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October 2014 to September 2015

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Council, Dimagi, Direct Relief, Fistula
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TERREWODE

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ACRONYMS AND ABBREVIATIONS

ACOG.....	American College of Obstetricians and Gynecologists
AgirPF.....	Agir pour la Planification Familiale
ANC.....	Antenatal Care
BCC.....	Behavior change communication
BD.....	Becton Dickinson
BMGF.....	Bill and Melinda Gates Foundation
BMMS.....	Bangladesh Maternal Mortality Survey
BRAC.....	Bangladesh Rural Advancement Committee
BSMMU.....	Bangabandhu Sheikh Mujib Medical University
C-Section.....	Cesarean Section
CBO.....	Community Based Organization
CCBRT.....	Comprehensive Community Based Rehabilitation in Tanzania
CDDM.....	Clinical Data for Decision-Making
CSME.....	Maternal and Child Health Center (Centre de Santé Mère / Enfant)
CRNFO.....	Centre National de Référence pour la Fistules Obstétricales
CSI.....	Centre de Santé Intégré
CYP.....	Couple-Years of Protection
DGHS.....	Directorate General of Health Services
DHIS.....	District Health Information System
DHS.....	Demographic and Health Survey
DRC.....	Democratic Republic of the Congo
ECOWAS.....	Economic Community of West African States
EH.....	EngenderHealth
EmOC.....	Emergency Obstetric Care
EmONC.....	Emergency Obstetric and Neonatal Care
FBO.....	Faith Based Organization
FC.....	Fistula Care
FC+.....	Fistula Care <i>Plus</i>
FIGO.....	International Federation of Gynecology and Obstetrics
FMOH.....	Federal Ministry of Health (Nigeria)
FP.....	Family planning
GOB.....	Government of Bangladesh
GMNHC.....	Global Maternal and Newborn Health Conference
G-WIN.....	Growing Girls and Women in Nigeria
HC.....	Health Center
HGR.....	General Reference Hospital
HMIS.....	Health Management Information System
IDEOF.....	International Day to End Obstetric Fistula
IGL.....	Imagerie des Grand Lacs
IOFWG.....	International Obstetric Fistula Working Group
IRAG.....	International Research Advisory Group
IRB.....	Institutional Review Board
ISOFS.....	International Society of Obstetric Fistula Surgeons
ISOWN.....	Institute of Social Works Nigeria
IUCD.....	Intrauterine contraceptive device
J&J.....	Johnson & Johnson
LGA.....	Local Government Area
MCH.....	Maternal and Child Health

MCSP	Maternal and Child Survival Program
ME&R	Monitoring, evaluation and research
M&E	Monitoring and evaluation
MHTF	Maternal Health Task Force
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MSF	Médecins Sans Frontières
MWASD	Ministry of Women Affairs and Social Development
NOFIC	National Obstetric Fistula Center
NTRLIC	Network of Traditional and Religious Leaders Committee
OF	Obstetric fistula
PFRD	Persistent Fistula Related Disorder
PHC	Primary Health Center
PMP	Performance Management Plan
POP	Pelvic organ prolapse
PPP	Public Private Partnership
PRH	Population and reproductive health
PROSANI	Le Projet de Santé Intégré
QI/QA	Quality improvement/ quality assurance
RCT	Randomized Controlled Trial
REDI Counseling	Rapport building, exploration, decision making, and implementing
REF	Réseau pour l’Eradication des Fistules (Niger)
RLAC	Religious Leaders Advocacy Champions
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SDI	Service delivery improvement
SGBV	Sexual and Gender-based Violence (SGBV)
SJH	St. Joseph Hospital (DRC)
STTA	Short-term Technical Assistance
TA	Technical Assistance
TOT	Training of trainers
TF	Traumatic fistula
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USAID/W	USAID/Washington
VHT	Village health team volunteer
VVF	Vesico Vaginal Fistula
WAHA	Women and Health Alliance International
WAHO	Organisation Ouest Africaine de la Santé
WDI	Women Deemed Incurable
WIF	Women with Incurable Fistula (preferred term, Uganda)
WPI	Women with Persistent Incontinence (preferred term, Nigeria)

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EXECUTIVE SUMMARY

The annual report presents key accomplishments and activities for the second fiscal year (October 1, 2014 to September 30, 2015) of *Fistula Care Plus* (FC+). EngenderHealth manages the project in collaboration with international and national partners. In FY14/15, USAID supported fistula treatment and prevention services through the FC+ project in **six** countries—Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, Togo, and Uganda. USAID also supports fistula activities in DRC, Ethiopia, Mali, Pakistan, and Tanzania through bilateral funding. EngenderHealth also supported fistula prevention and care activities in Guinea with non-USAID funds.

Key accomplishments during the October 2014 to September 2015 period included:

Objective 1: Strengthened enabling environment

- National fistula working group/strategy meetings in Bangladesh, Niger, and Uganda.
- National level meetings on women deemed incurable (WDI) in Nigeria and Uganda.
- Co-hosting and participation at annual International Society of Fistula Surgeons (ISOFS) and International Obstetric Fistula Working Group (IOFWG) meetings.
- Global and country-level events to celebrate International Day to End Obstetric Fistula on May 23.
- Founding membership and board participation in the new G4 Alliance for global surgery.
- Inventory and content analysis of tools for survey/interview-based fistula case identification
- Co-organization of Wilson Center panel: “Restoring Hope and Dignity: New Developments and Best Practices in Addressing Maternal Morbidities.”

Objective 2: Enhanced community understanding and practices

- 776 community volunteers/educators trained in tools and approaches to raise awareness regarding fistula prevention and repair. 1,990 community awareness-raising activities/events conducted by program partners, reaching 414,067 participants.
- Training and support for outreach activities of religious leaders in Uganda and Nigeria, village committees in Niger.

Objective 3: Reduced transportation, communications, and financial barriers

- Completion of systematic literature review of barriers to fistula treatment.
- Formative research to investigate barriers faced by women implemented in Nigeria and planned for Uganda (FY15/16).

Objective 4: Strengthened provider and health facility capacity

- 2,876 fistula repairs supported through FC+; 986 repairs supported by other bilateral USAID support.
- Site assessments and facility audits carried out in six countries.
- 31 sites supported by FC+ for fistula treatment and prevention activities; nine sites supported through other USAID bilateral support.
- 749 sites supported by FC+ for prevention-only activities; one site supported through other USAID bilateral support.
- 22 surgeons trained in fistula repair (including 11 first-time trainees)

- 1,065 health system personnel trained in non-surgical fistula repair and prevention topics
- Pelvic organ prolapse (POP)/fistula integration workshop convened, with selection of five sites in four countries for technical assistance to integrate POP into fistula services.

Objective 5: Strengthened evidence base

- Training for all FC+ M&E staff in DHIS2 platform established for FC+ and partner data collection, analysis, and storage.
- Collaborative secondary analysis of Demographic and Health Survey (DHS) fistula data and of FC project research data.
- Dissemination of findings from FC project randomized controlled trial on shorter-duration catheterization after fistula repair.
- Research consultation convened on catheterization for fistula prevention.

INTRODUCTION

This annual report provides a summary of accomplishments for the second fiscal year (October 1, 2014 – September 30, 2015) 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 project indicators as well as narrative updates organized into: Section I: Management Activities, Section II: Global Accomplishments, and Section III: Country Accomplishments. Global and country accomplishments are reported against the objectives of the FC+ Project Framework (see Figure 1 and Appendix Y) and in alignment with the USAID-approved Project Monitoring Plan (PMP). Section II is further organized by sub-objective.

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, 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.

As of September 30, 2015, FC+ is supporting fistula prevention and treatment activities with USAID funding at a total of 780 sites in Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, Togo and Uganda: 31 prevention and treatment sites and 749 prevention-only sites. See Appendix A for a full list of FC+ planned and actual supported sites.

In addition to the support provided via FC+, USAID provides bilateral support to fistula work in DRC (through ProSani), Ethiopia (through Pathfinder), Mali (through IntraHealth), Pakistan (through the Jinnah Post Graduate Medical Center), and Tanzania (through Vodafone/CCBRT).

In FY14/15, EngenderHealth has also continued fistula-related activities in Guinea with support from the Alcoa Foundation, the Donner Family Fund, Arden’s Fund, American Friends of Guinea, the *Fistula Foundation*, and the Islamic Development Bank.

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

Overview

During FY14/15, the global FC+ team's management activities focused on recruitment and orientation of outstanding staff positions, finalization and implementation of project subawards, workplan and budget development, and roll out of the project's data collection and monitoring system. Management activities provided the oversight and operational framework that enabled the achievements described in Sections II and III.

Project Director Karen Beattie retired in February 2015; recruitment and approval for a new Project Director culminated with hiring Dr. Lauri Romanzi, who officially began her position in April 2015. Lauren Bellhouse joined the project as a Program Associate in February 2015.

In FY 14/15, FC+ continued development of a data management system using the DHIS2 platform and carried out training for all field-based project M&E staff to orient them to the system. FC+ developed the FY15/16 workplan and budget, and submitted these to USAID for approval.

In FY14/15, FC+ experienced funding delays that impacted program activities, as described below.

Staffing and Recruitment

During FY14/15, the FC+ global team was comprised of the following staff:

Karen Beattie: Project Director (through February 2015)

Lauri Romanzi: Project Director (From April 2015)

Joseph Ruminjo: Clinical Director,
Acting Project Director (March 2015)

Vandana Tripathi: Deputy Director

Bethany Cole: Global Projects Manager

Joseph Osei: Financial Management &
Administration Specialist (50% LOE)

Isaac Achwal: Senior Clinical Associate

Lauren Bellhouse: Program Associate
(From February 2015)

Altiné Diop: Project Coordinator

Karen Levin: Senior Program Associate,
Monitoring and Evaluation (50% LOE)

Ellen Brazier: Senior Technical Advisor,

Dr. Lauri Romanzi joined Fistula Care Plus as Project Director on April 9, 2015. Dr. Romanzi is a medical doctor with a specialty in obstetrics and gynecology. Her career has included many years in academic urogynecology as Clinical Associate Professor at New York Presbyterian Hospital, followed by service as a Visiting Associate Professor from Yale University to the Human Resources for Health program in Rwanda. In addition to her professional work in the United States, Dr. Romanzi has extensive international project and program management experience in Africa and Asia. She has worked with a wide host of multilateral and bilateral agencies, international NGOs, professional associations and academic institutions as a surgical trainer in the field of obstetric fistula and female pelvic medicine.

Dr. Romanzi's vision is to fully integrate fistula into maternal health services, as well as broaden the scope of surgical services to reflect female pelvic medicine service models.

Community Engagement (STTA through April 2015)
 Mark Barone: Senior Clinical Advisor (STTA)
 Emma Reidy: Intern

Numerous positions were filled at the country level in FY 14/15. All new staff received orientations to EngenderHealth and USAID regulations and policies. Table 1 provides a recruitment list of open positions at the country level as of September 30, 2015.

Table 1: Open Positions at the Country Level, as of September 30, 2015

Country	Open Positions
Bangladesh	None
DRC	Deputy Country Manager (planned FY15/16)
WA/Niger	Program Officer for Social Communication for Behavior Change Office Driver
Nigeria	Office Assistant (Sokoto)
Uganda	Senior Clinical Associate (planned FY15/16, subject to funding)

Project Management

FC+ leadership oversaw project management, through participation in meetings with USAID/W; development of FY15/16 workplans and budgets; securing USAID Mission concurrence and USAID/W approvals for subawards; and working with partners and country-level staff to facilitate FC+ finance and M&E systems, and staffing and program support.

FC+ management prepared for and participated in two USAID Management Reviews in FY14/15, in December 2014 and September 2015 in Washington D.C. Management reviews addressed financial management, project management, progress towards results and new activities. See Appendices B and C for questions and responses.

In February 2015, FC+ submitted a revised, updated version of the global workplan and budget for the current year to USAID. FC+ global management worked closely with the Nigeria staff and USAID/Nigeria mission to negotiate the Nigeria workplan, and with the USAID/West Africa regional Mission to negotiate planning for activities in Niger and the larger region.

FC+ has designed and developed a low-cost, flexible, and robust data collection and management system using the DHIS2 platform. Staff orientations to data collections forms and processes were carried out in December 2014. All field-based M&E staff participated in a training focused on learning how to do data entry and create data outputs from the platform in March 2015. Activities related to this topic are described under Section II, Objective 5.

At the request of USAID/Washington, FC+ initiated on-going discussions with several projects supporting fistula-related work through USAID-supported bilateral funding in order to coordinate reporting of fistula-related data to USAID. FC+ was able to gather data from three bilateral projects for the current reporting period: ProSani in DRC, Pathfinder in Ethiopia, and Vodafone/CCBRT in Tanzania.

On February 5-6, 2015, the FC+ team held a strategy and technical workshop in Abidjan, Cote d'Ivoire for key global program staff, including all country Program Managers. The FC+ workshop was scheduled to capitalize on participants attending the EngenderHealth Program Managers meeting, also held in Abidjan, on February 9-13, 2015. From the global team, Joseph Ruminjo, Isaac Achwal, and Bethany Cole participated in the EngenderHealth Program Managers meeting and provided updates on the project as well as inputs into agency strategy review. The FC+ workshop included discussions on program interventions for bladder catheterization; translating research to practice; and strategy for integration of pelvic organ prolapse (POP) into fistula programming. Global staff shared technical updates and lessons learned on global and country experiences.

FC+ held a one-day program management meeting in NYC in September 2015 with all country Program Managers. The meeting was scheduled to immediately precede the Prolapse Integration workshop held at the end of the month (see Objective 4), to minimize travel time and cost. The meeting allowed the full FC+ global team and all country Program Managers to discuss opportunities and challenges for the upcoming FY15/16 as well as reflect on current project status, including review of data and achievements.

Partnership: Global and Country-Level

FC+ global staff worked with international project partners to develop and implement plans for their engagement in project activities. At the country level, partnership-related activity focused on development and implementation of subawards and further activity planning. Please refer to Appendix E for a complete list of present and planned FC+ partnerships.

Throughout the fiscal year, FC+ identified many opportunities for partnership and collaboration with global partners to strengthen and disseminate the evidence base for improved fistula care. FC+ co-hosted events with the International Society of Obstetric Fistula Surgeons (ISOFS), UNFPA and the International Obstetric Fistula Working Group (IOFWG) in Uganda during the first quarter. FC+ organized a panel on iatrogenic fistula with country partners for the 2015 Global Maternal and Newborn Health Conference (GMNHC), see Appendix D. As part of ongoing collaboration with USAID's flagship Maternal and Child Survival Program (MCSP) to support quality maternal health services, FC+ also developed content for an MCSP panel on quality of care for the GMNHC. FC+ worked with the Demographic and Health Survey (DHS) Program to commission a secondary analysis on prevalence and trends in DHS data. Additional detail on these activities can be found below and in Section II, Objective 5 of this report.

During the ISOFS meeting in October 2014, the Project Director was able to meet with TERREWODE, FC+ partner, to discuss subaward terms and content specifically targeted towards women with fistula deemed incurable (WDI). The subaward is now approved and active. In March 2014, the Acting Project Director met with Alice Emasu, director of TERREWODE, and two members of her Board to further discuss their work both for Uganda and the Global project. Discussion focused on development of a reintegration strategy for WDI.

FC+ has coordinated with UNFPA on several fronts: field-level activities, particularly in Nigeria; the United Nations proposal for making fistula a “notifiable condition;” activities related to the completion of a compendium of “super-core” indicators for fistula; submission of a panel for the October 2015 International Federation of Obstetricians and Gynecologists (FIGO) conference; and activities to mark the International Day to End Fistula. Together with UNFPA, USAID, Direct Relief, and Johnson & Johnson, FC+ helped to organize a panel presentation on obstetric fistula held at the Woodrow Wilson Center in Washington D.C. on July 14, 2015.

In May 2015, FC+ participated in the launch of the Global Alliance for Surgical, Obstetric, Trauma, and Anesthesia Care (G4 Alliance: <http://www.theg4alliance.org/>) during the 2015 World Health Assembly. The G4 Alliance was formed in response to growing recognition of the global burden of surgical disease and related costs in low- and middle-income nations as outlined in the Lancet Commission on Global Surgery (<http://www.lancetglobalsurgery.org/>). G4 Alliance goals are relevant to strengthening the enabling environment for fistula prevention and treatment programs and policies, as discussed in Section II, Objective 1. FC+ serves on the G4 Alliance Interim Board of Directors.

In September 2015, the Project Director participated in a meeting of clinical trainers, trainees and partners from FIGO, UNFPA, WAHA, and EngenderHealth, held in Addis Ababa, Ethiopia. The purpose of the meeting was to review the FIGO fistula training program, consider changes to the Global Competency-Based Fistula Surgery Training Manual, and to look for solutions regarding implementation.

During FY14/15, country programs have progressed in finalizing and implementing in-country partnerships and subawards for facilities that receive FC+ support. As of September 30, 2015, there are 13 active subawards approved by USAID, see Table 2 for detail.

Table 2: Active Subawards as of September 30, 2015

Institution	Start Date	End Date	Number	Amount	Description
Global					
Population Council	1-Oct-14	30-Sep-15	SUBA094	\$202,244	To build institutional knowledge about interventions to reduce financial barriers, particularly related to transportation, by women seeking fistula repair services with a focus on Nigeria and Uganda.
Bangladesh					
Ad din Hospital	1-Sep-14	31-Oct-15	SABD001	\$31,710	To continue providing obstetric fistula prevention, detection, treatment, and reintegration services at Ad-Din Hospital, Dhaka and to continue organizing periodic fistula repair concentrated efforts at Ad-Din Hospital in Jessore.
BRAC	1-Jan-15	31-Dec-16	SABD007	\$114,762	To identify and refer women suffering from fistula for treatment. Increase awareness of fistula and strategies for prevention.

