory and contextual factors. **METHODS:** Confidential inquiries and clinical audits were conducted at 14 fistula repair sites in seven resource-poor countries. Data collection included interviews with key personnel involved in the clinical management of the deceased and a review of hospital records and client files following an audit protocol. **RESULTS:** Thirty deaths occurred from 26,060 fistula repair surgeries from 2005 to 2013, 21 attributable to surgery; the case fatality was 0.08 per 100 procedures. The causes of death for nearly half of the cases were various manifestations of sepsis and inflammation. **CONCLUSIONS:** This case fatality rate for fistula repair surgery is in the same range as comparable gynecologic operations in high-resource settings. Clinical and systemic issues should be addressed to minimize chances of recurrence, improve perioperative care and follow-up, assure prudent referral or deferral of difficult cases, and maintain better records.

- Ruminjo J. 2007. Obstetric fistula and the challenge to maternal health care systems. *IPPF Medical Bulletin* 41(4):3-4. [COMMENTARY – NO ABSTRACT]
- Tunçalp Ö, Isah A, Landry E, Stanton CK. Community-based screening for obstetric fistula in Nigeria: a novel approach. *BMC Pregnancy Childbirth*. 2014 Jan 24;14:44.

BACKGROUND: Obstetric fistula continues to have devastating effects on the physical, social, and economic lives of thousands of women in many low-resource settings. Governments require credible estimates of the backlog of existing cases requiring care to effectively plan for the treatment of fistula cases. Our study aims to quantify the backlog of obstetric fistula cases within two states via community-based screenings and to assess the questions in the Demographic Health Survey (DHS) fistula module. **METHODS:** The screening sites, all lower level health facilities, were selected based on their geographic coverage, prior relationships with the communities and availability of fistula surgery facilities in the state. This cross-sectional study included women who presented for fistula screenings at study facilities based on their perceived fistula-like symptoms. Research assistants administered

the pre-screening questionnaire. Nurse-midwives then conducted a medical exam. Univariate and bivariate analyses are presented. RESULTS: A total of 268 women attended the screenings. Based on the pre-screening interview, the backlog of fistula cases reported was 75 (28% of women screened). The backlog identified after the medical exam was 26 fistula cases (29.5% of women screened) in Kebbi State sites and 12 cases in Cross River State sites (6.7%). Verification assessment showed that the DHS questionnaire had 92% sensitivity, 83% specificity with 47% positive predictive value and 98% negative predictive value for identifying women afflicted by fistula among women who came for the screenings. CONCLUSIONS: This methodology, involving effective, locally appropriate messaging and community outreach followed up with medical examination by nurse-midwives at lower level facilities, is challenging, but represents a promising approach to identify the backlog of women needing surgery and to link them with surgical facilities.

II. In press/under review/in draft

- Barone M, Widmer M, Arrowsmith S, Ruminjo J, Seuc A, Landry E, Hamidou Barry T, Danladi D, Djangnikpo L, Gbawuru-Mansaray T, Harou I, Lewis A, Muleta M, Nembunzu D, Olupot R, Sunday-Adeoye I, Wakasiaka WK, Landoulsi S, Delamou A, Were L, Frajzyngier V, Beattie K, A Gülmezoglu AM. 7 day bladder catheterization is not inferior to 14 day catheterization following repair of female genital fistula: a randomized controlled, non-inferiority trial. *Lancet*. Under review. Requested revisions submitted.

BACKGROUND: Duration of bladder catheterization after female genital fistula repair varies widely. We aimed to establish whether 7 day bladder catheterization was not inferior to 14 days in terms of incidence of fistula repair breakdown among women with simple fistula. METHODS: We conducted a non-inferiority randomized controlled trial at eight hospitals in eight African countries. Women with a simple fistula that was closed after surgery and that remained closed until postoperative day 7 were eligible. Participants were randomized in a 1:1 ratio to 7 or 14-day bladder catheterization. The primary outcome was fistula repair breakdown, based on dye test results, any time after day 7 after catheter removal up to 3 months post-surgery. Secondary outcomes included: repair breakdowns at 7 days after catheter removal or thereafter, urinary retention on day 1, 3 and/or 7 after catheter removal; infections and febrile episodes potentially related to the treatment; catheter blockage; prolonged hospitalization; and residual incontinence at 3 months. The trial is registered with ClinicalTrials.gov, Identifier NCT01428830. FINDINGS: 524 participants were randomized and followed up between January 2012 and August 2013; 261 in the 7-day group and 263 in the 14-day group. The analysis population included 250 participants in the 7-day group and 251 in the 14-day group. There was no significant difference in the rate of fistula repair breakdown between the groups (risk difference 0.8%; 95% CI -2.8-4.5). There were no significant differences in the secondary outcomes between the groups. INTERPRETATION: 7 day bladder catheterization after repair of simple fistula was non-inferior to 14 day catheterization. It is safe and effective for managing women following repair of simple fistula without a significant increased risk of repair breakdown, urinary retention or residual incontinence through 3 months after surgery.

- Landry E, Pett C, Forentino R, Ruminjo J, Mattison C. Determining the feasibility of a cesarean indication classification system from a retrospective record review in five countries. *BMC Reproductive Health*. Request for revisions received, under discussion.

BACKGROUND: Cesarean section (CS) rates continue to rise around the world, raising concerns about the under and overuse of this life saving procedure. While CS audits may be carried out in many countries, there is no internationally accepted standardized classification system for CS. Indication based classification systems can help answer the question about why the CS was performed and these data are generally available in maternity wards. Regular review of cesarean indication trends at the facility level is recommended as a useful indicator to monitor the appropriate use of CS for valid clinical reasons. Regular review of indications could assist in understanding why CS rates are changing. The objective of this study is to assess the feasibility of applying the Immpact/International Federation of Gynecology and Obstetrics (FIGO) classification system, using indication data from a retrospective records review. METHODS: A multicenter retrospective record review of CS that took place in 2008 was carried out at nine facilities in five countries between 2009 and 2010. A total of 2,941 cesarean delivery records were reviewed. The Immpact/FIGO classification system based on absolute maternal and nonabsolute indication categories was applied retrospectively to the primary indication data. Key informant interviews were conducted with 57 hospital staff. RESULTS: Ninety-nine percent of all records reviewed had at least one indication recorded. None of the sites were using any formally documented CS classification system. A wide range of terminology to describe CS indications was found in patient records. Applying the Immpact/FIGO classification, CS performed for absolute

maternal indications ranged from 11.1% to 81.6%, while CS for nonabsolute indications ranged from 17.3% to 62.9%. Key informants were unanimous that CS records need to include a clearly documented, standardized indication in order to facilitate clinical audit. Most providers interviewed at the study sites thought that this system seemed feasible to implement because of its relative simplicity. CONCLUSION: While the key informants were positive about feasibility of implementing the Immpact/FIGO classification, the practicality is unclear given the wide range of terminology utilized by providers across sites. This analysis highlights the potential challenges for reaching agreement on standardized indications.