Institution	Start Date	End Date	Number	Amount	Description
BSMMU	1-Jan-15	31-Dec-15	SABD008	\$36,499	To develop and strengthen capacity to prevent fistula and perform surgical repair and to establish an “Advanced Fistula Surgery and Management Training Center” at BSMMU for doctors and nurses. In addition to its maternal health and fistula services, BSMMU will continue to enhance the quality of its maternal health services through training of staff at various levels in technical areas as well as infection prevention, counseling, and effective supervision.
LAMB Hospital	1-Sep-14	31-Dec-15	SABD002	\$57,140	To enable LAMB Hospital to further strengthen and develop its capacity to perform surgical repair of fistula, and to increase staff and public awareness of the problem and its prevention.
Kumudini Hospital	1-Sep-14	31-Aug-15	SABD003	\$9,582	To provide support to build the capacity of Kumudini Hospital to improve the quality and availability of fistula treatment services, and prevent fistula through strengthening maternal health services and increasing access to family planning.
DRC					
St. Joseph Hospital	1-Sep-14	31-Dec-15	SACD002	\$331,079	To improve access to quality fistula services through improved fistula service delivery, training of providers and strengthening quality assurance mechanisms.
HEAL Africa	1-Sep-14	31-Dec-15	SACD001	\$127,264	To strengthen the capacity of HEAL Africa and its staff to provide accessible, quality obstetric fistula repairs and prevention services.
Imagerie Des Grands Lacs (IGL)	1-Oct-14	31-Dec-15	SACD004	\$122,207	To build the capacity of IGL staff to prevent obstetric fistula through strengthening maternal health services and family planning.
Maternité Sans Risque de Kindu (MSRK)	1-Oct-14	31-Dec-15	SACD005	\$154,601	To build the capacity of MSRK staff to prevent obstetric fistula through the strengthening of maternal health services and family planning.
Panzi Hospital	1-Sep-14	31-Dec-15	SACD003	\$133,222	To improve access to fistula care, build the capacity of General Reference Hospital Panzi to repair obstetric fistula, improve the clinical services provided in the hospital and prevent fistula through strengthening maternal health services including increasing access to family planning.
Uganda					
Kitovu Hospital	1-Aug-14	30-Sep-15	SAUG001	\$249,930	To enhance community understanding and practices to prevent fistula, improve access to treatment, reduce stigma and support reintegration of women with fistula, including those whose fistula is deemed incurable and those whose fistula is the result of sexual violence; to Reduce transportation, communication and financial barriers to accessing preventive care, detection, treatment and reintegration support; and to Strengthen provider and health facility capacity to improve and sustain quality services for fistula prevention, detection and treatment.
TERREWO DE	1-Sep-14	31-Aug-15	SAUG002	\$51,109	To individualize reintegration services after fistula repair surgery

In addition to work with project partners, FC+ staff participated in several meetings and coordination processes led by USAID and its flagship projects. These include the 15th Annual Meeting of the Inter-Agency Working Group on Reproductive Health in Crises, the LeaderNet seminar on Ebola preparedness and response, the RMNCAH Global Financing Facility Consultation, meetings of the Bureau of Global Health Cooperating Agencies (CAs) M&E Technical Working Group, and meetings of the PRH Service Delivery Improvement (SDI) CAs. A draft gender equity strategy for FC+ was shared on the project's behalf at the February 2015 meeting of the PRH Gender Working Group, and the project's social and behavior change communication (SBCC) materials were shared at the April 2015 meeting of the SDI CAs.

Bethany Cole and Joseph Osei participated in the second USAID/West Africa Regional Health Office Partners Meeting in Accra, Ghana on February 18-20, 2015. This highly participatory meeting allowed regional partners to meet and strategize about improving health outcomes for the population of West Africa. Some of the main themes of the meeting included: fostering a regional approach and collaboration; regional and global partnerships; integrating gender, environment, and mobile solutions in programming; discussing best practices and lessons-learned; and Ebola preparedness, mitigation, and recovery.

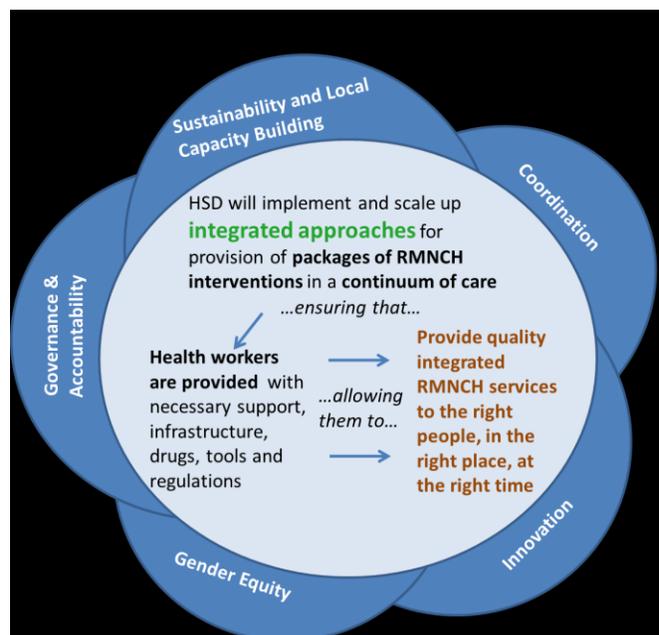
FC+ has sought other opportunities to support USAID-led initiatives addressing maternal morbidity. In March 2015, FC+ held a conference call and provided e-mail follow-up with USAID and MCSP staff in Washington and Rwanda to discuss the fistula program in Rwanda and what efforts/inputs are needed. FC+ shared project resources, including the Competency-Based Training fistula manual, equipment lists, and screening and assessment tools. FC+, USAID/Bangladesh and UNFPA/Bangladesh-led teams met to discuss future coordination of all fistula-related activities with the Bangladesh National Fistula Task Force. FC+ has also been providing technical assistance on fistula and POP measurement to the Bangladesh USAID Mission-led team developing the Bangladesh Maternal Mortality Survey and a nested clinical validation study. See Section II, Objective 5 for additional details.

Leveraging FC+ for Additional Fistula Programming

As of January 1, 2015, EngenderHealth has reopened an office in Guinea and is continuing to work toward a fistula free generation in the country. Much effort was invested during FY13/14 and the beginning of FY14/15 to develop resources to continue the work done in that country under the FC project, including for family planning services. Challenges of reopening were compounded by the Ebola outbreak that necessitated careful strategy to facilitate continuation of this work in an Ebola context. EngenderHealth successfully raised private funds from the Alcoa Foundation, which has significant mining interests in Guinea, as well as the Donner Family Fund, Arden's Fund and American Friends of Guinea. These funds have enabled EngenderHealth to continue the work of the evidence-based Village Safe Motherhood Committee model over the past year; former FC project staff continued to serve in the role of consultants on this work and provided expertise to colleagues in Niger and Togo.

During FY13/14 and FY14/15, EngenderHealth worked with the Islamic Development Bank and the Fistula Foundation to fund fistula treatment activities in Conakry, Kissidougou, and Labe. Current funding is for one year, and additional resources are being sought to continue this work, including a larger proposal submitted to the Islamic Development Bank in collaboration with the Guinea Ministry of Health.

In FY14/15, FC+ participated as the fistula service partner in an application led by Jhpiego, for the USAID Guinea RFA-OAA-15-000024 Guinea Health Service Delivery (HSD) project for family planning and maternal, newborn, and child health (MNCH). This project aims to “build on the strong foundations and relationships created in Guinea through the MCHIP and MCSP projects led by Jhpiego with Save the Children, (and) the USAID-funded Fistula Care projects led by EngenderHealth.” The 4.5 million USD earmarked for fistula services in HSD would be implemented in a 5-year time frame toward a “fistula free generation” in Guinea, expected to launch in FY15/16.



International Clinical Support and Technical Assistance (TA) Travel

FC+ global staff and consultants have carried out international clinical support and TA visits to six countries during FY14/15 (see Table 3). This travel included:

- Site assessments, TA to the MoH in the development of a national strategy on fistula, training and support for fistula repair (West Africa/Togo);
- Baseline site/needs assessments (DRC);
- TA for/provision of fistula repair (Bangladesh, West Africa/Togo);
- Training of clinicians (Bangladesh, Nigeria, West Africa/Niger, West Africa/Togo);
- TA for community outreach activities (West Africa/Niger);
- Clinical monitoring (Bangladesh, DRC, West Africa/Niger);
- FY15/16 workplan development (Bangladesh, Nigeria); and
- Orientation to Sexual Reproductive Health and Rights (Nigeria) and Gender (West Africa/Niger).

Additionally, M&E program staff from each FC+ country traveled to Kampala to participate in a March 2015 DHIS2 training where they received an orientation to and an opportunity to practice on the project’s new DHIS2 platform for data collection and management.

Table 3: International Technical Assistance Travel, October 2014 – September 2015

Traveler	Dates/Location	Purpose
Bethany Cole Sita Millimono Cyrille Guede	October 15-25, 2014/ Togo	Conduct site assessment with the MoH and UNFPA and contribute to the national strategy.
Kindi Diallo (consultant)	December 1-17, 2014/ Togo	Participate as a member of surgical team for a fistula repair campaign at Sokode hospital in Togo in collaboration with MOH and UNFPA ¹
Christine Edwards (consultant)	November 15-9, 2014/ Bangladesh	Conduct fistula repair concentrated effort at LAMB Hospital
Marrietta Mahendeka (consultant)	November 5-26, 2014/ Bangladesh	Conduct fistula repair surgeries at Ad din and Jessore Hospitals
Isaac Achwal	October 11-24, 2014/ DRC	Document baseline information for FC+ and level of effort required to continue strengthening the facilities supported under FC.
Karen Levin Bethany Cole Isaac Achwal Chidimma Anyanwu Joseph Gwamzhi Alexandre Delamou Sk Nazmul Huda Michel Mpunga Aboubacar Garba Birni	March 8-15, 2015/ Uganda	Conduct training for field based M&E staff in project data collection and DHIS2 database (see event in Table 4)
Ellen Brazier	April 2-10, 2015/ Niger	Support team in planning and introducing site walk through approach in Maradi
Bethany Cole	April 4-13, 2015/ Bangladesh	Conduct FY1516 workplanning using ExpandNet tools .
Habib Sadauki Issoufou Balarabe	April 10-19, 2015/ New York	Fistula Care Plus Project staff orientation at EH headquarters in New York
Isaac Achwal Elizabeth Arlotti-Parish	May 20-27, 2015/ DRC	Conduct FY15/16 workplanning workshop with staff and selected persons in DRC, attend 23 May activities at partner site, visit two subawardees and conduct management review
Sita Millimono	May 21-June 1, 2015/ Togo	Conduct training in nursing skills and infection prevention at Sokode site in Togo ²
Justus Barageine	May 25-June 5, 2015/ Bangladesh	Conduct fistula repair surgeries and refresher training for surgeons on Fistula Care Plus at Kumudini Hospital, Tangail and Bangabandhu Sheikh Mujib Medical University, Dhaka during 25 May to 5 June 2015.

¹ These repairs were supported by UNFPA, and are not included in the reported FC+ fistula repair numbers.

² This training is not included in the reported FC+ training numbers.

Traveler	Dates/Location	Purpose
Kindy Diallo	May 30- June 6, 2015/Togo	Conduct fistula repair at Sokode site in Togo ³
Bethany Cole	June 1-5, 2015/ Uganda	Conduct FY15/16 workplanning workshop with staff and selected partners and conduct management review
Lauren Bellhouse Joseph Ruminjo Elizabeth Arlotti – Parish	June 18 – July 4, 2015/ Nigeria	FY15/16 work planning, orientation to Sexual and Reproductive Health and Rights , presentations at Provider Network Meeting. Clinical monitoring visits conducted at Zaria, Zamfara, Kebbi, Sokoto. Staff also had advocacy meetings with the newly elected Kebbi State governor and the First Lady.
Lauri Romanzi Bethany Cole	July 24-28, 2015/ Niger	Conduct management site visit in Niger
Marietta Mkwya Mohendeka	July 30-August 13, 2015/Bangladesh	Conduct fistula repair surgeries and to facilitate hands on training and service on fistula surgery
Lauri Romanzi Bethany Cole	August 1-8, 2015/ Nigeria	Conduct management site visit in Niger
Bethany Cole	August 1-14, 2015/ Nigeria	Conduct FP integration TOT in Abuja and site visits
Lauri Romanzi Joseph Ruminjo	August 14-26, 2015/ Bangladesh	Meet with Mission and to conduct clinical monitoring for supported sites
Fred Kirya	August 20-September 3, 2015/ Bangladesh	Conduct fistula repair surgeries and to facilitate hands on training and service on fistula surgery
Isaac Achwal Fred Ndede Jeal Alaro	September 6-17, 2015/ Bangladesh	Facilitate trainings on fistula counseling, facilitative supervision
Lauren Bellhouse	September 11-23, 2015/Niger	Attend and co-facilitate a gender workshop for FC+ Niger staff and participants from the DRC.
Alexandre Delamou Maimouna Toliver Marie-Joseph Mayinga (SJH Kinshasa, DRC) Grace Muhima (Panzi, DRC) Barthelemy Aksanti (HEAL, DRC)	September 12-19, 2015/Niger	Attend 5 day gender training workshop in Niamey for representatives from Niger, DRC, and the West African region

Meetings

FC+ global staff convened, attended and presented at numerous meetings throughout FY14/15, as noted above and summarized in Table 4.

³ These repairs were supported by UNFPA, and are not included in the reported FC+ fistula repair numbers.

Table 4: Meetings and Presentations, October 2014 – September 2015

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
WHO Maternal Morbidity Measurement Stakeholders Meeting	October 2-3, 2014/Istanbul, Turkey	No	Vandana Tripathi	Feedback on tools and research plans presented byWHO
RMNCAH Global Financing Facility Consultation	October 16, 2014/ Washington, D.C.	No	Vandana Tripathi	Participation
International Fistula Obstetric Working Group meeting	October 27-28, 2014/Kampala, Uganda:	No	Bethany Cole Joseph Ruminjo Karen Beattie Rose Mukisa	Presentations, facilitation See Appendix F
Meeting for Fistula Surgeons involved in Kitovu Hospital	October 27-28, 2014/Entebbe, Uganda	No	Joseph Ruminjo	Interactive sharing of lessons learned, technical updates
The LeaderNet seminar on Ebola preparedness and response	October 28-30, 2014/Online seminar	No	Altine Diop	Participation
International Society of Obstetric Fistula Surgeons	October 29-31, 2014/Kampala, Uganda	No	Joseph Ruminjo Karen Beattie Bethany Cole Isaac Achwal From DRC : Pascal Manga Justin Paluku Tina Amisi Dolores Nembunzu Michel Mpunga Angela Mukuliboy From Nigeria: Paul Njagu Steven Arigidi Binyerem Suleiman Zakariya Amir Yola Hassan Wara Idris Saad Adamu Isah Habib Sadauki Youssouf Harou Amadou Abdou From Niger: Sanda Ganda Issoufou Balarabe From Bangladesh:	Presentations, facilitation See Appendix G

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
			Beatrice Berger Farhana Akhter	
APHA 2014	November 19, 2014/New Orleans	No	Ellen Brazier	Presentation on “Rethinking Birth Preparedness Interventions” and poster on “Enhancing Community Capacity for Maternal Health Promotion: Evidence from Guinea”
FC+ Project Management Review	December 8, 2014/Washington D.C.	No	Karen Beattie Vandana Tripathi Joseph Ruminjo Bethany Cole Yetnayet Asfaw (EH)	Semi-annual project management review with USAID/W
DHIS2 Global Symposium	January 29-30, 2015/ Washington D.C.	No	Karen Levin	Presentation on “EngenderHealth/Fistula Care <i>Plus</i> : DHIS2 Development”
FC+ Team Strategy and Technical Workshop	February 5-6, 2015/Abidjan, Cote d’Ivoire	Yes	Bethany Cole Joseph Ruminjo Rose Mukisa Abu Faisel Habib Sadauki Yetnayet Asfaw Michel Mpunga Moustapha Diallo Joseph Osei Adamu Isah Issoufou Balarabe Isaac Achwal	Organization, presentation, facilitation See Appendix H
EngenderHealth Program Managers and Finance and Operations Meetings	February 9-13, 2015/Abidjan, Cote d’Ivoire	No	Joseph Ruminjo Agnes Ampeire Stanley Obinna Bethany Cole Isaac Achwal Michel Mpunga Moustapha Diallo Joseph Osei Adamu Isah Issoufou Balarabe Rose Mukisa Abu Faisel Habib Sadauki	Participation
USAID West Africa Regional Health Office Partners’ Meeting	February 18-20, 2015/Accra, Ghana	No	Bethany Cole Joseph Osei	Participation
1st African Federation of Obstetrics and Gynecology Congress and 39th Kenya Obstetrical &	February 18-20, 2015/Nairobi, Kenya	No	Isaac Achwal	Presentation on “Non-inferiority of short-term bladder catheterization following repair of female genital fistula”

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Gynecological Society Conference				
Fifteenth Annual Meeting of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises	February 25-27, 2015/ Amman, Jordan	No	Adamu Isah	Participation in panel on Sexual and Gender-Based Violence
DHIS2 Training	March 10-13, 2015/ Kampala, Uganda	Yes	Karen Levin Bethany Cole Leah Jarvis Isaac Achwal Rose Mukisa Simon Ndizeye Lucy Asaba Molly Tumusiime Michel Mpunga Mai Birni Aboubacar Alex Delamou Chidimma Anyanwu Joseph Ringpon Sk Nazmul Huda Eric Munyambabazi Prosper Behumbiize	Organized, presented, participated See Appendix I
EngenderHealth meeting on Clinical Data for Decision-Making (CDDM): Generation, Synthesis and Application for Clinical Program Data	March 23-28, 2015/Istanbul, Turkey	No	Vandana Tripathi Joseph Ruminjo Mark Barone Simon Ndizeye Isaac Achwal Chidimma Anyanwu Aboubacar Mai Birni Adamu Isah	Facilitation, presentations on CDDM in FC+, including country case studies from Bangladesh/Nigeria and FC+ M&E tools See Appendix J
SDI CAs Meeting	April 28, 2015/ Washington DC	No	Lauri Romanzi Vandana Tripathi	Discussion of SBC/BCC approaches/circulation of materials
Lancet Commission Global Surgery North America Report/Action Plan Launch	May 6, 2015 / Boston, MA	No	Lauri Romanzi Vandana Tripathi	Participation
G4 Alliance Launch event	May 18, 2015/ Geneva	No	Joseph Ruminjo	Representation of maternal/reproductive health; membership in interim Board of Directors
13 th Workshop of Reconstructive	May 20-28, 2015/ Mozambique	No	Isaac Achwal Sanda Ganda	Presentation of fistula classification that may guide in choosing appropriate surgical technique based

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Surgery			Sa'ad Idris Imam Amiru Yola	on anatomic, size and functional criteria founded on several recognized existing genital fistula classifications.
Measurement & Accountability for Health Summit + Civil Society Pre-Meeting	June 8-11, 2015/ Washington D.C.	No	Vandana Tripathi	Participation
A Service Integration Approach to Strengthening Postabortion Family Planning (Webinar)	June 11, 2015/ Washington D.C.	Yes	Betty Farrell Joseph Ruminjo Christopher Lindahl	Facilitation and Presentation on sharing learnings about integration approaches and practices.
International Urogynecological Association 40 th Annual Meeting	June 7-13, 2015/ Nice, France	No	Lauri Romanzi Bethany Cole	Participation Presentation at workshop: Fistula in Low and Middle Income Countries Participation in planning 2016 conference
Brown Bag for USAID HIDN Saving Mothers' Lives team	June 25, 2015/ Washington D.C.	No	Vandana Tripathi	Presentation of quality of care research
Nigeria Fistula Provider Network Meeting	June 30, 2015/ Kaduna, Nigeria	Yes	Lauren Bellhouse FC+/ Nigeria staff	Logistics and general organization; facilitation of full-day discussion; presentation of country-level DDM data
Restoring Hope and Dignity: New developments and best practices addressing maternal morbidities	July 14, 2015/ Washington D.C.	Yes	Lauri Romanzi Bethany Cole Lauren Bellhouse	FC+ co-sponsored event, Dr. Romanzi gave panel presentation.
FC+ Research consultation: Catheterization after obstructed labor	July 17, 2015/ New York	Yes	Steven Arrowsmith Mark Barone, Lauren Bellhouse, Michel Boulvain Suzy Elneil Vera Frajzyngier Erin Mielke Celia Pett Lauri Romanzi Joseph Ruminjo Mary Ellen Stanton Vandana Tripathi	Facilitation and presentation See Appendix K
National Stakeholders	July 28-20, 2015	No	Agnes Were Lucy Asaba	Participation

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Conference on Adolescent Health: "Strengthening systems and partnerships for responsive and sustainable adolescent health programming in Uganda"			Simon Ndizeye	
1 st ECOWAS Good Practices in Health Forum	July 28-31, 2015/ Burkina Faso	No	Lauri Romanzi Bethany Cole Isaac Achwal Joseph Ruminjo Issoufou Balarabe Suleiman Zakariya Adamu Isah Chidimma Anyanwu Alexandre Delamou	See Appendix L for complete list of FC+ posters and presentations http://www.fistulacare.org/pages/blog/2015/08/good-practices-shared-at-waho-forum-in-burkina-faso
What works to delay child marriage: Pop Council and USAID data release event	August 13, 2015/ New York	No	Lauren Bellhouse	Participation
Meeting of clinical trainers, trainees and partners from UNFPA, WAHA and EH	September 5-10, 2015/Ethiopia	No	Lauri Romanzi	Inputs into review of the Global Competency-Based Fistula Surgery Training Manual
Customizing DHIS2 for iNGOs	September 10, 2015/Webinar	No	Karen Levin	Participation
USAID Project Management Review	September 15, 2015/ Washington D.C.	No	Lauri Romanzi Vandana Tripathi Joseph Ruminjo Bethany Cole Yetnayet Asfaw (EH)	Semi-annual project management review with USAID/W.
SDI CAs Meeting	September 16, 2015/ Washington D.C.	No	Bethany Cole Lauri Romanzi	Attendance
FC+ Management Meeting	September 28, 2015/New York	Yes	FC+ Global Team Isaac Achwal Michel Mpunga Rose Mukisa-Bisoborwa Nazmul Huda Habib Sadauki Adamu Isah	Management meeting to discussion opportunities and challenges for FY15/16 and current project status.

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
			Issoufou Balarabe	
Pelvic Organ Prolapse Integration Consultative Workshop	September 29 – October 2, 2015/ New York	Yes	FC+ Global Team Isaac Achwal Michel Mpunga Rose Mukisa-Bisoborwa Maura Lynch Nazmul Huda Habib Sadauki Adamu Isah Oladosu Ojengbede Idris Saad Sunday Adeoye Suzy Eneil Kenny Raha Issoufou Balarabe Celia Pett Betty Farrell Fekade Ayenechew Jessica McKinney Laura Keyser	Facilitation and presentations. See Appendix M

Funding

The FC+ project was awarded on December 12, 2013 with a ceiling of \$74,490,086. Of the total FY13/14 funding of \$7.36M, \$3.9M (53%) was obligated in December 2013 and the balance of \$3.46M (47%) was obligated in May 2014. The late obligations of field support funding in FY13/14 resulted in delays for subawards relating to fistula treatment, most of which could not be put in place until the first quarter of FY14/15. As of September 2015, 13 subawards are in place (see Table 2), worth about \$1.62M; about \$1.12M remains yet to be expended.

In FY14/15, \$6.13M (63%) was received in November 2014, \$1.84M (19%) was received in March 2015, \$1.1M (11%) in May 2015 and \$0.7M (7%) in September 2015 to bring the total FY14/15 obligations to \$9.77M.

In FY14/15 funding for several countries was delayed six or more months: DRC funding and West Africa PRH funding was received in March 2015, Uganda funding received in May 2015. As a result of these delays, FC+ has to manage with significant cost overruns in the respective funding streams.

Cumulative expenditures and subaward commitments are projected to be \$12.8M, leaving an obligated pipeline of \$4.6M, as of September 30, 2015.

SECTION II: GLOBAL ACCOMPLISHMENTS

Fistula Care *Plus* Achievements

In the second fiscal year, FC+ made significant achievements in line with the aims and targets of its global workplan. The funding delays described in Section I above hampered the project's ability to meet first year benchmarks; some delays continued to have effects well into FY14/15. However, towards the end of the fiscal year, nearly all funds were obligated and subawards were in process, with the project achieving many of its benchmarks for FY14/15 and making substantial progress towards those that were not met.

FC+ started implementing newly developed data collection and analysis tools in FY14/15, including back entry of data from the first year of the project and data from other USAID-supported bilateral projects. Project M&E tools were refined and updated in the second half of the year based on clinical input from the new Project Director. Table 5 provides a snapshot of FC+ achievements in FY14/15. Full reporting on FC+ benchmarks for core indicators is updated annually and included in Appendix Y of this annual report. Appendix N provides information on all USAID-supported fistula repair surgeries from 2005-present.

Table 5: Select Fistula Care Plus Achievements and Benchmarks as of September 30, 2015⁴

	FY 13/14 Actual	FY14/15 Planned	FY14/15 Actual
Number of countries supported by FC+	5	5	6
Number of sites supported by FC+ for fistula repair and prevention	25	32	31
Number of prevention-only sites supported by FC+	16	39	749
Number of participants in community volunteer/educator training in tools and approaches to raise awareness regarding fistula prevention and repair	114	494	776
Number of community awareness-raising activities/events conducted by program partners	12	586	1,990
Number of participants reached through community awareness-raising events/activities conducted by program partners	10,745	232,100	414,067
Number of fistula repairs	873	3,830 ⁵	2,876
Number of participants in health systems personnel training, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider) ⁶	161	929	1,065

⁴ Please note, this table in the FC+ FY 14/15 semi-annual report provided slightly different planned numbers for supported treatment and prevention sites, prevention only sites, and numbers of community volunteer educators and health personnel trained. This table contains corrected information.

⁵ The fistula repair benchmark for FY 14/15 has been updated since the submission of the core FY 14/15 workplan to USAID to reflect increases in targets in the Bangladesh and Nigeria country workplans, at the request of their local USAID missions.

⁶ This does not include training of surgeons to provide fistula repair.

Number of family planning counseling sessions provided	38,373	117,800	149,610
Number of CYP provided	40,039	90,500	107,986

Clinical training is one of the key mechanisms by which FC+ advances project aims across objectives; training outputs are summarized in Table 6. Training accomplishments are described in greater detail in Objective 4, and in Section III, by country. With USAID bilateral support, Pathfinder also carried out training in Ethiopia for 535 health providers, focusing on fistula identification and referral.

Table 6: Total Number of Clinical Training Participants, by Country, by Topic, FY 14/15

	Bangladesh	DRC	WA/Niger	Nigeria	Uganda	WA/Togo	Total
First Training in Surgical Fistula Repair	3	2	4	2	1	0	12
Continuing Training in Surgical Fistula Repair	4	4	0	4	1	0	13
ANC	0	0	0	0	0	0	0
Community, outreach and advocacy	4	92	14	28	68	0	206
Data management	0	0	16	89	0	0	105
EmONC	95	0	0	0	0	0	95
EmONC and labor monitoring	0	58	0	0	30	0	88
FP counseling	35	0	0	100	0	0	135
FP methods	6	0	29	13	25	0	73
FP and fistula counseling	11	22	0	22	0	0	55
Fistula counseling	0	0	0	26	13	0	39
Gender	0	0	7	0	0	0	7
Infection Prevention	42	0	0	27	0	0	69
Labor monitoring	0	38	20	0	0	0	58
Non-surgical POP treatment	0	0	0	0	0	0	0
Pre- and Post-Operative Care	0	10	4	0	0	18	32
Quality Assurance	16	50	30	0	0	0	96
Other	7	0	0	0	0	0	7
TOTAL	222	274	124	311	138	18	1,087⁷

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

FC+ strengthens the enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors by improving country and facility policies, guidelines, and resources allocated to fistula prevention and treatment, including addressing the needs of particularly vulnerable women (e.g., WDI and those with traumatic fistula (TF)).

⁷ Please note, three surgeons received both first and continuing training during the fiscal year. Therefore the totals, by country, and the grand total of all training are representative of the actual number of individuals trained (i.e. cell totals minus three)

Sub-Objective 1.1: Establish sustainability plans: from policy to implementation

FC+ continues to develop projects with potential for public private partnerships. In FY14/15, following an introduction from Johnson & Johnson (J&J), the Project Director and Clinical Director met with several individuals from Becton Dickinson (BD) in December 2014, in hopes of developing partnership related to catheter procurement. Meeting participants included the Vice President, Global Health; Director, Social Investing; Manager, Product Donations and Community Relations, Social Investing. However, BD does not make the appropriate type of catheter for FC+ services. The meeting did provide FC+ with more information on PPP models, with BD sharing experiences partnering to advance the Odon Device for assisted delivery.

The Project Director has engaged in discussion with a PPP consultant to further develop possible options, including pessaries from Cooper Surgical. The Project will align pessary PPP with implementation of POP technical assistance in FY16, with possibilities including but not limited to established pessary distributors, 3-D printing of pessaries, and/or local pessary manufacture.

In addition to FC+ activities in DRC and Uganda, EngenderHealth has embarked on a two year, \$3 million Bill and Melinda Gates Foundation (BMGF) grant project, ExpandFP. 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.

At the country level, FC+ teams continue to maintain and expand partnerships with private entities, such as media outlets, for cost share and other supports to FC+ activities. See Section III, by country.

Sub-Objective 1.2: Improve data available on OF to facilitate planning

FC+ has carried out several activities during FY14/15 to promote the availability of improved data about fistula.

At the 2014 FC+ International Research Advisory Group (IRAG) meeting, participants judged it important to work toward improved methods for the measurement of fistula incidence and prevalence. Advisors at a linked consultation on measurement and estimation agreed that FC+ should develop an inventory of tools that have been used to identify fistula cases in recent studies and surveys, map the content of question topics and wording in these tools, and conduct a study to develop and validate a non-clinical diagnostic interview/survey tool.

The Deputy Director conducted an inventory of tools that have been used in published studies (technical briefs or peer-reviewed journals) to identify suspected fistula cases through interviews and/or surveys. A review of dozens of studies around the world resulted in the identification of 13 distinct questionnaires and forms, and copies were secured of 11 of these tools. FC+ summarized the characteristics of these tools using a structured spreadsheet. The findings of this mapping are summarized in an internal, draft brief (see Appendix O). In FY 15/16, FC+ will finalize and expand this into an external technical brief.

The Deputy Director has shared tools and findings from this inventory with the USAID/Bangladesh supported team developing the Bangladesh Maternal Mortality Survey (BMMS). FC+ has advocated with the BMMS team to incorporate fistula and pelvic organ prolapse (POP) in the survey, and begun providing technical assistance for a clinical validation study to evaluate the sensitivity and specificity of a questionnaire to screen for fistula and POP cases. This TA has included support for the development of a morbidity module for the BMMS and for protocol development for a clinical validation sub-study. This support comes at the request of USAID/Bangladesh and TA will continue into FY15/16. FC+/Bangladesh will also be engaged in this sub-study in FY15/16, coordinating clinical exams of suspected fistula cases and referral for care, in partnership with the MaMoni project in Bangladesh.

Because of the BMMS opportunity and other research efforts that FC+ has become aware of, rather than developing a stand-alone study to validate a survey/interview-based diagnostic tool, the project has focused its efforts on providing technical support and evidence-based guidance to other studies that are seeking to answer the same question.

FC+ also commissioned a secondary analysis of fistula data from the Demographic and Health Surveys (DHS). See Objective 5 for details.

FC+ developed a process documentation template to describe past and ongoing processes related to the inclusion of fistula indicators in national Health Management Information Systems (HMIS). The documentation seeks to understand the degree to which recently selected fistula indicators have been adopted by national HMIS in countries in sub-Saharan Africa and South Asia; and the understanding and use of HMIS fistula data by health workers and managers at the facility, district, state/province, and national level. The template has been reviewed and expanded based on feedback from the global team. Due to other time-sensitive research activities undertaken by global/country M&E/research staff, this process documentation will be conducted in FC+ countries in FY15/16.

Sub-Objective 1.3: Advocate for a fistula-free generation

Activities to strengthen the enabling environment for fistula services and advocate for prevention and treatment needed to achieve a fistula-free generation have been taking place across countries throughout the fiscal year. National working groups have been meeting with FC+ support and participation in Bangladesh, DRC, and West Africa/Niger, to revise and update national strategies for the elimination of fistula.

Both Uganda and Nigeria held national level meetings to discuss the needs of WDI and ways to address them programmatically and clinically. Both meetings observed that the term WDI was stigmatizing and alternative nomenclature was offered: women with incurable fistula (WIF) or women with persistent incontinence (WPI). Details can be found in the country reports in Section III.

FC+ has partnered with professional organizations and other actors in the international maternal and child health community to plan and carry out advocacy efforts towards the eradication of fistula.

The Project Director and Deputy Director participated in the North American launch of the report of the Lancet Global Commission on Global Surgery (<http://www.lancetglobalsurgery.org>) and the special issue of Lancet Global Health devoted to this topic. Held on May 6, 2015 at Harvard Medical School, the launch discussed key findings, recommendations and indicators from the report, highlighting the role of various developed country stakeholders in strengthening global surgery, including academic medical institutions, hospitals, industry, researchers, the press, and donors.

In May 2015, FC+ participated in the launch of the Global Alliance for Surgical, Obstetric, Trauma, and Anesthesia Care (G4 Alliance www.g4alliance.org) during the 2015 World Health Assembly. The G4 Alliance was formed in response to growing recognition of the global burden of surgical disease and related costs in low- and middle-income nations. Both the G4 Alliance and the Lancet Commission agendas include specific focus on access to surgical family planning services, timely C-section delivery, prevention and treatment of genital fistula, and access to effective treatment for pelvic organ prolapse, all executed at or above minimum acceptable standards of care. By participating in this advocacy alliance, FC+ works to bring a family planning, reproductive health, and integrated maternal morbidity treatment perspective to the global surgical movement, and to support improved platforms of surgical capacity for the delivery of related services. FC+ is serving on the G4 Alliance Interim Board of Directors. The EngenderHealth Senior Clinical Advisor from Ethiopia and the FC+ Program Director from Uganda will participate in EH representation of the G4 Alliance. Through this leadership role, FC+ is also facilitating an initiative to launch participation of reproductive health surgeons in the membership of the College of Surgeons of East, Central and Southern Africa (www.cosecsa.org), an organization that is currently excludes obstetrician/gynecologists from eligibility for fellowship.

Through advocacy by G4 Alliance members and others, a resolution on "Strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage" was unanimously approved at the 2015 World Health Assembly. This historic resolution will help open the door to national capacity building, health systems strengthening, and overall greater prioritization of essential surgical and anesthesia care for those in need, often at the community and district hospital level. The full resolution can be viewed here: http://apps.who.int/gb/ebwha/pdf_files/EB136/B136_CONF1-en.pdf

The FC+ global team joined all country programs, as well as partners UNFPA, Fistula Foundation and other key members of the global MCNH community in commemorating the International Day to End Obstetric Fistula (IDEOF) on May 23, 2015. This day of advocacy is a platform to raise awareness, collaborate with global partners, and intensifying activities toward ending obstetric fistula. Extensive planning and preparation across the project resulted in a

robust array of activity across country programs and at the global level. Illustrative IDEOF activities are described here, with additional detail in Section III.

- In Bangladesh, the FC+ team hosted a radio talk show to discuss maternal health and fistula prevention. This was accompanied by articles published in the *Daily Star* and *News Hour* newspapers on the link between poverty and obstetric fistula.
- In DRC, events commemorating IDEOF were held at many partner health facilities, including Panzi in Bukavu, St. Joseph Hospital in Kinshasa, and IGL in Beni.
- In West Africa/Niger, FC+ organized a day of meetings with national fistula stakeholders and a special committee of the Niger Ministry of Health.
- In Nigeria, a ceremony for women who had recently undergone fistula repair surgery was held at the Government House in the northern city of Kano, organized in collaboration with the Ministry of Women’s Affairs, Commissioner for Health, and local religious leaders. Radio programs and other media events were conducted in other states where FC+ is active.
- In Uganda, FC+, with partners TERREWODE and UNFPA, sponsored a fistula treatment camp at Hoima Regional Referral Hospital to commemorate IDEOF.