- Ngongo C, Levin K, Landry E, Sutton I, Ndizeye S. What to measure and why? Experience developing and using novel monitoring indicators in maternal health: the case of obstetric fistula. *Global Health Science and Practice*. Revision submitted in response to editorial comments.

The field of obstetric fistula has historically lacked common definitions for measuring outcomes. This paper recounts the process of developing, refining, and using standardized monitoring indicators and approaches as part of a fistula prevention and repair project working in fourteen countries. The process included the development and refinement of clinical indicators, the introduction of standardizing data collection and reporting at partner health facilities, building capacity to use data for decision making locally, nationally, and within the project, institutionalizing data review meetings and partner health facilities, and supporting the introduction of fistula treatment indicators into national Health Management Information Systems to enable continued measurement and support for fistula treatment services. As monitoring in the field of obstetric fistula continues to become more standardized and routine, the multi-country scope of the project enabled a wide-ranging effort through which indicators for a “new” maternal health content area were developed and applied. This experience provides lessons for other initiatives seeking to strengthen monitoring and reporting related to novel or emerging topics in maternal health services.

- Tunçalp O, Tripathi V, Landry E, Stanton CK, Ahmed S. Measurement of Fistula: What does the future hold? *Bulletin of the World Health Organization*. Accepted; in press. [COMMENTARY - NO ABSTRACT]

APPENDIX F: DISSEMINATION OF FC+ RESEARCH AND EVIDENCE THROUGH THE MATERNAL HEALTH TASK FORCE, FY13/14

FC+ articles highlighted in the Maternal Health Buzz

- *April 22, 2014 Issue:* Assessing the quality of record-keeping for cesarean deliveries: Results from a multicenter retrospective record review from five low-income countries
- *August 29, 2014 Issue:* Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries
- *September 24, 2014 Issue:* Rethinking How to Promote Maternity Care-Seeking: Factors Associated With Institutional Delivery in Guinea

FC+ posts in the Maternal Health Blog

- January 7, 2014. No author.
<http://www.mhtf.org/2014/01/07/usaids-announces-new-award-to-prevent-and-repair-obstetric-fistula/>
- May 29, 2014. Bethany Cole, Global Projects Manager, FC+.
<http://www.mhtf.org/2014/05/29/connecting-fistula-care-and-the-manifesto-for-maternal-health/>
- July 24, 2014. Mary Nell Wegner, Executive Director, MHTF.
<http://www.mhtf.org/2014/07/24/obstetric-fistula-technical-meeting-convened-by-maternal-health-task-force-and-engender-health/>
- July 25, 2014. Vandana Tripathi, Deputy Director, FC+.
<http://www.mhtf.org/2014/07/25/experts-gather-to-discuss-new-methods-for-measuring-obstetric-fistula/>
- August 13, 2014. Carrie Ngongo, Field Projects Manager, FC+.
<http://www.mhtf.org/2014/08/13/obstetric-fistulas-caused-by-medical-intervention-more-common-than-we-may-think/>

APPENDIX G: FC/FC+ PUBLICATION METRICS

FIRST AUTHOR	TITLE	VIEWS	JOURNAL	PUB YEAR
Arrowsmith S	Current practices in treatment of female genital fistula: a cross sectional study	5993	BMC Pregnancy and Childbirth	2010
Arrowsmith S	Outcomes in obstetric fistula care: a literature review	n/a	Current Opinion in Obstetrics and Gynecology	2013
Barone M	Determinants of postoperative outcomes of female genital fistula repair surgery	n/a	Obstetrics and Gynecology	2012
Barone M	Non-inferiority of short-term urethral catheterization following fistula repair surgery: study protocol for a randomized controlled trial	2728	BMC Women's Health	2012
Brazier E	The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea	n/a	Health Policy and Planning	2014
Brazier E	Rethinking how to promote maternity care-seeking: Factors associated with institutional delivery in Guinea	n/a	Health Care for Women International	2014
Frajzyngier V	Factors influencing choice of surgical route of repair of genitourinary fistula, and the influence of route of repair on surgical outcomes: findings from a prospective cohort study	11	BJOG	2012
Frajzyngier V	Factors influencing urinary fistula repair outcomes in developing countries: a systematic review	n/a	American Journal of Obstetrics and Gynecology	2012
Frajzyngier V	Development and comparison of prognostic scoring systems for surgical closure of genitourinary fistula	n/a	American Journal of Obstetrics and Gynecology	2013
Landry E	Profiles and experiences of women undergoing genital fistula repair: findings from five countries	622	Global Public Health	2013
Landry E	Assessing the quality of record keeping for cesarean deliveries: results from a multicenter retrospective record review in five low-income countries	1283	BMC Pregnancy and Childbirth	2014
Longombe A	Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies	n/a	Reproductive Health Matters	2008
Ngongo C	Striving for excellence: nurturing midwives' skills in Freetown, Sierra Leone	n/a	Midwifery	2013
Raassen T	Iatrogenic genitourinary fistulas: An 18-year retrospective review of 801 iatrogenic injuries	n/a	International Journal of Urogynecology	2014
Ruminjo J	Obstetric fistula and the challenge to maternal health care systems	n/a	IPPF Medical Bulletin	2007
Ruminjo J	Mortality risk associated with surgical treatment of female genital fistula	n/a	International Journal of Gynecology and Obstetrics	2014
Ruminjo J	Clinical procedures and practices used in the perioperative treatment of female genital fistula during a prospective cohort study	1213	BMC Pregnancy and Childbirth	2014
Tuncalp O	Community-based screening for obstetric fistula in Nigeria: a novel approach	1247	BMC Pregnancy and Childbirth	2014
	TOTAL	12,682		

NOTE: Metrics available for 7 of the 18 published articles, as of September 30, 2014.