At the global level, in addition to supporting country programs with IDEOF activities, the FC+ global team used online and social media as a platform for awareness raising and global advocacy. An article authored by EngenderHealth CEO Pam Barnes and actress Mira Sorvino was published in the Huffington Post (http://www.huffingtonpost.com/pamela-barnes/end-the-inequity-end-fistula_b_7344624.html), which is among the 50 most popular websites in the United States and reaches more than 200 million unique visitors per month. A piece on inequities leading to obstetric fistula by FC+ Project Director Lauri Romanzi was published on the FC+ and EngenderHealth blogs (<http://www.fistulacare.org/pages/blog/2015/05/end-the-inequity-the-journey-to-eradicate-obstetric-fistula/>). FC+ participated in the J&J Global Health led Twitter chat with key partners on “Ending the Inequity–The Journey to Eradicate Obstetric Fistula” leveraging the hashtag #EndFistula and #WomenInspire. Highlights of that chat can be found here: <https://storify.com/JNJGlobalHealth/womeninspire-a-world-without-fistula>.

An End Fistula communications toolkit was compiled and circulated for use by all FC+ and EngenderHealth staff during the week of IDEOF (<https://www.engenderhealth.org/media/2015/05-21-endfistula-toolkit.php>). The toolkit included infographics, a quiz, sample Facebook posts and Tweets, copies of relevant blog posts and articles and linkage to the FC+ website where an overview of the importance of the day as well as the exciting activities happening in each country were featured (<http://www.fistulacare.org/pages/blog/2015/05/international-day-to-end-obstetric-fistula-2015/>).

FC+ conceived and helped organize a FC+, UNFPA, USAID, and J&J panel event on July 14, 2015 at the Woodrow Wilson International Center for Scholars in Washington, D.C., entitled “Restoring Hope and Dignity: New Developments and Best Practices in Addressing Maternal

Morbidities”(<https://www.wilsoncenter.org/event/restoring-hope-and-dignity-new-developments-and-best-practices-addressing-maternal-morbidities>). Congresswoman Carolyn Maloney (D-NY) also spoke at this event, which was moderated by Sandeep Bathala of the Wilson Center. Speakers highlighted both obstetric fistula and POP, with Mary Ellen Stanton from USAID and Erin Anastasi from the UNFPA Campaign to End Fistula describing the prevalence and clinical consequences of these conditions, as well as the social isolation and stigma they may cause. The discussion flagged the preventability of acute obstructed labor morbidities, particularly by ensuring that poor and rural women have adequate access to emergency obstetric care as well as quality family planning services. FC+ Project Director Dr. Lauri Romanzi emphasized the crucial role of programs to screen for and rapidly respond to obstructed labor, which underlies these and other important maternal and neonatal morbidities and adverse health outcomes. Conrad Person of J & J discussed efforts to increase data on preventable maternal morbidities, including the global fistula map (<http://www.globalfistulamap.org/>) collaboratively launched by J & J, UNFPA, the Fistula Foundation, and Direct Relief International. Congresswoman Maloney described the importance of progress on these issues. Approximately 100 people registered to attend the event. An article about the event and its webcast were also shared on the Huffington Post (http://www.huffingtonpost.com/francesca-cameron/build-it-and-they-will-co_b_8123676.html).

FC+ introduced a Twitter account in April, 2015 and the FC+ blog (<http://www.fistulacare.org/pages/blog/>) has been updated regularly throughout the fiscal year. During FY14/15 the blog has featured 23 postings highlighting current issues in maternal health and FC+ activities. There were five posts each in the first and second quarters, nine in the third quarter and four in the fourth quarter of the fiscal year. During FY14/15, the FC+ site has had a total of 36,658 page views, see Figure 2 for views by month. The FC+ Twitter account metrics are presented in Table 7. FC+ has created an Online Strategy that outlines the vision and specific plans for FC+’s website and social media efforts, which can be found in Appendix P.

Figure 2. Fistula Care Plus Website Views, by Month, FY14/15.

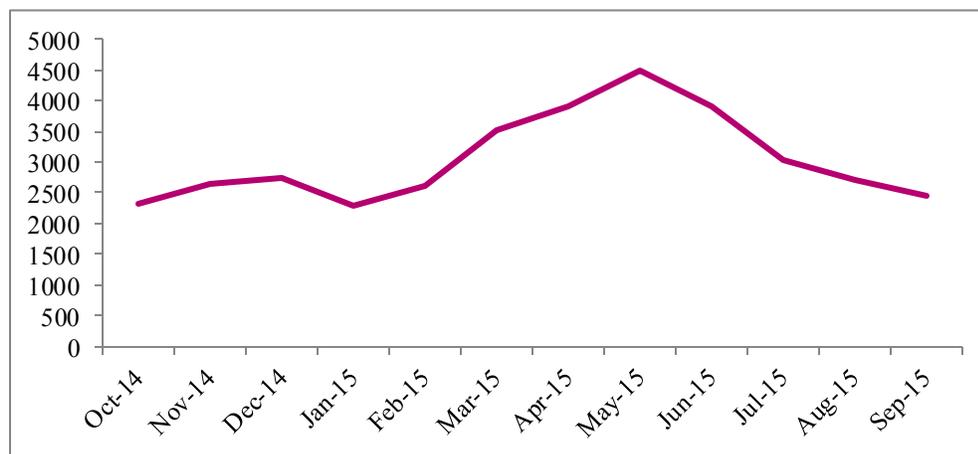


Table 7. FC+ Twitter Account Metrics, April 18 – September 30, 2015.

Metric	Value
Twitter Followers	204
Impressions	158,928
Link clicks	109
Retweets	334; peaked on May 23 during IDEOF publicity
Favorites	180
Mentions	176; peaked on May 23 during IDEOF publicity.
Total Engagements ('the number of times someone interacted with a tweet')	982
Potential Reach	1.7 million users

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+ enhances community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula by building community awareness, skills, and mobilization regarding the behaviors and services that can prevent fistula, as well as those that enable treatment.

FC+ has prepared a draft strategy addressing the role of gender inequality in fistula programming, and circulated it to USAID and partners (Appendix Q). In the second half of the fiscal year, FC+ worked to further elaborate this strategy and schedule gender workshops across three FC+ countries. A training in was held in Niamey, Niger for participants from West Africa/Niger and DRC (see Section II, Objective 2 for additional detail).

Sub-Objective 2.1 Create awareness and reduce stigma about OF

Country-level activities to increase community understanding and practices on preventing fistula and the availability of fistula repair services have been undertaken in Bangladesh, DRC, West Africa/Niger, Nigeria, and Uganda during FY14/15. A total of 1,990 community outreach/education/advocacy events were carried out, reaching 414,067 attendees. Additional detail by can be found in Table 8 below, as well as in Section III, by country.

Table 8: Community Outreach/Education Events, by Country, FY14/15.

Country	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Bangladesh	2	94	41	1,900	229	135,752	42	1,419	314	139,165
DRC	1	25	6	239	9	10,871	7	240	23	11,375
WA/Niger	2	24	0	0	1	200	175	13,448	178	13,672
Nigeria	4	100	0	0	72	19,302	301	163,085	377	182,487
Uganda	644	30,605	414	21,708	37	14,764	4	291	1,099	67,368
Total	652	30,848	461	43,149	348	181,118	529	178,483	1,990	414,067

Additionally, a total of 776 community volunteers and educators were trained in Bangladesh, DRC, West Africa/Niger, Nigeria, and Uganda. Participants included cured fistula patients, community partners and local religious leaders; see Table 9 and Section III, by country, for more information. In West Africa/Niger, community outreach efforts have been launched through the identification and training of community volunteers and mayors, who have now begun carrying out activities.

Table 9: Community Volunteer/Educator Training, Participants by Country, FY14/15.

Country	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Bangladesh	0	10	11	44	65
DRC	0	0	0	3	3
WA/Niger	0	0	0	360	360
Nigeria	27	28	245	0	300
Uganda	0	0	48	0	48
Total	27	38	304	407	776

Sub-Objective 2.2 Establish partnerships to facilitate achievable, holistic goals for reintegration to meet the needs of women with fistula

As noted earlier, global staff provided technical and management input to the subawards development process for all countries; including support to TERREWODE, a resource partner on the FC+ project, for the development of a scope of work specifically targeting WDI. This subaward has received USAID approval and began in FY14/15. A major collaboration activity is a study to understand the needs of WDI as well as the effects of social reintegration services for this group. See Objective 5 and Section III for additional details. Country reports describe other individual partnerships for reintegration of women following fistula repair.

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

Efforts to reduce transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support target the challenges that keep women from being able to access and use fistula services, particularly for repair, and will involve testing innovative incentives and enablers to help women overcome these obstacles.

Sub-Objective 3.1 Reduce transportation barriers for prevention and treatment of OF
Sub-Objective 3.3 Reduce financial barriers to fistula prevention, treatment, and reintegration

The Population Council, FC+ implementing partner, completed a systematic literature review of barriers to obstetric fistula treatment in developing countries. The review included structured searches of target databases and identification of resources for abstract review followed by review of abstracts for selection and synthesis of included full-text resources. The review has identified nine distinct categories of barriers to fistula treatment. The Abstract and Executive Summary of the systematic review can be found in Appendix R. A manuscript based on the review has also been developed for submission to a peer-reviewed journal.

These review findings guided the development of a conceptual framework and plan for formative research to further investigate these barriers in Nigeria and Uganda. FC+ staff and USAID reviewed and discussed multiple draft protocols for this formative research, drafted by the Population Council; the final protocol received ethical approval from the Population Council Institutional Review Board (IRB), and USAID approval in the third quarter of the fiscal year. Following state-level ethical approvals in Nigeria, Population Council conducted the formative research in Ebonyi and Bauchi states in FY14/15. Ethical approval was extremely delayed in Uganda, and the formative research has had to extend into the first quarter of FY15/16.

Data collection for this formative research is qualitative and includes Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) with a range of informants from communities in each of the study sites. The interviews explore fistula clients' and community members' attitudes towards fistula; motivations for maternal health and fistula service use; rationale in selection and utilization of health care; and communication and interaction with different providers, including participants' suggestions on how more women living with fistula might access treatment. Women with fistula describe the event that resulted in fistula; their previous experiences with maternity and/or fistula care; and (when applicable) their treatment pathway, from diagnosis, to the decision to seek care, to reaching and receiving care.

Findings from the formative research will be used to guide the development of interventions that will be tested in Nigeria and Uganda in FY15/16. FC+ and Population Council will convene a workshop to review the formative research findings in December 2015.

Sub-Objective 3.2 Improve communication in support of fistula prevention, treatment, and reintegration

The global team, including the Senior Technical Advisor for Community Engagement and the Deputy Director, provided technical guidance to Nigeria staff in conceptualizing and developing a communications assessment. USAID approval has been received for the assessment research protocol and local approvals are nearly complete. This assessment, which will identify current knowledge, sources of information, and available communication channels for messages related to fistula, maternal health, and family planning, will guide a Nigeria communications strategy. Please see Section III, Nigeria for more information.

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

FC+ strengthens provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment, supporting health facilities and their staff to deliver effective clinical care and monitoring of topics ranging from family planning (FP) counseling to fistula repair outcomes.

Sub-Objective 4.1 Strengthen facility-level capacity to prevent fistula

Good quality obstetric care, including timely recognition and management of prolonged/obstructed labor, is the cornerstone of fistula prevention. FC+ efforts to strengthen fistula prevention at the facility level primarily relate to increasing capacity for FP, labor monitoring, and EmOC. Training efforts, as well as provision of FP counseling and services are described below.

To assess the quality of obstetric and management of prolonged/obstructed labor, FC+ has planned to conduct partograph reviews annually at facilities that receive FC+ support for labor and delivery care. Such support may include training, supervision or other inputs related to EmOC, BEmOC, partograph/labor monitoring, C-section, etc. When possible, partograph reviews will also be conducted annually at facilities where FC+ plans to provide such support during the life of the project, even if the support is not currently being provided. In the third quarter, FC+ redesigned the partograph monitoring tool that had been developed and implemented under the FC project. The tool now includes both review of the sites' partograph utilization and completion as well as questions related to facility and workforce labor and delivery capacity. The tool was not finalized and rolled out to country programs until the fourth quarter of FY14/15. As a result, partograph monitoring findings for FY14/15 will be included in the FY15/16 semi-annual report.

During FY14/15, FC+ supported sites reported a total of 73,762 obstetric deliveries in four program countries. Data was not available from Nigeria as work directly related to supporting obstetric care services has not yet begun at supported sites.

C-section rates at supported sites vary widely at the country level (from 22% in Uganda to 65% in Bangladesh) and at the facility level, due to varied patient profiles and clinical mandates of different facilities. FC+ supported sites tend to be higher-level facilities that are more likely to receive referrals and complications; this contributes to a high proportion of C-section deliveries – 42% across FC+ sites (Figure 3).

Across supported sites, 2.3% of all deliveries had prolonged/obstructed labors, with 15% of those prolonged/obstructed labors receiving catheterization for fistula prevention. Reported rates for prolonged/obstructed labor also vary widely by site and by country (e.g., Bangladesh 0.4% obstructed/prolonged and 76% receiving catheterization and WA/Niger 16% obstructed/prolonged and 7.5% receiving catheterization). Site-level data can be found in Section III, by country.

Figure 3: C-Section Rates, by Country, FY14/15 (n=75,762 deliveries).



FC+ and the American College of Obstetrics and Gynecology (ACOG) have begun discussions for a potential partnership in designing and implementing C-section/EmOC training in Uganda. This ACOG Global Programs (<http://www.acog.org/About-ACOG/ACOG-Departments/Global-Womens-Health>) initiative rejuvenates the prior under-funded Canadian Network for International Surgeons (www.CNIS.ca) cesarean skills program in Uganda. Geared toward assuring minimum acceptable levels of cesarean delivery skills among house officers in their final year of obstetrics training, FC+ will participate by sending two female obstetricians from FC+ sites as observers in the launch activities in early FY15/16. This will be followed by summary feedback and active participation in later phases of the ACOG/CNIS cesarean skills program in Uganda, and eventually, throughout the East African region.

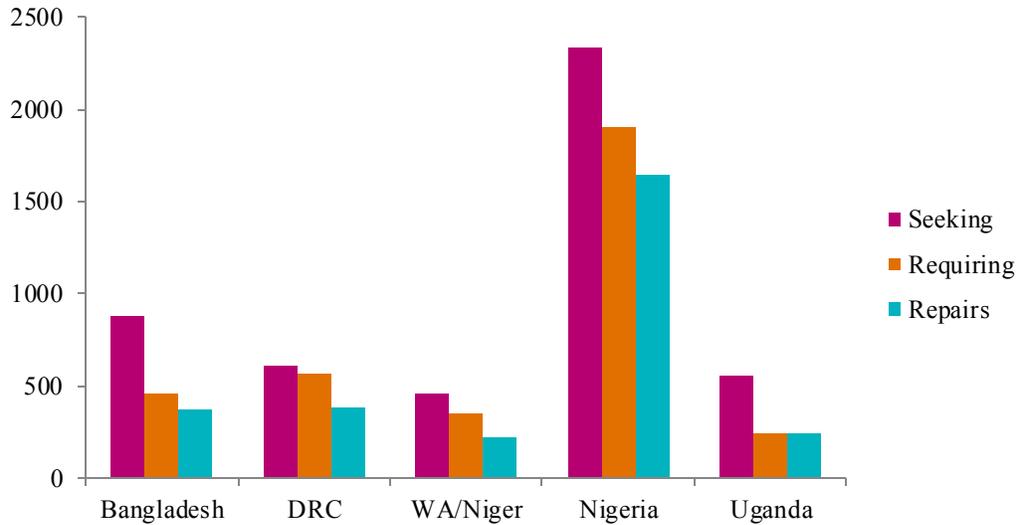
Sub-Objective 4.2 Increase capacity for treatment

During FY14/15, a total of 4,836 women with severe incontinence symptoms sought fistula care services at FC+ supported sites. Of these women, 3,790 were diagnosed with fistula (78% of those seeking). Of those diagnosed, 3,538 were medically eligible for surgical repair. FC+ supported the provision of 2,876 fistula repairs in FY14/15, nearly a 240% increase over FY13/14. See Figure 4 for data on women seeking and requiring fistula treatment and the number of repairs supported, by country. Site level information is presented in Section III, by country.

Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or

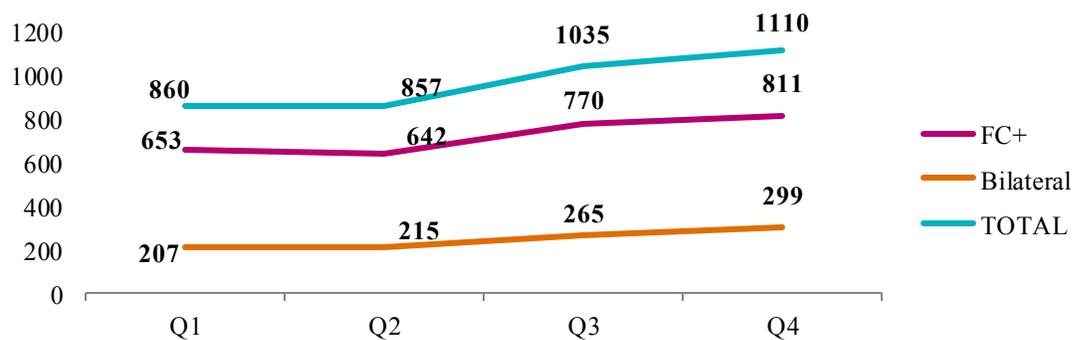
repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

Figure 4: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, By Country, FY14/15.



Including projects receiving bilateral funding, a total of 3,862 repairs were supported by USAID in six⁸ countries (Bangladesh, DRC, West Africa/Niger, Nigeria, Tanzania, and Uganda) during FY14/15, of which 2,876 (75%) were supported through FC+ (see Figure 5 and Table 10 for detail). The remaining 986 repairs were supported by USAID bilateral projects. Site level repair data is presented in Section III, by country.

Figure 5: USAID-Supported Surgical Fistula Repairs, by Quarter, FY14/15 (n=3,862)



⁸ FC+ supported a surgeon to attend and provide repairs at a UNFPA sponsored repair camp at Sokodé, Togo in Dec 2014 and May/June 2015. Because UNFPA funded repair costs, we are not reporting on these repairs, but are counting this site as a supported treatment site.

Table 10: Number of USAID-Supported Surgical Fistula Repairs, by Country, FY14/15.

Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Bangladesh	87	61	112	110	370
DRC	62	91	110	122	385
WANiger	21	63	83	60	227
Nigeria	410	365	416	454	1645
Uganda	73	62	49	65	249
Total FC+	653	642	770	811	2876
DRC: ProSani (bilateral)	38	NA	60	60	158
Tanzania: Vodafone/CCBRT (bilateral)	169	215	205	239	828
Total USAID bilateral	207	215	265	299	986
Total All USAID-supported	860	857	1035	1110	3862

Provider error during medical procedures has emerged as an important contributor to the fistula burden, likely causing a higher proportion of cases than traumatic fistula in most settings. FC+ is therefore collecting data from supported sites on the number of cases that are deemed by the operating surgeon to be iatrogenic fistula. Currently, 32 supported sites report this data, indicating that, in FY14/15, 7.1% (n=270) of all diagnosed fistula cases (n=3,810) at these sites were identified as iatrogenic in nature. However, a notably higher percent of cases were identified as iatrogenic in Bangladesh (23.4%) and DRC (14.4%) (see Section III, by country). Increasing discussion with country and site teams is required to ensure that all sites are identifying probable iatrogenic fistula cases with consistent criteria. FC+ has considered recommending the algorithm proposed in an FC+ co-authored paper on iatrogenic fistula;⁹ however, there continues to be debate in the treatment community about the optimal signs of iatrogenic fistula. The FC+ team will work with country and site staff to implement the use of a consistent algorithm in FY15/16.

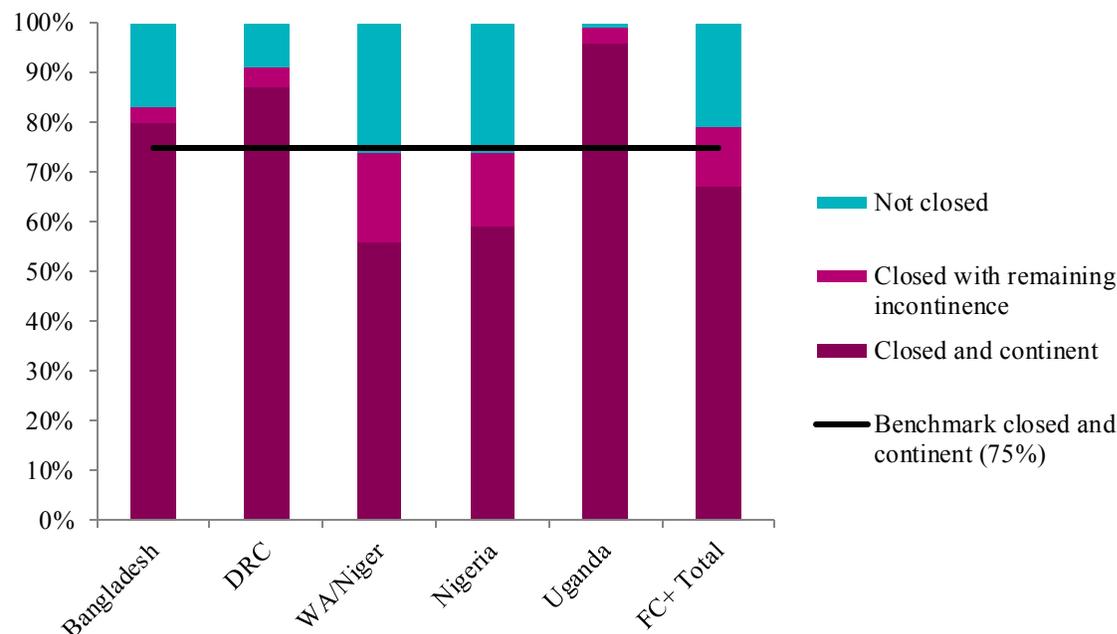
During FY14/15, 79% of all discharged FC+ repair cases were closed at the time of discharge. 67% of all cases are closed and continent (i.e., dry in the case of fistula resulting in leakage of urine) at discharge, 12% were closed with remaining incontinence, and 21% were not closed.

Closed and continent rates are a challenging, potentially non-informative indicator for quality of care, in that a patient can have suboptimal outcome even when the quality of care occurs at or above an acceptable standard. This is exacerbated by variations in case mix, i.e., if some facilities are caring for many more patients with complex fistulas and complicating co-morbidities. However, in tandem with other clinical indicators (e.g., complications, infections), this indicator may be useful in identifying settings where audit and analysis of the case mix, quality of care, and other issues may be warranted. The project has set a benchmark of 75% for the proportion of discharged cases deemed closed and continent. Therefore, when rates fall below benchmarks, FC+ investigates the causes to determine whether follow-up action is necessary. As presented in Figure 6, national closed and continent rates in West Africa/Niger and Nigeria fell below this benchmark. Explanations for low closed and continent rates during this

9 Raassen TJ, Ngongo CJ, Mahendeka MM. Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries. *Int Urogynecol J.* 2014 Dec;25(12):1699-706. <http://www.ncbi.nlm.nih.gov/pubmed/25062654>

reporting period and, when relevant, the steps being undertaken to address them are discussed in Section III, by country.

Figure 6. Outcome Rates for Fistula Surgical Repairs, by Country, FY14/15.



Reported complication rates for surgically repaired fistula cases at supported sites were generally low (2.2% project-wide), with countries reporting rates ranging from 0.6% in Bangladesh to 3.1 in DRC. Project benchmarks define a complication rate of <20% to be acceptable. Country-specific data on complication rates can be found in Section III.

To strengthen provider capacity for fistula repair, during FY14/15, FC+ has trained 22 surgeons in five countries (Bangladesh, DRC, Niger, Nigeria and Uganda) based on the FIGO training curriculum. Eleven surgeons participated in their first training in fistula surgical repair, 12 took part in continuing trainings and one surgeon received training to be a trainer¹⁰ (see Table 11). More detailed training information can be found in Section III, by country.

Table 11: Training in Surgical Fistula Repair, Participants by Quarter, FY14/15¹¹.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
First Training in Surgical Fistula Repair	0	6	0	6	12
Continuing Training in Surgical Fistula Repair	3	1	4	6	13
Training to be a Trainer	0	1	0	0	1
Total	3	8	4	12	22

¹⁰ These numbers total to more than 21 because several surgeons received both first and continuing training during the course of the fiscal year.

¹¹ Please note: rows and columns in the table do not add up across quarters because surgeons may receive both first and continuing training, or multiple continuing trainings, across quarters.

A total of 1,065 health system personnel in five countries (Bangladesh, DRC, Niger, Nigeria, and Uganda) participated in training in non-surgical topics during FY14/15, including data management, EmONC, FP provision, fistula and FP counseling and infection prevention (see Table 12). These trainings contribute to fistula prevention, identification, referral, treatment, and post-repair services as well as clinical data management.

Table 12: Training for Health System Personnel (excluding fistula/POP surgery), Participants by Quarter, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
ANC	0	0	0	0	0
Community, outreach and advocacy	68	4	92	42	206
Data management	17	16	56	16	105
EmONC	0	0	79	16	95
EmONC and labor monitoring	57	16	15	0	88
FP counseling	0	25	0	110	135
FP methods	60	0	13	0	73
FP and fistula counseling	0	11	22	22	55
Fistula counseling	0	0	16	23	39
Gender	0	0	0	7	7
Infection Prevention	17	10	18	24	69
Labor monitoring	0	0	58	0	58
Non-surgical POP treatment	0	0	0	0	0
Pre- and Post-Operative Care	4	0	0	28	32
Quality Assurance	0	30	0	66	96
Other	0	0	7	0	7
Total	223	112	376	354	1,065

FC+ has updated its “Updated Fistula Facility Prevention, Detection and Treatment Services: Site Needs Assessment Tool (with Optional Pelvic Organ Prolapse Supplement).” The updated tool is available on the FC+ website (http://www.fistulacare.org/pages/resources/Needs%20Assessment%20Tool_fistula%20plus%20prolapse%20supplement1.pdf). Moving forward, the project also seeks to strengthen data collection for topics such as EmOC, C-section skills monitoring, and co-morbidities associated with fistula.

The Clinical Director participated in a meeting held October 27-28, 2014 in Entebbe, convened by surgeons who have worked in Kitovu Hospital in Uganda and other faith-affiliated hospitals in countries including Zambia, Niger, and Ethiopia. The 17 meeting participants included urologists, general surgeons, OB-GYNs, fistula care nurses and researchers. Participants were based in Angola, Burundi, Niger, Tanzania, Uganda, United Kingdom, and the United States. The focus of the meeting was in-depth discussion about technical problems related to difficult fistula repairs, e.g., clinical and surgical management of very large fistulas, tiny lateral fistulas, urethral strictures, residual incontinence, and diversion challenges. Surgeons felt these topics were receiving progressively less attention at the ISOFS congress and wanted to ensure an opportunity for discussion. Other topics included updating client record forms and conducting research for a fistula diagnostic score. There was discussion about formulating research for a

study on catheterization to prevent fistula, but estimated client numbers to adequately power a study were too high for immediate feasibility. FC+ was able to share the discussions about the feasibility of such a study that came out of the July 2014 FC+ consultations on a project research agenda. The group plans to hold a follow-up meeting preceding the next ISOFS meeting.

FC+ has begun to evaluate how it can collect more informative, in-depth clinical data for locally-owned, sustainable quality assurance/improvement (QA/QI), including individual-level tracking of clinical skills acquisition and patient outcomes. Draft tools and models from other organizations have been reviewed in FY14/15; these will be finalized in FY15/16 and adopted at the country level for data collection and use. Systems and staff roles related to this in-depth clinical monitoring are in discussion and development.

Sub-Objective 4.3 Integrate family planning (FP) services to respond to client needs

FC+ supports efforts to strengthen integration of FP in fistula treatment services and broader maternal health care at supported sites.

During FY14/15, a total of 149,610 counseling sessions were provided at supported sites, and family planning services resulted in a total of 107,986 Country Years of Protection (CYP). This represents a 290% increase in counseling sessions and 170% increase in CYP over the first year of the project (FY13/14). The method mix contributing to this total CYP includes implants (42%), injectables (18%), tubal ligation (15%), and IUCD (12%). Country specific counseling information is provided in Figure 7 and CYP information in Figure 8, with country- and site-specific information provided in Section III.

Figure 7. Family Planning Counseling Sessions, by Country, FY14/15 (n=149,610).

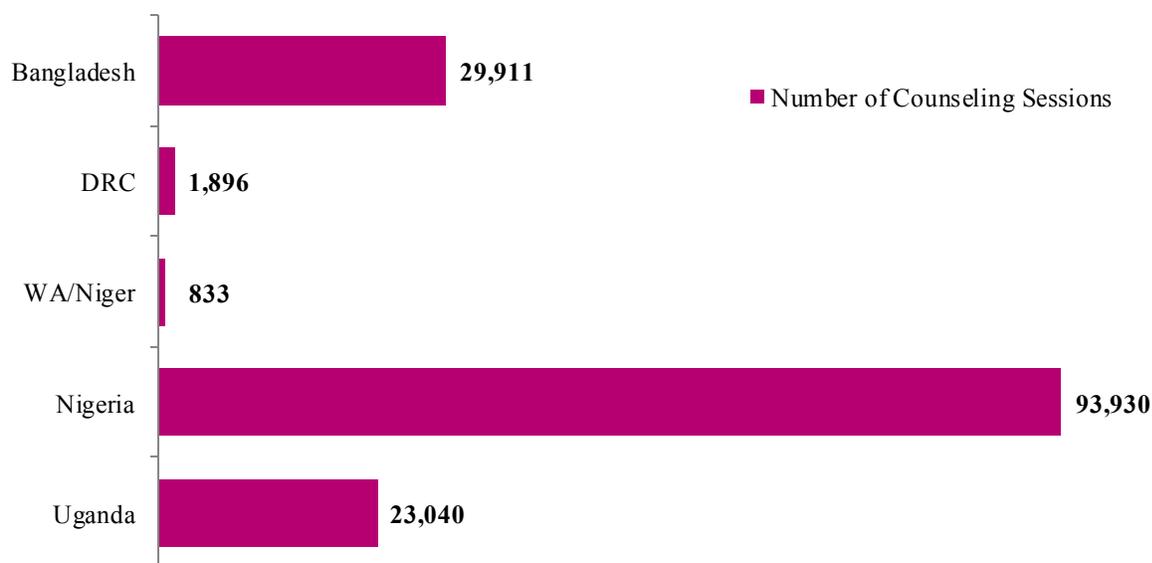
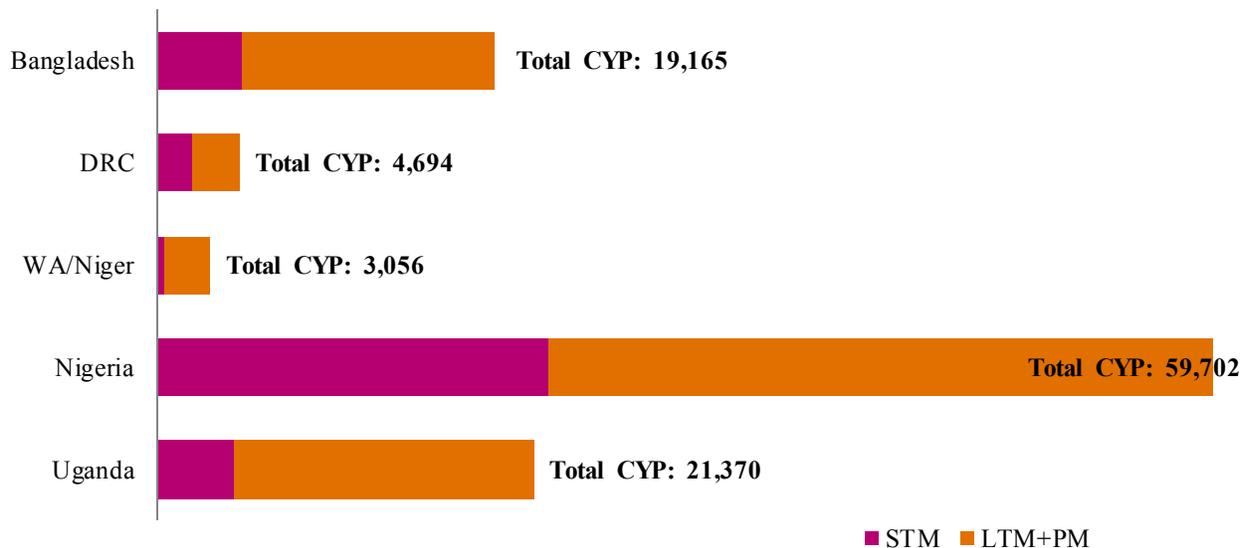


Figure 8. Family Planning CYP, Short-Term vs. Long-Term/Permanent Methods, by Country, FY14/15 (n=107,986).



Sub-Objective 4.4 Support and establish treatment/care programs for WDI and POP

During FY14/15, FC+ has worked to develop program plans for the establishment and support of treatment for WDI and women suffering from POP.

As part of efforts to address incurable fistula, referred to as persistent fistula-related disorders (PFRD) in the clinical literature, the FC+ project organized a meeting in Nigeria in collaboration with the Federal Ministry of Health, entitled the Clinical Meeting on Women with Persistent Incontinence. Held February 24-25, 2015, this meeting was attended by prominent fistula surgeons in Nigeria, representatives of key federal ministries, USAID, UNFPA, and the Society of Gynecologists and Obstetrics of Nigeria. During the meeting, a draft national guideline on the management of WDI was adopted. For more information, please see Section III, Nigeria.

To lay the foundation for piloting the integration of POP services, FC+ convened a POP integration workshop in New York (September 29-October 2, 2015). Facilitated by consultant Betty Farrell, the workshop included providers and program staff from all FC+ supported countries; the current ISOFS and G4 Alliance presidents; and stakeholders from partner organizations such as USAID, UNFPA, Hamlin Hospital, and the Fistula Foundation. Five sites for POP integration in four countries (Nigeria, West Africa/Niger, Uganda and DRC) were identified and participants began the process of developing action plans for this work, to be initiated in FY15/16. A workshop report summarizing discussion and action steps is under development. The workshop agenda and participant list are in Appendix M.

A project survey administered to all treatment sites (see Objective 5) included questions on current needs, capacity, and practices related to POP services. 26 of the 32 FC+ treatment sites

submitted responses to the survey; the resulting data were analyzed and a summary presentation was shared at the FC+ POP integration workshop (see Appendix S).

As of September 30, 2015, 10 FC+ supported sites (five in DRC, two in West Africa/Niger, two in Uganda, and one in Nigeria) report providing conservative and surgical POP treatment. During the fiscal year, these sites reported that 1,308 women sought treatment for possible POP symptoms with 1,013 women diagnosed with and requiring treatment for POP (77% of those seeking). A total of 805 women received POP treatment during this period (80% of those requiring). Supported sites provided 734 conservative POP treatments and 600 surgical POP treatments (some women may receive both conservative and surgical treatment). POP treatment data is presented by country in Table 13, site-specific data can be found in the relevant country reports in Section III.

Table 13. Number Seeking, Requiring, and Receiving POP Treatment, by Country, FY14/15.