APPENDIX H: FC+ PLANNED PRESENTATIONS AT THE ISOFS 5TH SCIENTIFIC CONFERENCE

ISOFS 5 th Scientific Conference Kampala, Uganda 29 – 31 October, 2014				
Wednesday 29 October, 2014				
PRESENTATION TIME	SESSION TIME	SESSION TITLE	PRESENTATION TITLE	PRESENTER
11:24–11:32am	11:00am–1:00pm	Parallel Oral Session 1B: Policy and Program 1	Rural radio: a media used to raise awareness among women in the community regarding fistula care at Saint Joseph Hospital in Kinshasa, Democratic Republic of Congo	Dolores Nembunzu
11:32–11:40am	11:00am–1:00pm	Parallel Oral Session 1A: Treatment 1	Complications Risk Associated With Surgical Treatment of Female Genital Fistula	Joseph Ruminjo
Thursday 30 October, 2014				
9:56–10:04am	8:00–10:30am	Plenary 3	Mortality Monitoring Metrics in a Fistula Program: Development of standardized approaches and tools	Joseph Ruminjo
10:12–10:20am	8:00–10:30am	Plenary 3	Socio-demographic and Clinical Profile of Fistula Cases Treated at the National Fistula Centre, Bangladesh	SK Nazmul Huda
11:45am–1:00pm	11:00am–1:00pm	End Fistula Campaign and Fistula Research to Practice	Fistula Research to Practice: RCT on non-inferiority of short term postoperative bladder catheterization: 1. Presentation: Development of a research agenda- history, priority setting, collaborations and consensus building 2. Presentation: Research protocol and rationale for approaches 3. Discussion: Research protocol and rationale for approaches 4. Presentation: Study results, conclusions and implications; 5. Discussion: Study results, conclusions and implications; 6. Discussion: Opportunities for individual champions, institutions and professional associations to move. 7. Discussion Research to Practice; Next steps.	Mark Barone
2:00–2:08pm	2:00–4:00pm	Parallel Session 2B: Programs/advocacy	Community Radios may play a role in prevention of Obstetric Fistula and stigma elimination and social reintegration of Fistula cases	SK Nazmul Huda
2:40–2:48pm	2:40–2:48pm	Programs/advocacy	Opportunities for integration of Fistula Services with Micro-Credit Program: Experience of Ad-Din Foundation; Bangladesh.	Farhana Akhter
Friday 31 October, 2014				
12:20–12:45pm	8:00am – 1:30pm	Research Methods Workshop	Fistula research: Proceedings of the consultative meeting on Research prioritization and measurement.	Karen Beattie

APPENDIX I: FC+ TALKING POINTS - THE BURDEN OF FISTULA AND MEASURING FISTULA PREVALENCE

I. Global prevalence

A. Key talking/messaging point:

- *"While global prevalence numbers are difficult to establish, it is estimated that 1-2 million women are affected around the world."*
- Citations:
 - Adler AJ, Ronsmans C, Calvert C, Filippi V. Estimating the Prevalence of Obstetric Fistula: A Systematic Review and Meta-Analysis. BMC pregnancy and childbirth. 2013;13(246).
 - In: C.J. Murray, A.D. Lopez (Eds.), Health dimensions of sex and reproduction: the global burden of sexually transmitted diseases and HIV, maternal conditions, perinatal disorders and congenital anomalies, Global Burden of Disease and Injury Series, vol. 3, Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Cambridge, MA, USA (1998)

B. Background:

- Earlier UN estimates of global prevalence (2 million cases) were based on estimates of obstructed labor, provider estimates, country reports, and other sources of information.
- The 2013 Adler et al. estimates of global prevalence (1 million) were based on a meta-analysis of a small number of studies, most of which did not generate national estimates. According to the authors, the analysis is heavily weighted by data from Ethiopia. There are questions about the validity of the global estimate.
- Challenges in estimation of fistula burden are well summarized by Stanton et al.
 - Citation: Stanton C, Holtz SA, Ahmed S. Challenges in measuring obstetric fistula. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics. 2007;99 Suppl 1:S4-9. Epub 2007/09/04.

II. Global incidence

A. Key talking/messaging point:

- *"New fistula cases occur each year, and at current levels of global fistula repair capacity the backlog of women living with fistula continues to grow annually."*

B. Background:

- 2003 UN estimates of global incidence (50-100,000, point estimate 73,000) were based on estimates of obstructed labor and likelihood of fistula occurring in such cases.
 - Citation: AbouZahr C. Global burden of maternal death and disability. Br Med Bull. 2003;67:1-11.
- The 2013 Adler et al. estimates (6,000) are based on even less data than the prevalence numbers; the authors themselves are very cautious about this number.

III. Challenges with household surveys to measure fistula prevalence

A. Key talking/messaging points:

- *It is not recommended that household surveys exclusively focused on fistula be conducted, as they are not cost-effective and not likely to generate information that is useful for planning, organizing, and locating fistula services.*
- *It is recommended that a rigorous validation study be conducted to identify a sensitive and specific interview-based diagnostic tool for use in future surveys of maternal morbidity including obstetric fistula.*

B. Background:

The Fistula Care *Plus* (FC+) Project and the Maternal Health Task Force held a technical consultation on measurement was held in July 2014 with experts (surgeons, epidemiologists, demographers, DHS). An internal report was circulated to FC+ staff in August. This report included a presentation on the challenges of household surveys, as well as an Appendix including recommendations for future measurement/estimation activities. Among the main points:

- Household surveys are a popular way to try to get information about fistula prevalence.
- However, they face several important challenges:
 - High cost and poor input/output ratio
 - Results may not provide information to plan and locate services – usually so few cases are identified that only national estimates can be made.
 - Non-standardized interview/survey tools
 - Wide range of questions
 - Wide-range of sensitivity/specificity (as assessed by % of suspected cases that are clinically confirmed)
 - No tools, including the DHS module have been validated
 - Possible over-estimation
 - If questions identify conditions that could be other types of incontinence
 - Possible under-estimation:
 - Because many surveys exclude women under 15 and over 49
 - Because many surveys exclude women who are not in a household (e.g., isolated in community, in shelter/waiting home)
 - Useful references:
 - Jokhio A, Rizvi R, Rizvi J, Macarthur C. Prevalence of obstetric fistula: a population-based study in rural Pakistan. *BJOG*. 2014 Mar 31. [Epub ahead of print]
 - Muleta M, Fantahun M, Tafesse B, Hamlin EC, Kennedy RC. Obstetric fistula in rural Ethiopia. *East Afr Med J*. 2007 Nov;84(11):525-33.
 - Tunçalp Ö, Isah A, Landry E, Stanton CK. Community-based screening for obstetric fistula in Nigeria: a novel approach. *BMC Pregnancy Childbirth*. 2014 Jan 24;14:44.