Country	#Seeking	#Requiring	% of Seeking	#Receiving	% of Requiring
DRC	1049	788	75%	662	84%
WANiger	129	119	92%	86	72%
Nigeria	57	49	86%	0	0%
Uganda	73	57	78%	57	100%
FC+ Total	1,308	1,013	77%	805	84%

All women receiving surgical POP treatment were cured at discharge and 0.3% experienced complications. Given the nature of POP repair, it is to be expected that all treated women would be considered “cured” at the time of discharge. The project is not currently able to gather longer term follow up data to monitor success rates and POP recurrence after discharge. However, such follow-up data will be sought at sites where FC+ will be piloting the active integration of POP and fistula services in FY15/16.

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

FC+ strengthens the evidence base for approaches to improve fistula care and promotes M&E scale-up by ensuring that FC+ activities are appropriately documented and disseminated and by learning from and contributing to the knowledge of the fistula community as well as the broader maternal health sector.

Sub-Objective 5.1 Increase standardization in terminology, classification, and indicators

In the first quarter of FY14/15, the Deputy Director attended the WHO Maternal Morbidity Measurement Stakeholders Meeting held on October 2-3, 2014 in Istanbul, Turkey. The purpose of the meeting was to convene stakeholders to offer input on a BMGF-funded WHO project to define maternal morbidity and develop tools to measure its incidence and cause-specific distribution. Stakeholders were asked to review the definition of maternal morbidity developed

by the core working group, review a draft measurement tool that will be piloted in the near future, and offer feedback for the process in general. In addition to signs/symptoms and treatment/management, the working group emphasized that it seeks to include women's perspectives in measurement of morbidity, including impact on wellbeing and functioning. Once pilots using the tools have been implemented and published, the fistula questions will be included in the ongoing FC+ inventory of survey/interview-based measurement tools.

As noted in Objective 1, the Deputy Director, at the request of USAID/Bangladesh, has engaged with the Bangladesh Maternal Mortality Survey (BMMS) team in an advisory role. FC+ inputs are supporting the integration of standardized clinical terminology; research evidence on measurement approaches; and best practices for screening, examination, and treatment into the BMMS and a clinical validation sub-study.

As described under Objective 2, the Deputy Director worked together with project partner TERREWODE to apply validated quality of life assessment tools and develop indicators and data collection tools for a joint study on the psychosocial reintegration of women with incurable fistula (the locally adopted term for WDI/PFRD).

Recommendations from the 2014 FC+ technical consultation on measurement and estimation of fistula incidence, prevalence, and treatment backlog were highlighted in a commissioned commentary in *Lancet Global Health* ([http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)70105-1/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)70105-1/fulltext)).

FC+ worked with WHO colleagues on a secondary analysis of data collected in two FC project studies: the observational study on fistula outcomes and the randomized controlled trial (RCT) on duration of catheterization. This effort is applying cluster analysis to study data to identify groups (i.e. clusters) of homogeneous cases in order to determine if it is possible to classify fistulas using patterns that naturally present. FC+ has provided clinical and analytical input to this process, and preliminary results suggesting an inductive classification system are under discussion between WHO and FC+. Because the emerging classification categories merge sociodemographic and clinical characteristics, it is unclear whether these categories will be more useful as measures of social vulnerability or as prognostic tools for repair outcomes. Further refinement of the analytic model is required, and this work will continue in FY15/16.

Sub-Objective 5.2 Strengthen monitoring and evaluation/research (ME&R) systems and use of data

Engender Health's Monitoring, Evaluation, and Research (M&ER) team and Clinical Support Team co-convened a workshop on March 23-27, 2015 in Istanbul, Turkey on using clinical data for decision-making (CDDM) in EngenderHealth programs. Participants from FC+ included the Deputy and Clinical Directors as well as clinical and M&E staff from the global team, Nigeria, West Africa/Niger and Uganda. The meeting sought to promote communication and coordination between M&E and clinical staff in EngenderHealth programs, as well as to create a shared understanding of and priorities for a CDDM conceptual framework and related tools. FC+

presentations included country case studies from Bangladesh and Nigeria, an overview of FC+ M&E tools, and use of CDDM in FC+. At this meeting, the importance of data validation was also discussed. The FC+ Nigeria team is leading the way in implementing data validation activities at supported sites. See Section III, Nigeria country report for more information. Meeting outcomes included development of an internal framework for CDDM and an action plan for improving clinical/M&E linkages. Please see Appendix Z for a technical brief that resulted from the meeting discussion; in this document, the EngenderHealth M&ER team highlighted FC+ DDM approaches.

To operationalize the FC+ PMP, a key activity in FY13/14 and FY14/15 has been updating FC+ M&E and data management systems. FC+ has built a DHIS2 platform to function as the global M&E database for the current project. DHIS2 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. Several other EngenderHealth programs are in the process of developing their own DHIS2 platforms, and EngenderHealth is in the initial stages of developing an organizational-level platform.

FC+ completed the core modules of its DHIS2 database in the first quarter of FY14/15. FC+ held “virtual” orientations for all global staff involved in data collection and monitoring in December 2014. The orientations included an overview/refresher of FC+'s PMP, as well as detailed walk-throughs of all data collection forms.

Building on those orientations, the project designed and carried out DHIS2 training for all field-based M&E staff on March 10-13 in Kampala, Uganda. The DHIS2 training included 16 participants including M&E staff from Bangladesh, DRC, West Africa/Niger, Nigeria, and Uganda; an M&E consultant from Guinea; US-based M&E and program staff; and two co-trainers from the Health Information Systems Program (HISP) Uganda. This event introduced the project's DHIS2 platform and provided training in theoretical concepts as well as significant time devoted to hands-on exercise and practice opportunities to ensure adequate comfort level with the platform. The training agenda can be found in Appendix I. FC+ has produced a training slide set (English/French), a DHIS2 glossary (English/French), and an End User manual (currently English only but will soon be translated). The Senior M&E Associate also held an orientation for the FC+ global team in the third quarter on how to conduct queries, generate reports, and otherwise use the data captured by DHIS2.

As an early NGO adopter of DHIS2, FC+ was invited to participate in and present at the DHIS2 for iNGOs Global Symposium, held on January 29-30, 2015 in Washington D.C. The symposium was organized by Population Services International (PSI) and The University of Oslo (UiO), in partnership with the NonProfit Organizations Knowledge Initiative (NPOKI) and InsideNGO. FC+ presented on the EngenderHealth/FC+ development experience, and has received multiple inquiries for follow up conversations from other international NGOs who are interested in developing their own platforms. In addition to sharing actual project

implementation cases, the symposium provided an opportunity to for input into how to enhance DHIS2 as an enterprise M&E management tool for iNGOs.

FC+ has also provided technical assistance to the Fistula Foundation as they explore the possibility of using the FC+ project's DHIS2 database format to track clinical repair information from their supported sites. This assistance has included training, development of a mock DHIS2 framework and actual data entry to test whether the DHIS2 platform can successfully meet their needs. Discussions are ongoing with both organizations committed to maximizing use of available data for programmatic advancement.

In the third and fourth quarters of the fiscal year, FC+ conducted extensive review and revision of project clinical monitoring and evaluation tools. This was catalyzed by the arrival of a new Project Director with extensive clinical experience. In FY14/15, FC+ also developed tracking forms to monitor project and site level compliance with various clinical and monitoring and evaluation requirements. Orientation to the updated clinical data collection tools took place in the fourth quarter of FY14/15 and the tools will be implemented beginning in the first quarter of FY15/16. The FC+ DHIS2 platform is being updated to facilitate capture of new areas of data collection, while retaining historical data for the project. As noted in Objective 4, the project is also considering how to expand clinical data collection and use for QA/QI. It is anticipated that, starting in FY14/15, there will be two streams of ongoing data management in FC+: aggregated program and clinical monitoring, as has been conducted and reported in the first two project years; and in-depth clinical monitoring for local QA/QI through the new tools now in development.

All data included in this annual report were drawn from the project's now fully functioning DHIS2 database. The platform allows for easy generation of standard indicators and calculations for project data, as well as dashboards that provide graphic representations of up-to-date data. A DHIS2 dashboard has been developed and shared with USAID/Washington, and will be refined further to meet USAID's information needs. A screenshot of the dashboard prepared for USAID/Washington is included in Appendix T.

FC+ conducts internal DDM exercises after the close of each quarter to discuss program data and identify issues in need of follow-up. Country programs are beginning to implement similar processes on a quarterly basis. In Nigeria, the annual Providers' Network Meeting, convened by FC+ and the MOH, provides an opportunity to reflect on both national and site level data trends.

The project works with supported treatment sites to encourage ongoing review of site-specific data to identify and act upon areas of clinical and programmatic concern and opportunity to improve fistula services. While it is ideal for sites to review data on a monthly or quarterly basis, depending on service volume, experience from the original FC project indicates that this is very difficult for sites to achieve, given shortages in human and other resources. 55% of FC+ supported treatment sites met at least twice during the fiscal year to review their data; 66% met at least once (See Appendix U for country and site details). In addition to facilitating such

reviews when requested, FC+ has also trained 105 health personnel throughout the fiscal year in data for decision making.

Sub-Objective 5.3 Use research findings to improve practice

As described above, FC+ has sought to ensure that new efforts to measure and estimate the fistula/POP burden and to evaluate fistula program services are informed by the findings of past research. This has included technical inputs to processes such as WHO's maternal morbidity measurement tool development, the BMMS questionnaire and clinical protocol development, and TERREWODE's development of a research protocol to evaluate services for WDI.

In FY14/15, FC+ also continued to share results from the FC project RCT on the non-inferiority of shortened duration of catheterization after surgical repair (see publication information in Objective 5.4). The results provide solid evidence that short-duration bladder catheterization is a safe and effective approach for management of women after repair of simple genital fistula. The project seeks to use these findings to foster changes in clinical practice that will reduce discomfort for women after fistula repair, reduce costs of services, and allow for more women to have their fistulas repaired than at present. FC+ is now developing a clinical guideline to enable health care providers to incorporate the findings into their services for women with fistula. FC+ also employed a focused media strategy to disseminate the publication and the research findings, including through a widely-distributed press release and the infographic presented in Appendix V.

Formal changes in Ministry of Health training and service delivery standards require time. FC+ is working through technical working groups and provider network groups to influence government bodies. While this moves forward, individual champions and collaborative discussions can catalyze change. For example, in FY14/15, FC+ supported site Kitovu Hospital in Uganda formally adopted short-term catheterization as the post-operative standard of care for simple fistula.

Between August and October 2015, FC+ surveyed 17 clinicians who were directly or indirectly involved in the RCT to assess post-repair catheterization practices, and 14 clinicians responded. At the time of response, only two were not undertaking short duration catheterization for simple fistula, but all are doing so now. Most respondents are teaching new fistula surgeons and/or advocating with peers to use short duration as the standard. Several are already collecting data to share with program colleagues and FC+ plans to support their ability to share such data at a suitable forum, such as ISOFS, in FY15/16.

FC+ collaboration with WHO on the RCT has resulted in an invitation to partner on a systematic review of the literature on catheterization, which will lead to a consultative meeting and, potentially, issuance of a formal statement and guidelines in support of short duration catheterization.

FC+ has documented the impact of other prior research conducted by the prior FC project. For instance, results from the earlier C-section studies have led to improvements in some of the organizational gaps identified, such as processing and storage of client records in Uganda. In Bangladesh, findings led to a renewed focus on supporting partograph use, as well as redefining indications for C-section, and some early discussion on appropriate classification systems. FC/FC+ supported research by Dr. Thomas Raassen and others has led to increased awareness of the magnitude of iatrogenic fistula and the need to document it, as well as identifying systemic causes, such as indications for C-section and hysterectomy, inadequate provider training, and unsupportive work environments.

Conference presentations and publications continue to be an important strategy for FC+ to share the findings of its research and evaluation activities, and to foster evidence-based change in research and program practices. Throughout the fiscal year, FC+ convened and presented at multiple meetings and conferences as part of efforts to disseminate findings from research and program evaluations, see Table 4 for details.

As mentioned under Objective 1, FC+ helped organize and present at meetings held in October 2014 in Kampala, Uganda by ISOFS, IOFWG, and UNFPA.

FC+ co-hosted the IOFWG/UNFPA meeting held on October 27-28, 2014. On the second day of the meeting, FC+ presented on various research-related topics including results from project consultations on research priorities and measurement of the fistula burden; findings from research on community engagement for fistula prevention/treatment in Guinea; and findings from analysis of media coverage of fistula treatment and related barriers. The meeting agenda can be found in Appendix F.

The ISOFS meeting was held on October 29-31, 2014. FC+ staff and partners made eight presentations at the meeting on topics including complications risk associated with surgical treatment of genital fistula, using radio to raise community awareness in Bangladesh, DRC, mortality monitoring metrics, and applying findings from the RCT on non-inferiority of short duration postoperative bladder catheterization. Details on FC+ participation can be found in Appendix G. Additionally, FC+ staff in New York and Uganda supported a day-long workshop at ISOFS on research methods, attended by approximately 200 participants in the ISOFS meeting.

In Nigeria, FC+ co-sponsored and participated at the 3rd Nigerian Family Planning Conference in Abuja in November 2014. FC+ sponsored some FP providers from supported states to attend the conference. Dr. Adamu Isah made a presentation titled, “The 5-Step Program Approach: Integration of Family Planning and Fistula Services in Nigeria.”

Also in November 2014, FC+ presented at the American Public Health Association (APHA) annual meeting on research evaluating maternal health interventions and community outreach efforts in Guinea.

In January 2015, the project submitted an abstract to the Fifteenth Annual Meeting of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises on FC+ work developing support for the girls abducted by Boko Haram in Chibok, Nigeria in April 2014. The organizers invited Dr. Adamu Isah of the Nigeria team to take part in a panel/interactive session on Sexual and Gender-Based Violence, with full financial support from the organizers. The meeting was held February 25-27, 2015 in Amman, Jordan.

FC+ had a strong presence at the July 29-31, 2015 Organisation Ouest Africaine de la Santé (WAHO)/Economic Community of West African States (ECOWAS) 1st Good Practices in Health Forum held in Ouagadougou, Burkina Faso. The forum was supported by donors including USAID and attended by over 300 delegates. FC+ contributions focused on regional experience with community engagement, maternal health, fistula repair, and family planning integration. Nine FC+ staff participated in the forum (from West Africa/Niger, Nigeria, and the global team), giving eight oral and three poster presentations (see Appendix L and <http://www.fistulacare.org/pages/blog/2015/08/good-practices-shared-at-waho-forum-in-burkina-faso>). All presentations are available on the WAHO website (<http://www.wahooas.org/index2.php?lang=fr>), along with pictures and daily overviews of the conference in English, French, and Portuguese.

FC+ submitted abstracts and panel presentations to several upcoming conferences. During the first quarter of FY14/15, 16 abstracts were submitted for the 2015 FIGO Congress, all of which were subsequently accepted (10 oral presentations and six posters). Five country programs were represented in the submissions as well as two globally-focused abstracts. During the second quarter of FY14/15, in collaboration with Direct Relief International, the Fistula Foundation, and UNFPA, FC+ contributed to a panel session submission on “Improving the Health of Socially Vulnerable Women: Building partnerships and capacity to address obstetric fistula” for APHA 2015. A number of abstracts were submitted for consideration for GMNHC 2015, including a panel on iatrogenic fistula.

As part of continued collaboration with MCSP, the Deputy Director developed abstracts for GMNHC 2015, sharing the results of research on improving maternal and newborn care quality measurement.

FC+ has also sought to contribute to the evidence informing fistula and related programs through the continued publication of reports, briefs, and journal articles. During FY14/15, seven articles were accepted or published in peer-reviewed journals (see Table 14). FC+ ensures that all articles supported with project resources and included in approved workplans are published open-access, in line with USAID policy on research.

A commentary on measurement and estimation of the prevalence and incidence of fistula, co-authored by the Deputy Director and representatives of WHO and the Johns Hopkins Bloomberg School of Public Health, was published in the *Bulletin of the World Health Organization* (<http://www.who.int/bulletin/volumes/93/1/14-141473/en/>).

M&E consultant Alex Delamou published two articles in *Tropical Medicine and International Health* entitled “Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea” (<http://www.ncbi.nlm.nih.gov/pubmed/25706671>) and “Factors associated with loss to follow up in women undergoing repair for obstetric fistula in Guinea” (<http://www.ncbi.nlm.nih.gov/pubmed/26250875>). He also had a correspondence on Ebola in Health Care Workers in Guinea published in *The Lancet* (<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2960193-3/fulltext>).

Several current and former FC+ staff co-authored an article on "What to measure and why. Experience developing monitoring indicators for an emerging maternal health issue: the case of obstetric fistula," published in the *Journal of Health Informatics in Developing Countries* (<http://www.jhidc.org/index.php/jhidc/article/view/133>).

Mark Barone et al.'s manuscript “Breakdown of simple female genital fistula repair after 7 day versus 14 day postoperative bladder catheterisation: a randomised, controlled, open-label, non-inferiority trial” ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)62337-0/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62337-0/abstract)) was published in *The Lancet* in April 2015. Efforts to move these findings from research to practice are described above.

In June 2015, *PLOS ONE* published the article “Development and Validation of an Index to Measure the Quality of Facility-Based Labor and Delivery Care Processes in Sub-Saharan Africa,” authored by the Deputy Director and describing work conducted through support from the USAID Maternal and Child Health Integrated Program (MCHIP) (<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0129491>).

Appendix W provides a complete list of FC/FC+ peer-reviewed journal publications and Appendix X provides metrics for readership of articles published by FC/FC+. While metrics are only available for some FC/FC+ articles, these have been viewed more than 22,000 times. The *Bulletin* commentary, *Tropical Medicine and International Health* article, and *PLOS ONE* article were all featured in the “5 Things You Need to Know about Maternal Health” bulletin of the Maternal Health Task Force (MHTF). Additionally, an FC+-supported article on maternity care-seeking in Guinea was among the top three most downloaded articles in the journal *Women in Health*.