APPENDIX J: FC+ SAMPLE DHIS2 DATA COLLECTION SCREEN

Data Entry

Ad-Oni Dhaka (BD001) - July - September 2014 - Number of "urinary and RVF" repairs (default)

Organisation Unit	Ad-Oni Dhaka (BD001)
Data Set	FC+ FTrack
Period	July - September 2014 <input type="button" value="Prev year"/> <input type="button" value="Next year"/>
Filter on section	Show all sections

<input type="button" value="Run validation"/>
<input type="button" value="Print form"/>
<input type="button" value="Free blank form"/>

I. Seeking and diagnosis

Filter in section	Value
Number of women arriving and seeking care and treatment for incontinence	
2. Number of women diagnosed with fistula (total)	
3. Number of women whose fistula is deemed iatrogenic	
4. Number of women requiring any type of fistula treatment	
5. Number of women requiring fistula repair surgery	
6. Number of women requiring conservative treatment (catheterisation for an existing fistula)	

II. Fistula repair surgery

Filter in section	Value
7. Number of women receiving fistula repair surgery	
8. Number of "urinary only" repairs	
9. Number of "RVF only" repairs	
Number of "urinary and RVF" repair	

III. For urinary-only repairs (first, second or >2 repairs)

Filter in section	Value
Number of women receiving "urinary only" repair undergoing their first surgical repair	
Number of women receiving "urinary only" repair undergoing their second repair	
Number of women receiving "urinary only" repair who have undergone >2 repairs	

IV. For RVF-only repairs (first, second or >2 repairs)

Filter in section	Value
14. Number of women receiving "RVF only" repair undergoing their first surgical repair	
15. Number of women receiving "RVF only" repair undergoing their second repair	
16. Number of women receiving "RVF only" repair who have undergone >2 repairs	

V. For urinary/RVF repairs (first, second, >2 repairs)

Filter in section	Value
17. Number of women receiving "urinary and RVF" repair undergoing their first surgical repair	
18. Number of women receiving "urinary and RVF" repair undergoing their second repair	
19. Number of women receiving "urinary and RVF" repair who have undergone >2 repairs	

VI. For surgical repairs discharged during the quarter

Filter in section	Value
20. Number of "urinary only" repairs discharged	
21. Number of "RVF only" repairs discharged	
22. Number of "urinary and RVF" repairs discharged	
23. Number of women discharged this quarter after surgical repair (total)	
24. Number of women seeking surgical repair not discharged this quarter	

VII. Outcome of urinary-only surgical repairs discharged

Filter in section	Value
25. Number of "urinary only" repairs closed and dry at discharge	
26. Number of "urinary only" repairs closed with residual urinary incontinence at discharge	
27. Number of "urinary only" repairs not closed at discharge	

VIII. Outcome of RVF-only surgical repairs discharged

Filter in section	Value
28. Number of "RVF only" closed and dry at discharge	
29. Number of "RVF only" not closed, incontinent with water stool and/or flatus (gas) at discharge	
30. Number of "RVF only" not closed, incontinent with firm stool at discharge	

IX. Outcome of urinary/RVF surgical repairs discharged

Filter in section	Value
31. Number of "urinary and RVF" closed and dry at discharge	
32. Number of "urinary and RVF" closed with residual urinary incontinence at discharge	
33. Number of "urinary and RVF" not closed, urinary incontinence at discharge	
34. Number of "urinary and RVF" not closed, incontinent with water stool and/or flatus (gas) at discharge	
35. Number of "urinary and RVF" not closed, incontinent with firm stool at discharge	

X. Complications

Filter in section	Value
36. Number of women discharged this quarter after surgical repairs who experienced complications (total)	
37. Number of major surgical complications	
38. Number of anesthesia-related complications	
39. Number of post-operative complications related to perceived failure/success of surgery	

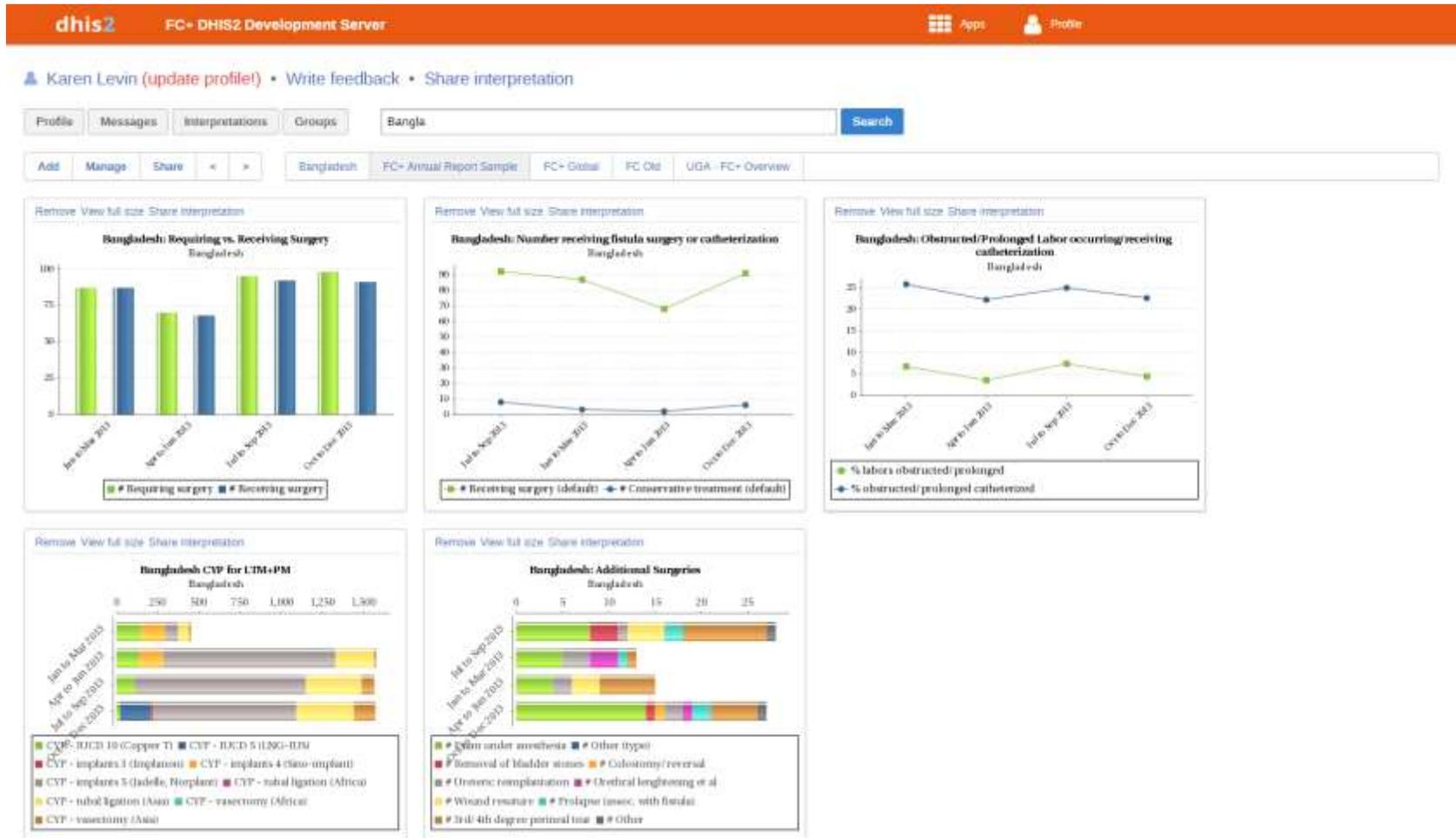
XI. Conservative treatment (catheterization)

Filter in section	Value
40. Number of women seeking conservative treatment (catheterization) for fistula during the quarter (total)	
41. Number of women seeking catheterization who are closed and dry	
42. Number of women seeking catheterization who are closed with residual incontinence	
43. Number of women seeking catheterization who are not closed, with no further treatment indicated	
44. Number of women seeking catheterization who are not closed and are referred for surgery	

Complete

Completed by: Klevin on 2014-10-07 See details

APPENDIX K: FC+ SAMPLE DHIS2 DASHBOARD



APPENDIX L: FC+ CORE INDICATORS: ANNUAL ACHIEVEMENTS

Note: Benchmarks for FY13/14, FY15/16, and FY17/18 are drawn from the approved FC+ PMP. Benchmarks for FY15/16 have been estimated based on FY13/14 performance and country workplans for the coming fiscal year.

Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia.

Indicator 1: Number of countries supported by Fistula Care Plus (FC+)			
Definition: # of countries in which FC+ is supporting fistula repair sites and other activities to strengthen fistula-related policy, community capacity, and services			
Additional description/context: FC+ will support countries to strengthen capacity for obstetric fistula prevention, detection, repair, and reintegration of affected women.			
Data source and collection: Collected quarterly from project reports by FC+ staff			
Benchmark Values¹³			
<i>Year</i>	<i>Target</i>	<i>Actual</i>	<i>Notes</i>
FY2013/14	5	5	
FY2014/15	5		
FY2015/16	6		
FY2016/17			
FY2017/18	7		

Indicator 2: Number of sites supported by FC+ for fistula repair and prevention
Definition: # of facilities to which FC+ is providing support for fistula repair services.
Additional description/context: FC+ will support facilities to provide fistula repair services. The majority of these sites will also provide some level of prevention care. Support can include: provider training and clinical mentoring, equipment, and/or other site strengthening activities such as quality improvement (QI) and management capacity building. Support to clients at these sites can include: transport costs to hospitals for surgery, temporary shelter, costs for repair, post-operative hospitalization costs, pre and post operative counseling, and client rehabilitation services during post-operative recovery. Supported sites will provide data to FC+ on clinical indicators including numbers of clients seeking and requiring fistula repair services, the number of repairs performed, and the outcomes for those clients. Supported sites may also be engaged in fistula prevention activities, as defined in indicator 3. However, in reporting, sites will be disaggregated into prevention-only sites and repair/prevention sites. Sites that provide both are

¹³ Benchmarks are aggregated for all indicators unless otherwise stated.

reported via indicator 2.			
Data source and collection: Collected quarterly from project reports by FC+ project staff and in-country partners			
Benchmark Values			
<i>Year</i>	<i>Target</i>	<i>Actual</i>	<i>Notes</i>
FY2013/14	26	25	One additional treatment site was supported in DRC through USAID bilateral agreement with PROSANI
FY2014/15	29		
FY2015/16	30		
FY2016/17			
FY2017/18	36		

Indicator 3: Number of prevention-only sites supported by FC+			
Definition: # of facilities to which FC+ is providing support only for fistula prevention services.			
<p>Additional description: FC+ will support facility sites to provide services that prevent fistula. Support can include: include provider training and clinical mentoring, equipment, minor renovation or rehabilitation of facilities, other site strengthening activities such as quality improvement (QI) and management capacity building; and/or community outreach for awareness, screening, detection, and referral activities. FC+ will focus prevention interventions in three areas: a. Emergency obstetric services (EmOC) with immediate interventions to help prevent fistula. We will track three key immediate term interventions which will be a focus of strengthening at selected sites:</p> <ul style="list-style-type: none"> • Correct use of the partograph to manage labors • Availability of caesarean section services • Routine use of catheterization for women who had prolonged/obstructed labor. <p>b. Family Planning (FP) services as a medium term fistula prevention intervention</p> <p>c. Screening, detection, and referral of women needing fistula treatment to repair sites.</p> <p>As noted above, facilities will be classified as either prevention-only or repair/prevention sites. Repair sites may also be engaged in any or all of the prevention activities outlined here.</p>			
Data source and collection: Collected quarterly from project reports by FC+ staff and in-country partners			
Benchmark Values			
<i>Year</i>	<i>Target</i>	<i>Actual</i>	<i>Notes</i>
FY2013/14	43	16	Delays in funds release and sub-award agreements negatively affected prevention-only site support

FY2014/15	37		
FY2015/16	50		
FY2016/17			
FY2017/18	50		

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment and reintegration in the public and private sectors

Indicator 4: Number of countries receiving support from FC+ where governments or supported facilities have revised/adopted/ initiated/implemented policies or guidelines for fistula prevention or treatment

Definition: # of supported countries or facilities (some private sites may develop their own policies/guidelines) that have revised/adopted, initiated, or are continuing to implement policies in support of fistula prevention and treatment services.