In addition to the journal publications already described and published with FC+ resources, clinicians and researchers trained through the project are also continuing to conduct and share their own research to improve fistula prevention and treatment programs. For example, a staff member from the Bwera Hospital in Uganda who was a “Partograph Champion” trained by FC/FC+ published the paper, “Improving Partograph Documentation and Use by Health Workers of Bwera Hospital: A Process Improvement Research,” in the *International Journal of Nursing and Health Sciences* (http://www.researchgate.net/profile/Simon_Katongole/publication/279178403_Improving_Partograph_Documentation_and_Use_by_Health_Workers_of_Bwera_Hospital_A_Process_Improvement_Research/links/558c37aa08aee43bf6ae24ea.pdf).

FC+ has also continued to disseminate research findings online. In FY14/15, FC+ staff contributed six posts to the MHTF blog including:

- October 2014: Moustapha Diallo and Ellen Brazier, “Building community capacity for maternal health promotion” (<http://www.mhtf.org/2014/10/23/building-community-capacity-for-maternal-health-promotion-an-important-complement-to-investments-in-health-systems-strengthening/>).
- May 2015: Vandana Tripathi, “New research to shorten recovery time for fistula repair.” (<http://www.mhtf.org/2015/05/04/new-research-to-shorten-recovery-time-for-fistula-repair/>)
- May 2015: Vandana Tripathi, “Ending preventable maternal mortality: Bridges to morbidity reduction” (<http://www.mhtf.org/2015/05/29/ending-preventable-maternal-mortality-bridges-to-morbidity-reduction/>)
- June 2015: Vandana Tripathi, “How to measure the quality of facility-based labor and delivery care in sub-Saharan Africa” (<http://www.mhtf.org/2015/06/25/how-to-measure-the-quality-of-facility-based-labor-and-delivery-care-in-sub-saharan-africa/>)
- October 2015: Lauri Romanzi, “Let’s create disruptive innovation for maternal newborn health at GMNHC 2015” (<http://www.mhtf.org/2015/10/16/lets-create-disruptive-innovation-for-maternal-newborn-health-at-gmnhc2015/>)
- October 2015: Vandana Tripathi, “Integration and equity in fistula care: Goals for GMNHC 2015” (<http://www.mhtf.org/2015/10/17/integration-and-equity-in-fistula-care-goals-for-gmnhc/>)

The MHTF blog also independently published several pieces related to FC+ project activities. FC+ staff additionally use the FC+ project website, blog, and Twitter feed to disseminate findings from project studies and evaluations.

Table 14: Peer-Reviewed Articles Published, FY14/15

Authors	Title	Journal
Tunçalp O, et al	Measuring the incidence and prevalence of obstetric fistula: approaches, needs, and recommendations	<i>Bulletin of the World Health Organization</i> . 2015 Jan; 93(1):60-62 http://www.who.int/bulletin/volumes/93/1/14-141473/en/
Ngongo C, et al	What to measure and why. Experience developing monitoring indicators for an emerging maternal health issue: the case of obstetric fistula	<i>Journal of Health Informatics in Developing Countries</i> . 2015 9(1): 14-22. http://www.jhidc.org/index.php/jhidc/article/view/133
Delamou A, et al	Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea	<i>Tropical Medicine in International Health</i> . 2015 Jun;20(6):813-9.. http://www.ncbi.nlm.nih.gov/pubmed/25706671
Brazier E, et al	The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea	<i>Health Policy and Planning</i> . 2015 Sep;30(7):885-94. http://www.ncbi.nlm.nih.gov/pubmed/25148842

Authors	Title	Journal
Barone M, et al	Breakdown of simple female genital fistula repair after 7 day versus 14 day postoperative bladder catheterisation: a randomised, controlled, open-label, non-inferiority trial	<i>The Lancet</i> . 386 (9988):56–62. July 2015. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62337-0/abstract
Tripathi V, et al	Development and validation of an index to measure facility-based labor and delivery care processes in sub-Saharan Africa	<i>PLOS ONE</i> . 2015. 10(6): e0129491 http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0129491
Delamou A, et al	Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea	<i>Tropical Medicine & International Health</i> . 2015 Nov;20(11):1454-1461.. http://www.ncbi.nlm.nih.gov/pubmed/26250875

Sub-Objective 5.4 Contribute to the evidence for improved programming and care

In FY14/15, FC+ conducted several activities to advance the priorities in the project research agenda developed through consultative meetings in 2014. A number of these have been described above, including: inventory and analysis of survey- and interview-based tools used to identify fistula cases, inputs to the BMMS and clinical validation sub-study, literature review on barriers to fistula treatment, formative research on treatment barriers in Uganda, and HMIS documentation template development.

FC+ also hosted a research consultation on July 17, 2015, to discuss the relevance, parameters, and feasibility of a study to evaluate the effects of urinary catheterization in preventing obstetric fistula and/or related outcomes in immediate postpartum women after prolonged/obstructed labor. Meeting participants included FC+ staff, clinical and research experts, members of the FC+ International Research Advisory Group, and USAID representatives. Presenters summarized the current literature and evidence related to the study topic as well as key issues and challenges in study design. Participants discussed these topics, coming to a consensus on some and identifying key questions and next steps to address others.

A primary area of consensus among participants was the need for a survey of maternity service providers in FC+ countries and other settings where fistula is an important problem, to understand current practices related to urinary catheterization after prolonged/obstructed labor. This information will be crucial in assessing whether and how a research study can be implemented in an ethical and rigorous way to generate adequate clinical evidence.

Areas of agreement related to study design included the importance of clear case definition for prolonged/obstructed labor, given the dearth of consistent terminology and criteria across facilities and countries; the selection of voiding dysfunction (impaired bladder emptying) as the postpartum condition most likely to be implicated in fistula formation; and the importance of individual (vs. facility-level) randomization in generating valid evidence for the effects of urinary catheterization.

However, there was considerable debate about other aspects of research such as inclusion/exclusion criteria, e.g., whether only women who have had vaginal deliveries in a facility should be eligible. It was also proposed that, given the absence of clinical evidence or information about urinary catheterization practices after prolonged/obstructed labor, a pilot study simply evaluating the feasibility of systematic urinary catheterization after prolonged/obstructed labor could generate valuable evidence in settings where fistula is prevalent. The meeting discussions and planned next steps are included in the meeting report, which has been shared with USAID. Appendix K provides the agenda and participant list; the meeting report has been submitted to USAID.

In FY14/15, FC+ designed and implemented the first of what is intended to be a series of health facility surveys, to understand practices and needs related to technical priority areas. The Project and Deputy Director developed the first survey, which targeted health facilities supported by FC+ for fistula repair. The survey had two parts: 1) processes for documenting and addressing fistula backlog at supported treatment sites, and 2) current need and capacity for POP services. 26 of the 32 FC+ supported treatment sites responded to the survey; findings related to POP have been summarized in Appendix S and a technical brief based on these will be developed in FY15/16. These findings have also been used to guide and contextualize the selection of pilot sites for POP integration, as discussed in Objective 4. Topics for future surveys (e.g., adoption of shorter duration catheterization following fistula repair) have been identified by the FC+ global team.

Since the last DHS comparative analysis on questions related to incontinence was published in 2008, numerous surveys have used the DHS fistula module. The Deputy Director requested the DHS Program to conduct an updated secondary analysis of the data from all surveys using the fistula module (including longitudinal comparison in countries that have now used the module in multiple years), providing requests for specific bivariate and multivariate regressions, data permitting. The DHS Program completed this analysis in the third quarter of FY14/15 and published the report in June 2015 on the DHS program website (<http://dhsprogram.com/publications/publication-OD67-Other-Documents.cfm>). The analysis and report were conducted entirely with DHS Program resources. The FC+ Deputy Director and DHS Program analyst are now working on manuscripts highlighting key findings of this analysis.

SECTION III: COUNTRY REPORTS

Please note: Reports are provided only for Objectives that were actively addressed in FY 14/15. All sub-objectives are consolidated for reporting.

Bangladesh

USAID-supported fistula services in Bangladesh began in July 2005 through the previous FC project and continue through FC+ in eight hospitals as of September 30, 2015. In Bangladesh, FC+ works with private hospitals and public sector institutions, including Medical College Hospitals and district Hospitals. The FC+ project is working in partnership with the Bangabandhu Sheikh Mujib Medical University (BSMMU) to set up a Fistula Prevention, Treatment and Training Center on-site. The project has plans to expand support to a total of ten treatment and prevention facilities as well as three prevention-only facilities. All currently supported fistula treatment sites in Bangladesh provide referrals to fistula clients for social and medical services as well as reintegration services.

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

The National Obstetric Fistula Strategy has been finalized and will be printed and disseminated once permission is granted by the Government of Bangladesh (GOB). The Ministry of Health and Family Welfare (MOHFW) has responded to FC+ advocacy efforts by issuing a letter to district hospitals allowing them to establish “Fistula Corners” using public funds to strengthen district-level efforts to prevent fistula and identify and refer women who need repair. A consultant has been engaged for developing a manual for the proposed fistula corners at district hospitals.

In the first quarter of FY14/15, FC+ participated in a coordination meeting organized by UNFPA in the Directorate General of Health Services (DGHS) and contributed to the meeting through a presentation on “Strengthening Coordination between GOB and Private Fistula Centers with a Mapping Exercise.”

In the third and fourth quarters, FC+ organized meetings of the National Fistula Task Force, in partnership with DGHS and UNFPA. FC+ is working together with UNFPA to map the location of fistula surgeons nationwide.

As part of efforts to develop public/private partnerships, FC+ submitted a proposal to HSBC Bank in Bangladesh to provide support for producing an audio-visual aid for educating school-age girls about safe motherhood to prevent maternal and newborn mortality and morbidity, including but not limited to fistula and stillbirth prevention. A response is pending.

The Bangladesh program celebrated the International Day to End Obstetric Fistula (IDEOF) on May 23, with a focus on local media and civil society institutions. FC+ Bangladesh produced two audio programs on fistula, which aired on 13 radio stations, including a free repeat broadcast. Several weeks prior to IDEOF, FC+ organized a fistula orientation workshop for 19

electronic and print media journalists. Ten newspapers subsequently had headlines related to fistula on International Fistula Day, including references to the FC+ project. A similar orientation was held for 15 community radio station managers, immediately following IDEOF. FC+ also supported BSMMU to host seminar on fistula, attended by more than 200 doctors and nurses. Community level activities are reported under Objective 2.



Fistula orientation workshop for journalists, Dhaka (Credit: Hena Baroi)

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In the second half of the fiscal year, FC+ signed an MOU with the NGO Health Service Delivery Project (NHSDP) for patient identification screening and referral; and with the Hope Foundation for Women and Children at Cox's Bazar for integration of FP services with fistula programs and improvement of infection prevention practices.

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 made efforts to build partnerships with both facilities and communities to strengthen efforts towards fistula prevention, treatment, and reintegration. During the first quarter of FY14/15, FC+ met with local health officials and staff at Kumudini hospital to discuss efforts to strengthen FP services at the hospital. Several fistula repair clients were referred by micro credit programs affiliated with FC+.

In March 2015, FC+ met with the Bangladesh Rural Advancement Committee (BRAC) to build a partnership for fistula case identification and referral. BRAC has subsequently held four fistula screening camps, see below.

In partnership with Ad-Din Khulna and BSMMU, FC+ has drafted and printed site-specific leaflets for distribution to spread information about available services.



BRAC Screening Camp, Uttara, Dhaka (Credit: Hena Baroi)



Community orientation, Gazipur (Credit: Nitta Biswas)

During FY14/15, a total of 314 community outreach/education/advocacy events were carried out for community members, health providers and local officials. These activities included orientation programs for medical students, journalists, and community members, in Dhaka, Chandpur, Jessore, Gaibandha, Gazipur, Kustia, Sathkira, and Tangail districts, covering topics related to fistula prevention, identification, treatment and reintegration as well as family planning. An example includes a May 2015

orientation in Mozaffar Garden, Sathkira, a remote district of Bangladesh. The event reached 219 school girls who are volunteers of the ‘Golden Girls Project’ that promotes safe motherhood within their neighborhoods. The program was co-hosted by FC+ partner, the Ad-din Welfare Center. Immediately following the orientation, the volunteers identified two fistula cases who were referred for repair. FC+ also hosted a radio show to discuss maternal health and themes around fistula prevention and awareness.

Nearly 140,000 participants were reached through community outreach, education and advocacy events. Information on community events, by type, is presented in Table BGD1. Screening camps were also held in multiple districts prior to each concentrated repair effort. During FY14/15, FC+ partner BRAC carried out a total of four screening camps identifying 120 fistula cases, of which 76 were referred for surgery.

Table BGD1: Community Outreach/Education/Advocacy Events, FY14/15.

Type of Event	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Existing community activity	0	0	9	510	0	0	0	0	9	510
Health facility	0	0	0	0	2	100	0	0	2	100
Health providers	1	50	4	192	155	2,627	32	440	192	3,309
Policy makers	0	0	4	197	18	1,749	10	979	32	2,925
Maternal health/fistula-focused	1	44	24	1,001	28	1,276	0	0	53	2,321
Radio/TV	0	0	0	0	26	130,000	0	0	26	130,000
Total	2	94	41	1,900	229	135,752	42	1,419	314	139,165

In the second, third and fourth quarters, LAMB hospital conducted training for a total of 62 fistula patients to provide information, skills development, and the opportunity for them to play a role in their communities as fistula educators, see Table BGD2. Trainings included participants from Ad-Din’s microcredit project and the Kumudini Welfare Trust (Objective 4). In addition, BRAC trained three community volunteers in client identification in the third quarter.

Table BGD2: Community Volunteer/Educator Training, Participants by Topic, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Cured Fistula Patients	0	10	11	44	65
Total	0	10	11	44	65

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

During FY14/15, several site assessments were conducted in Bangladesh. In the first quarter, a site assessment was carried out at Ad-Din Medical College Hospital in Khulna. FC+ already supports two other Ad-Din sites (Dhaka and Jessore). The site assessment findings indicated that the hospital is well-staffed with sufficient bed capacity and clinical facilities. FC+ has decided to support the site as an extension site for Ad-Din Jessore Hospital, with initial support for concentrated repair efforts through outside surgeons and potential for ongoing service provision after training of interested surgeons at the facility.



Ad-Din Khulna labor ward
(Credit: SK Nazmul Hudal)

In the third quarter, site assessments took place at two government medical college hospitals: Noakhali Government Medical College Hospital and Faridpur Government Medical College Hospital; two district hospitals: Patuakhali District Hospital and Moulvibazar District Hospital; and two private hospitals: Dr. Muttalib Community Hospital and Park Laboratory and MAMM’s Institute of Fistula and Women’s Health. In the fourth quarter, a site assessment was carried out at Gaibandha District Hospital in Gaibandha.

Revisions have been made to the Fistula Screening Checklist, now called the “4 Questions (4Q)” checklist in Bangladesh

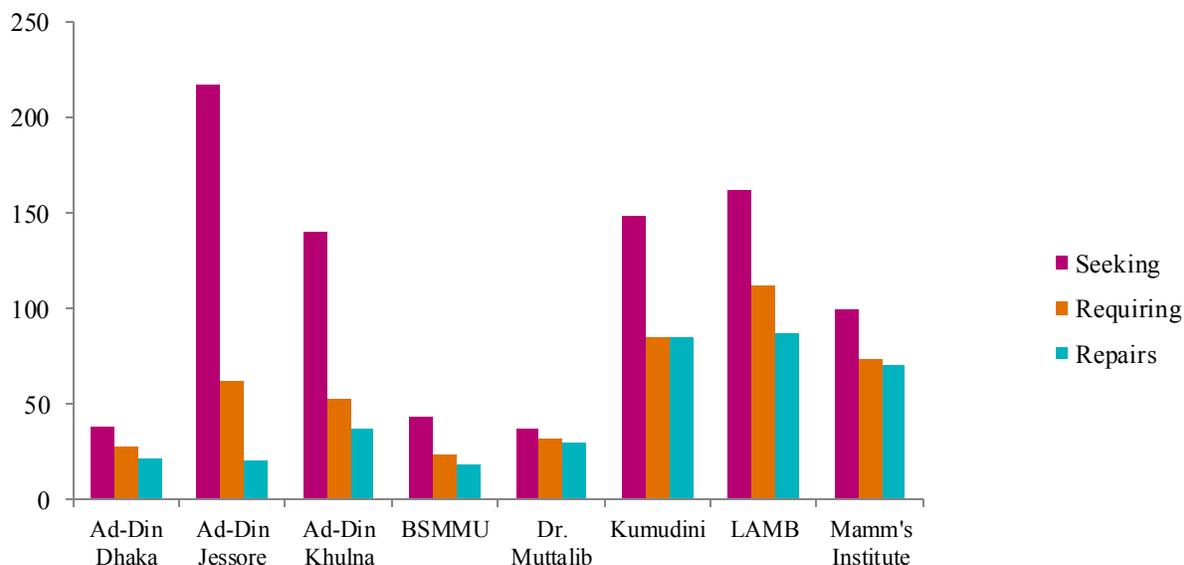
(<http://www.fistulacare.org/pages/pdf/Communications/Obstetric%20Fistula%20Identification%20Checklist-English.pdf>). The checklist was translated into Bangla printed in the second quarter and disseminated in the third quarter of FY14/15.

During FY14/15, 885 women with severe incontinence symptoms sought fistula care services at FC+ supported sites, of which 470 were diagnosed with fistula (53%). FC+ supported 370 surgical fistula repairs during this fiscal year (a 243% increase from 108 repairs in FY13/14). This increase was attributed to community outreach and identification efforts, an increase in supported sites, and the concentrated repair efforts organized throughout the year.

Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a

definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure BGD1 presents data on women seeking and requiring fistula treatment, and the number of fistula surgeries supported, by site.

Figure BGD1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY14/15.