Additional description/context: The FC+ Annual Report will include the name of policy/guideline, location, and status (e.g., under development or review, approved, implemented). Fistula-specific policies or guidelines can be part of broader reproductive and/or maternal health documents. For the purposes of FC+, a policy¹⁴ is an official statement by a government or health authority that provides an overall direction for a health issue by defining a vision, values, principles, and objectives, and establishing a broad model of action to achieve that vision. Policies may address financing, coordination among agencies and programs, necessary legislation, organization of services, procurement of material resources, required human resources, quality standards, and/or information systems. A guideline is a statement that provides a framework or course of action through which to implement policy objectives, including recommendations and best practices that ensure quality within services to be provided. This indicator includes countries that have fistula policies/guidelines in place at the start of the project.

Data source and collection: Collected annually from project reports and policy/guideline documents by FC+ staff and in-country partners

Benchmark Values

Year	Target	Actual	Notes
FY2013/14	5	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	5		
FY2015/16	6		
FY2016/17			
FY2017/18	7		

¹⁴ Adapted from World Health Organization definitions. Available at: http://www.who.int/mental_health/policy/services/1_MHPolicyPlan_Infosheet.pdf. Accessed January 22, 2014.

Indicator 5: Number of countries receiving support from FC+ where governments or supported facilities have addressed WDI, women with TF and/or POP in their fistula and/or broader reproductive/maternal health policies or guidelines			
Definition: # of supported countries or facilities (some private sites may develop their own policies/guidelines) that have addressed the needs of WDI, women with TF, and/or women with POP in their relevant policies/guidelines.			
Additional description/context: This incorporation can be within fistula-specific documents or broader policies/guidelines on reproductive and/or maternal health services. Annual report will include the name of policy/guideline, location, and status (e.g., under development or review, approved, implemented). The definitions of policies and guidelines described under indicator 5 will be applied here.			
Data source and collection: Collected annually from project reports and policy/guideline documents by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	N/A	Policy efforts related to WDI/TF/POP to begin in FY14/15
FY2014/15	1		
FY2015/16	2		
FY2016/17			
FY2017/18	4		

Indicator 6: Number of countries receiving support from FC+ in which governments have budget line item for fistula care			
Definition: # of supported countries with a specific annual budget allocation to fund fistula prevention, detection, repair, and/or reintegration services.			
Additional description/context: This is an annual, rather than aggregated, indicator.			
Data source and collection: Collected annually from project reports and key informant interviews by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	2	2	Budget allocations made in Nigeria and Uganda
FY2014/15	2		
FY2015/16	3		
FY2016/17			
FY2017/18	5		

Indicator 7: Number of countries with fistula indicators included in the health management information system (HMIS)			
Definition: # of supported countries whose HMIS includes fistula indicators.			
Additional description/context: The primary indicator of interest is the number of fistula repairs; however, additional relevant indicators that may be incorporated into HMIS include the number of women identified as needing repair.			
Data source and collection: Collected annually from project reports and key informant interviews by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	4	3	Along with Niger, Nigeria, and Uganda, indicators have also been approved in a 4 th country (Bangladesh), but data collection has not yet begun.
FY2014/15	4		
FY2015/16	4		
FY2016/17			
FY2017/18	6		

Indicator 8: Number of public/private partnerships established to address fistula prevention, repair, or reintegration by country			
Definition: # of public/private partnerships established to address country-level needs related to fistula prevention, repair, and/or reintegration.			
Additional description/context: Partnerships may include the leveraging of private (e.g., corporate) financial resources to fund fistula activities and/or the provision of in-kind support to enable fistula services (e.g., medical equipment, drugs, supplies, human resources).			
Data source and collection: Collected semi-annually from project reports by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	1 ¹⁵	3	In addition to the 3 PPPs (Bangladesh, Nigeria, and Uganda), an individual has also donated commodities in Uganda
FY2014/15	2		
FY2015/16	3		

¹⁵ This will be achieved in Y2 due to the shortened Y1.

FY2016/17			
FY2017/18	7		

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

Indicator 9: Number of community volunteers/educators trained in tools and approaches to raise awareness regarding fistulae prevention and repair

Definition: # of community volunteers/educators trained in topics and approaches and approaches, such as social and behavior change communication (SBCC), stigma, gender-based barriers, and male involvement to mobilize communities for fistula prevention, the use of safe motherhood services including family planning and EmOC, and fistula screening/detection/referral for repair.

Additional description/context: Community volunteers/educators are individuals affiliated with or employed by community-based organizations, non-governmental organizations, and/or faith-based organizations. In some countries, they are affiliated with government agencies (e.g., Ethiopia's Health Development Army); however, while these individuals may liaise with health facilities and providers, their role is restricted to health promotion and they are **not** formally attached to specific health facilities. These are considered to be distinct from the community health workers discussed in Indicator 18 below.

Data source and collection: Collected quarterly from training reports by FC+ staff and in-country partners

Benchmark Values

Year	Target	Actual	Notes
FY2013/14	227	114	Delays in funds release and sub-award approvals negatively affected ability to implement community volunteer/educator trainings in FY13/14
FY2014/15	500		
FY2015/16	600		
FY2016/17			
FY2017/18	1,100		

Indicator 10: Number of community awareness-raising activities/events conducted by program partners

Definition: # events carried out by program partners to provide information about EmOC availability, fistula prevention, screening and detection, repair, and other safe motherhood issues.

Additional description/context: Events may include community gatherings and broadcast messages.

Data source and collection: Collected quarterly from program monitoring reports by FC+ staff and in-country partners.

Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	570	12	Delays in funds release and sub-award approvals negatively affected ability to implement community outreach and education in FY13/14.
FY2014/15	582		
FY2015/16	3,600		
FY2016/17			
FY2017/18	5,580		

Indicator 11: Number of participants reached through community awareness-raising events/activities conducted by program partners			
Definition: # of participants reached through community awareness raising events/activities conducted by program partners.			
Additional description/context: Participants may include attendees at events in the community, as well as those listening to/watching broadcast messages. Numbers of persons reached will be estimates for some activities; e.g., radio partners will provide estimates of the listenership for broadcast events. ¹⁶			
Data source and collection: Collected quarterly from program monitoring reports by FC+ staff and in-country partners.			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	155,150	10,745	Delays in funds release and sub-award approvals negatively affected ability to implement community outreach and education in FY13/14
FY2014/15	232,000		
FY2015/16	480,000		
FY2016/17			
FY2017/18	1,200,000		

¹⁶ FC+ has expanded its definition of the reach of community activities to include the audience for radio broadcasts; not all countries have been able to establish baseline estimates of these audiences yet; these benchmarks may thus be revised based on Y1 experience.

Objective 3: Reduced transportation, communication, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

Indicator 12: Number and type of transportation initiatives introduced, enhanced, and/or tested			
Definition: # of initiatives introduced enhanced, and/or tested to reduce barriers faced by women in traveling to fistula services, particularly repair, in the catchment areas of FC+ sites.			
Additional description/context: Initiatives may include vouchers, support from local transportation networks, and other strategies to enable transportation to fistula services.			
Data source and collection: Collected semi-annually from program monitoring and evaluation reports by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	0	
FY2014/15	2		
FY2015/16	2		
FY2016/17			
FY2017/18	4		

Indicator 13: Number and type of communication technologies introduced, enhanced, and/or tested for improving communication with patients and/or providers			
Definition: # of initiatives introduced enhanced, and/or tested to improve communication with providers and/or patients engaged through FC+ sites.			
Additional description/context: Initiatives may target health behavior and service utilization messages for women, follow-up support and mentoring for trained providers, and/or monitoring of service provision/uptake by patients and providers.			
Data source and collection: Collected semi-annually from program monitoring and evaluation reports by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	0	
FY2014/15	1		
FY2015/16	2		
FY2016/17			
FY2017/18	4		

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Indicator 14: Number of women requiring fistula repairs			
Definition: # of women diagnosed with obstetric fistula at supported repair sites			
Additional description/context: This will be a subset of women seeking treatment at repair sites; women will be screened to determine whether their incontinence is due to obstetric fistula. This indicator encompasses all types of fistula, including urinary and RVF together, and RVF alone. ¹⁷			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	2,131	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	4,000		
FY2015/16	18,000		
FY2016/17			
FY2017/18	28,000		

Indicator 15: Number of fistula repairs			
Definition: # of fistula repair surgeries performed at supported sites.			
Additional description/context: This includes all types of fistula repairs, including urinary alone, urinary and RVF together, and RVF alone. Each time a woman has surgery it will be counted; however, it is unlikely that any woman would get more than one repair surgery per quarter. Therefore the quarterly figure for the number of surgeries should therefore equal the number of women getting fistula repair.			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes

¹⁷ We have included this indicator in our approved PMP instead of number of women seeking fistula repairs. We know from experience that many women seeking care are often not diagnosed with fistula, but rather have some other condition that results in some incontinence. FC+ will collect information on the number of women seeking care for urinary incontinence as part of our routine clinical monitoring as was done under Fistula Care. If the difference between the number seeking and the number requiring is large then we will know that work needs to be done to improve messages about fistula treatment. We believe for USAID reporting to Congress, the number requiring is more powerful. We are using the term urinary fistula instead of VVF since it more accurately describes the range of typical fistula cases seen at sites. Urinary type fistula includes: vesicovaginal, urethro-vaginal, uretero-vaginal, vesico-uterine.

FY2013/14	1,300 ¹⁸	873	Delays in funds release and sub-award approvals negatively affected ability to support fistula repairs during FY13/14.
FY2014/15	2460		
FY2015/16	11,000		
FY2016/17			
FY2017/18	19,000		

Indicator 16: Outcomes of fistula repair (percentage closed and dry)			
Definition: Numerator: # of women who received any type of fistula repair surgery (urinary alone, urinary and RVF together, and RVF alone) who when discharged, had a closed fistula and were dry at time of discharge / Denominator: # women who had any type of fistula repair surgery and were discharged X 100			
Additional description/context: N/A			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	75%	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	75%		
FY2015/16	75%		
FY2016/17			
FY2017/18	75%		

Indicator 17: Complications of fistula repair (percent of repairs with complications)			
Definition: Numerator: # of women discharged in a quarter whose fistula repair surgeries resulted in a reportable complication / Denominator: total # of women discharged in a quarter following fistula repair surgeries X 100			
Additional description/context: Reportable complications can either be major or minor related to the fistula surgery or to anesthesia. As one woman may have more than one complication, the occurrence types of complications will also be disaggregated. Deaths will be monitored separately and reported to			

¹⁸ Release of MCH funds were delayed in Nigeria and Uganda; these two countries account for a large proportion (73%) of the estimated repairs. This benchmark was calculated based on the provision of repairs for two quarters. However, repairs in Uganda were only carried out in the final quarter of the FY.

USAID annually in a special report. Guidelines regarding complications will be carried over from the Fistula Care Project.			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	<20%	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	<20%		
FY2015/16	<20%		
FY2016/17			
FY2017/18	<20%		

Indicator 18: Number of health systems personnel trained, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider)			
Definition: # of persons attending training in support of fistula services			
Additional description/context: Type of training will be reported by the primary training category. Training in surgical repair is included in this indicator, and will be disaggregated. Training will be reported for specific topics such as counseling, use of the partograph, quality improvement, data-driven management, etc.			
Categories of health system personnel trained may include:			
<ul style="list-style-type: none"> • Surgeons and other physicians • Nurses and midwives • Other non-physician clinicians (e.g., clinical officers) • Non-clinician counselors • Facility managers • Community health workers 			
For the purposes of FC+, community health workers are individuals formally affiliated with the health system and linked to specific health facilities, generally providing health education and services at the community/household level. This may include both unpaid and paid individuals. This term encompasses cadres known by other titles, depending on the country context (e.g., Ethiopia's Health Extension Workers).			
Data source and collection: Collected quarterly from training reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	526	161	Delays in funds release and sub-award

			approvals negatively affected ability to implement training in FY13/14
FY2014/15	925		
FY2015/16	3,400		
FY2016/17			
FY2017/18	6,800		

Indicator 19: Number of supported facilities that have introduced treatment for POP			
Definition: # of facilities to which FC+ is providing support that have introduced POP treatment services.			
Additional description/context: Support can include: provider training and clinical mentoring, equipment, minor renovation or rehabilitation of facilities, and/or other site-strengthening activities such as quality improvement (QI) and management capacity building. Supported sites will provide data to FC+ on the number of POP treatment services provided. Some POP facilities may also be providing fistula repair and/or prevention services. In that case, those sites will also be reported in Indicator 2 or 3, as appropriate; this will be disaggregated in the report.			
Data source and collection: Collected semi-annually from program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	0	
FY2014/15	1		
FY2015/16	8 ¹⁹		
FY2016/17			
FY2017/18	8		

Indicator 20: Number of POP treatment services provided			
Definition: # of POP treatment services performed at supported sites.			
Additional description/context: This includes both conservative treatment (e.g., treatment with a pessary) and all types of surgical treatment (e.g., hysterectomy with pelvic support repair, mesh, etc.). Reports will disaggregate by type of treatment.			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	Target	Actual	Notes

¹⁹ This is based on the assumption that FC+ will be supporting POP services in 2 countries.

FY2013/14	0	0	
FY2014/15	30		
FY2015/16	976 ⁶		
FY2016/17			
FY2017/18	1,758		

Indicator 21: Couple-years of protection in sites supported by FC+			
Definition: The estimated protection provided by family planning services, based upon the volume of all contraceptives distributed to clients during the reporting period			
Additional description/context: USAID-endorsed conversion factors for each family planning method will be used to calculate CYP. ²⁰ All CYP will be credited to the year in which the method was distributed, rather than annualizing CYP.			
Data source and collection: Collected semi-annually from facility FP registers by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	28,430	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	68,500		
FY2015/16	90,000		
FY2016/17			
FY2017/18	180,000		

Indicator 22: Number of FP counseling sessions provided to clients			
Definition: # of counseling sessions provided to clients at FC+ sites regarding FP methods.			
Additional description/context: As a woman may receive more than one FP counseling session in a given quarter, this indicator represents number of service encounters, rather than numbers of individual clients.			
Data source and collection: Collected semi-annually from facility FP registers by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes

²⁰ Office of Sustainable Development, Bureau for Africa, USAID. Health and Family Planning Indicators: A Tool for Results Frameworks Volume I. Accessed: January 20, 2014.

FY2013/14	53,698	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	60,000		
FY2015/16	70,000		
FY2016/17			
FY2017/18	80,000		

Indicator 23: Completion of partographs and management of labor according to protocol at sites receiving support for strengthening partograph use			
<p>Definition: A two part indicator will be used to assess partograph completeness and management of labor according to protocol.</p> <p>Part 1: Mean partograph completion score for labor records reviewed during the reporting period. Partograph completion scores will be based on five key items that should be present in all records, whether labor was normal or prolonged. 1 point will be assigned for each item, for score range from 0 to 5. These are selected based on USAID/MCHIP/WHO tools and guidelines. They are:</p> <ul style="list-style-type: none"> • Existence of partograph in labor & delivery file. • Fetal heart rate recorded every half hour on partograph. • Contractions plotted every half hour on partograph. • Maternal pulse recorded at least every half hour on partograph. • Blood pressure recorded at least every four hours on partograph. <p>Part 2: % of partographs with action line reached in which the correction actions were taken.</p>			
<p>Additional description/context: This information will be collected during medical monitoring supervision visits using FC+ medical monitoring tool. A systematic sample of up to 25 labor & delivery records for the reference period will be reviewed. Instructions for drawing a systematic sample are included in the monitoring tool. Information from partographs will be abstracted using a standardized form. Data will <u>only</u> be collected from sites where FC is working to strengthen the correct use of the partograph.</p>			
<p>Data source and collection: Collected annually from medical monitoring reports by FC+ staff and in-country partners</p>			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	NA	
FY2014/15	50% of sites receiving a mean score of ≥ 4 on reviewed partographs; 60% of reviewed partographs responding appropriately		

	action if action line reached		
FY2015/16	60% of sites receiving a mean score of ≥ 4 on reviewed partographs; 60% of reviewed partographs responding appropriately action if action line reached		
FY2016/17			
FY2017/18	70% of sites receiving a mean score of ≥ 4 on reviewed partographs; 70% of reviewed partographs responding appropriately action if action line reached		

Objective 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation indicators for prevention and treatment

Indicator 24: Number of evaluation or research studies completed			
Definition: # of evaluation or research studies completed that address fistula care services.			
Additional description/context: Studies may include evaluation of models of prevention and repair service delivery, quality assessment and improvement research, evaluation of clinical approaches, and assessment of strategies to reduce barriers to fistula treatment. Annual report will list studies by study name, location, and status (i.e., in development/ ongoing/ complete). Completion will be defined as the submission of a final study report to USAID or the submission of a manuscript documenting study findings for publication.			
Data source and collection: Collected annually from program research reports by FC+ staff and research partners			
Benchmark Values			
Year	Target	Actual	Notes

FY2013/14	0	0	
FY2014/15	1		
FY2015/16	2		
FY2016/17			
FY2017/18	5		

Indicator 25: % of supported sites reviewing fistula monitoring data bi-annually to improve fistula services			
Definition: Numerator: # of sites in which fistula monitoring data are reviewed at the facility to assess program progress / Denominator: # of supported sites X 100			
Additional description/context: This indicates the proportion of supported FC+ sites with a functioning process for reviewing fistula monitoring data in order to improve services. A functioning review process is defined as a team of staff from the site who meet at least twice a year ²¹ , with or without outside assistance (e.g., supervisory teams, FC+ staff) to review and discuss the data and make program decisions to improve fistula services based on these data.			
Data source and collection: Collected semi-annually from program monitoring reports by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	40%	NA	Data to be provided in FY14/15 semi-annual report (including back data), once full data collection commences
FY2014/15	45%		
FY2015/16	50%		
FY2016/17			
FY2017/18	75%		

²¹ The ideal is for these data to be reviewed on a monthly or quarterly basis, depending on service volume at a particular facility. However, experience from the original FC project indicates that this is very difficult, given shortages in human and other resources. FC+ will advocate with partner facilities to strengthen data monitoring and review systems, but has noted that in the approved PMP that bi-annual review is the minimum achievable floor for this indicator.