These 370 fistula repair surgeries were conducted at eight FC+ supported hospitals: Ad-Din Dhaka, Ad-Din Jessore, Ad-Din Khulna, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dr. Muttalib Community Hospital, Kumudini, LAMB, and Mamm's Institute of Fistula and Women's Health, see Table BGD3 for detail by quarter. In addition to those surgical repairs, 13 women received conservative treatment (catheterization) for fistula during the fiscal year. Support to BSMMU and Dr. Muttalib Community Hospital began in the second quarter of this FY. Concentrated repair efforts took place throughout the year at Ad-Din Jessore, Ad-Din Khulna, BSMMU and Kumudini. Dr. Justus Kafunjo, from Uganda, facilitated concentrated repairs efforts at BSMMU and Kumudini in the



Fistula Repair Concentrated Effort at Kumudini Hospital (Credit: SK. Nazmul Huda)

third quarter. These concentrated efforts enabled a higher number of repairs to be performed. Political instability in the second quarter may have had a negative effect on care seeking.

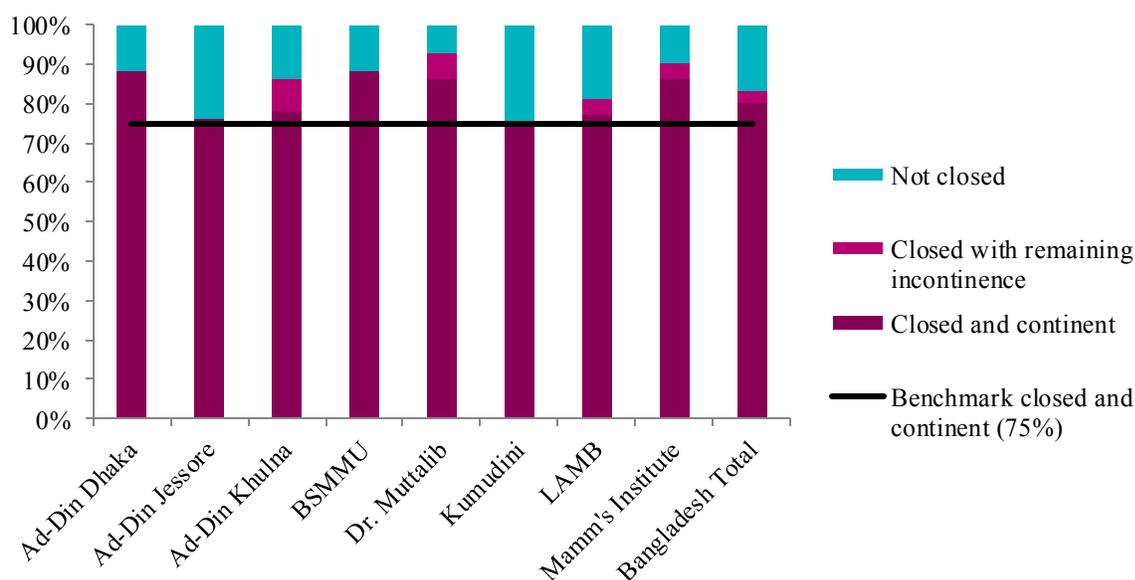
The proportion of fistula identified as iatrogenic in nature varied greatly between supported sites, from a low of 3% and Dr. Muttalib Community Hospital to a high of 50% at BSMMU. The overall reported proportion for the country was 23%. More cases were deemed iatrogenic in the second and fourth quarters (31% and 33%, respectively) than in the first and third quarters (15% and 18%, respectively). FC+ Bangladesh and global clinical staff are following up on this finding to gather more information and take action if needed.

Table BGD3: USAID-Supported Surgical Fistula Repairs, by Site, FY 14/15.

Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Ad-Din Dhaka	4	8	6	4	22
Ad-Din Jessore	16	1	0	4	21
Ad-Din Khulna	12	5	0	20	37
BSMMU	NS	2	7	9	18
Dr. Muttalib	NS	7	19	4	30
Kumudini	7	14	35	29	85
LAMB	24	16	26	21	87
Mamm's Institute	24	8	19	19	70
Total	87	61	112	110	370

83% of all fistula surgery cases in FY14/15 were closed at discharge; with 80% closed and continent and 3% closed and incontinent. 17% were not closed at discharge. Outcomes for discharged patients are presented, by site, in Figure BGD2. Reported complications were low at supported sites (0.6% overall) with a range of 0% (Ad-din Dhaka, Ad-din Jessore, BSMMU, Dr. Muttalib Community Hospital, Kumudini and LAMB) to 5% (Ad-Din Khulna).

Figure BGD2. Outcome Rates for Surgical Repairs, by Site, FY14/15.



During FY14/15, six surgeons from five facilities received training in fistula surgical repair. Two received first training, three received continuing training and one received both first and continuing training during the fiscal year (see Table BGD4 for detail, by trainee home institution).

Table BGD4: Surgical Fistula Repair Training, Participants by Trainee Institution, FY14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15		# Surgeons
	1st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont	Total
Ad-Din Dhaka	0	1	0	0	0	0	0	0	0	1	1
Monowara Hospital	0	1	0	0	0	0	0	0	0	1	1
Kumudini Hospital	0	0	0	0	0	0	0	1	0	1	1
Ad-Din Khulna	0	0	0	0	0	0	1	1	1	1	1 ¹²
BSMMU	0	0	0	0	0	0	2	0	2	0	2
Total	0	2	0	0	0	0	3	2	3	4	6

As part of fistula prevention efforts, FC+ Bangladesh has provided training to 216 health care providers during the fiscal year. Trainings covered EmONC, FP service provision, family planning and fistula counseling infection prevention, and working with cured fistula patients as community ambassadors (see Objective 2). FC+, in partnership with BRAC, carried out trainings in the third and fourth quarters for health personnel and community level health workers affiliated with health systems in training on fistula identification and counseling, gender, family planning counseling, and infection prevention. Two TOT trainings were carried out in Dhaka in the fourth quarter, covering the topics of facilitative supervision and clinical monitoring. Table BGD5 provides additional detail on non-surgical trainings for health system personnel.

Table BGD5: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
FP Methods	6	0	0	0	6
Community, outreach and advocacy	0	4	0	0	4
Facilitative supervision and medical monitoring	0	0	0	16	16
Family planning counseling	0	0	0	35	35
Family planning and fistula counseling	0	11	0	0	11
Fistula prevention and identification (including EmONC, FP and fistula counseling, gender, and IP)	0	0	79	16	95

¹² The same surgeon received first and continuing training in the fourth quarter and is therefore only counted once in the annual total.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Infection prevention	0	0	18	24	42
Dye test	0	0	7	0	7
Total	6	15	104	91	216

FC+ supports family planning counseling and service provision at most supported sites in Bangladesh. During FY14/15, nearly 30,000 counseling sessions took place at supported sites and 19,165 CYP were provided (see Table BGD6 for detail, by site). Method mix in Bangladesh is primarily comprised of IUCD-10 (Copper T), oral contraceptives, male condoms, Implanon, Depo, and tubal ligation.

Table BGD6: Family Planning Counseling Sessions and CYP, by Site, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP ¹³
Ad-Din Dhaka	5,500	2,570	4,300	2,437	4,100	1,644	3,200	1,906	9,800	8,556
Ad-Din Jessore	717	369	675	381	735	317	795		1,392	1,067
Ad-Din Khuna	640	465	55	253	35	312	45	155	705	1,186
BSMMU	NS	NS	651	472	1,200	601	1,500	498	651	1,572
Kumudini	15	686	270	653	265	486	295	710	285	2,535
LAMB	200	1,144	700	1,002	1,860	973	2,148	1,130	900	4,249
Total	7,082	5,234	6,651	5,199	8,195	4,333	7,983	4,399	29,911	19,165

FC+ supported sites reported an overall C-section rate of 65% during the fiscal year. Information on number of deliveries, by site, is represented in Figure BGD3 and C-section rates, by site, are presented in Figure BGD4.

¹³ Due to rounding, totals may differ slightly from the sum of individual quarters.

Figure BGD3. Number of Obstetric Deliveries, by Site, FY14/15 (n=29,192)

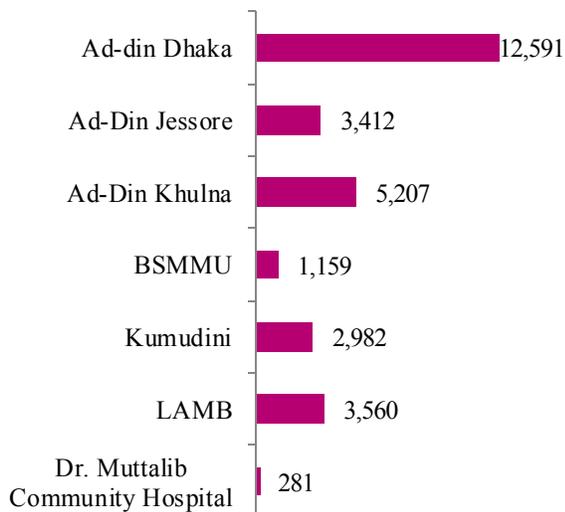
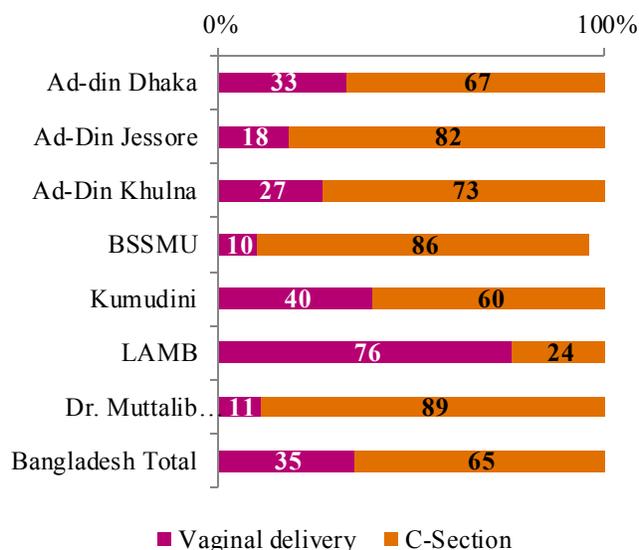


Figure BGD4. C-Section Rates, by Site, FY14/15



As described in Section II, Objective 2, the Bangladesh Country Program Manager attended the POP/fistula integration meeting in New York in September 2015.

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

During FY14/15, FC+ began designing a partners’ forum in Bangladesh to exchange lessons learned and discuss cross cutting issues in fistula program implementation. A coordination meeting with GOB and private partners is also planned. The first meeting is expected to take place in the first half of FY15/16.

During the second and third quarters, FC+ worked with supported sites to update and disseminate fistula registers to reflect changes in FC+ data collection.

Data quality assessments and review were conducted at LAMB (third and fourth quarter) and Kumudini (fourth quarter).

The DGHS HMIS includes seven fistula indicators. FC+ is preparing to organize a workshop to introduce these HMIS fistula indicators to our partner sites.



Fistula register orientation, Dhaka (Credit: Asifur Rahman)

Members of the FC+ Bangladesh team attended and presented at the 5th Conference of ISOFS held in Uganda in 2014. Presentations covered the socio-demographic profiles of fistula clients, opportunities for integration of fistula services with a micro-credit program, based on experience with the Ad-Din Foundation, and the role of community radio in preventing obstetric fistula and enhancing stigma elimination and social reintegration. The FC+ Bangladesh team submitted an abstract for FIGO and a presentation for the panel on iatrogenic fistula developed by the project for GMNHC 2015.

Democratic Republic of Congo

USAID-supported fistula services in DRC began in 2008 through the previous FC project and continue through FC+ in five hospitals as of September 30, 2015. USAID also provides bilateral support to the Projet de Santé Intégré (ProSani) for mobile outreach fistula repair efforts in DRC.

In DRC, FC+ has partnered with health centers and hospitals to support fistula repairs, train doctors and nurses in fistula-related skills and topics, improve EmONC, and conduct outreach to rural clinics to ensure that women in need of medical attention are referred to the hospitals for repair.

The target number of surgical fistula repairs in DRC for FY14/15 was raised to 468 (from the original figure of 258) in the third quarter, with approval from the local USAID mission. Subawards were extended through the end of December 2015.

The city of Beni and its surroundings remain subject to insecurity due to violence in the area. This permanent instability and insecurity cause frequent displacements of the population.

In addition to FC+ activities in DRC, EngenderHealth has embarked on a two year, \$3 million BMGF grant project, ExpandFP. 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.

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

FC+ has been part of ongoing efforts to develop a National Strategy for Fistula in DRC. To promote policy level support for the national fistula strategy and coordination of activities that can support fistula prevention, FC+/DRC Senior Program Manager Michel Mpunga has attended all MOH Task Force meetings on maternal and neonatal health.

FC+ participated in the SMNE Task Force (Santé de la Mère, du Nouveau né et de L'Enfant – Maternal, Newborn and Infant Health) during the first and third quarters, along with experts from the MOH and professionals working in the field of MNCH and fistula. The task force has provided a platform for reflection, designing standards and guidelines and monitoring activities and progress. Preparations for the dissemination of the standards and guidelines of Maternal, Neonatal and Child Health (MNCH) across the country continue. FC+ will contribute more during the coming year by training part of the central dissemination teams and by disseminating the documents at supported sites.

Throughout FY14/15, planning has been underway for a meeting of a fistula surgeon's Community of Practice (COP), which is now planned for the first quarter of FY15/16.

FC+ has worked with several local partners in DRC during FY14/15 including: a technical collaboration with “Médecins Sans Vacances” (Medics without Vacation) to share experiences and consumables for fistula surgery; a partnership with “Fistula Aide” in which they provide housing for clients pre- and post-repair; assistance with costs related to laboratory testing from

CBM/DRC; support for providing food and hygiene kits to fistula clients from the Association des Cadres Camerounais en RDC (The Association of Cameroonians in DRC) and Kin Accueil; and reintegration efforts carried out in Kinshasa by the Ministry of Gender and Family.

Supported sites have also directly leveraged funds from their own partners to complement the activities they are able to do with FC+ funds. St. Joseph Hospital (SJH) has constructed a hospital ward for women with fistula through partnership with the “Kin Accueil” association. The hospital also received equipment from the CURE Project. Heal Africa has several partnerships with the World Bank; Healing art, CBM and World Food Program (WFP). MSRK/IMA and Caritas have worked as partners, as part of the ASSP project funded by DFID for fistula treatment.

FC+ supported sites commemorated IDEOF through community engagement activities. HGR Panzi organized a visit to a school to meet 100 students; a visit to the hospital to present gifts to women with fistula; and, finally, a lively discussion between FC+ staff, Panzi HGR authorities, and the provincial coordinator of the reproductive health program. Imagerie des Grand Lacs (IGL) held a parade of health care workers, community groups, and other stakeholders in Beni. SJH held a celebration and invited health care workers, hospitalized clients, as well as women who had been repaired and their families. They also arranged for men to give testimonies to highlight the importance of male involvement.

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

During FY14/15, FC+ supported sites in DRC carried out 23 community outreach efforts reaching 11,375 people, see Table DRC1.

As part of efforts to increase public awareness of fistula prevention and treatment, in the first quarter FC+ carried out orientations for 25 Bureau Diocesain des Oeuvres Medicales (BDOM) community volunteers (relais communautaires) to re-orient them to the FC+ project and work towards strengthening their ability to provide referrals to SJH and Kisenso Hospital for treatment services. Kisenso Hospital is a satellite facility of SJH. Any reporting for activities at Kisenso is done through SJH.

International Women’s Day in March was recognized at SJH with a radio program that discussed fistula and the importance of male involvement in seeking prevention and treatment services. Heal Africa participated in community meetings to discuss issues related to maternal mortality and morbidity in Africa and family planning and other prevention efforts. Panzi Hospital conducted an outreach effort to community members and health systems personnel covering FP, fistula, and gender-related topics.

Also during the second quarter, IGL worked with local churches and schools to carry out three outreach/education activities, reaching 40 participants, covering topics related to maternity care

and fistula. IGL also hosts an ongoing show on a local radio channel to raise awareness of fistula and POP.

In the third quarter, Heal, Panzi and SJH held community meetings with churches and schools during which fistula prevention and treatment were discussed along with safe motherhood. Panzi held four community meetings around Bukavu (in Murhesa, Mugogo, Kasha, and Kaziba) reaching over 200 women. Panzi also organized three networking meetings, bringing together nearly 300 people in area schools and churches, which resulted in referrals of four new fistula clients.

SJH organized a meeting in the Health Zone of Nsele with community mobilizers from the Expand FP Project that covered topics related to obstetric fistula prevention, treatment, and socioeconomic and psychosocial consequences. Information was provided about prevention and access to repair at SJH and Kisenso. Several activities were planned as a result of this meeting including community outreach focused on identifying risks during pregnancy and childbirth, safe birth planning, and identification and referral of women with fistula. In addition, SJH has involved two husbands of former fistula clients that are now using their experience to help identify and refer clients in Mbanza Ngungu (Bas Congo).

Table DRC1: Community Outreach/Education/Advocacy Events, FY14/15.

Type of Event	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Existing community activity	0	0	4	140	2	30	1	80	7	250
Maternal health/fistula-focused	1	25	1	99	0	0	2	160	4	284
Health facility	0	0	0	0	2	138	0	0	2	138
Radio/TV	0	0	1	NA ¹⁴	5	10,703	4	NA ¹⁵	10	10,703
Total	1	25	6	239	9	10,871	7	240	23	11,375

As part of celebrations for IDEOF, FC+ and SJH staff participated in a television program about obstetric fistula as well as organizing an event on “Ending Fistula Now, Restore the Dignity of Women” to discuss fistula prevention and treatment and how members of the community can be involved in these efforts.

In the fourth quarter, IGL and HEAL Africa were unable to carry out community based activities due to insecurity in their regions. SJH and Panzi continued with their community activities via community and networking meetings. MSRK provided training to three community volunteers during the final quarter of the fiscal year, see Table DRC2. As described in the West Africa

14 Estimates of radio broadcast audience were unavailable

15 Estimates of radio broadcast audience were unavailable

section of this report, three participants from DRC were able to take part in a gender workshop held in Niamey, Niger during the fourth quarter.

Table DRC2: Community Volunteer/Educator Training, Participants by Topic, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Community volunteers	0	0	0	3	3
Total	0	0	0	3	3

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

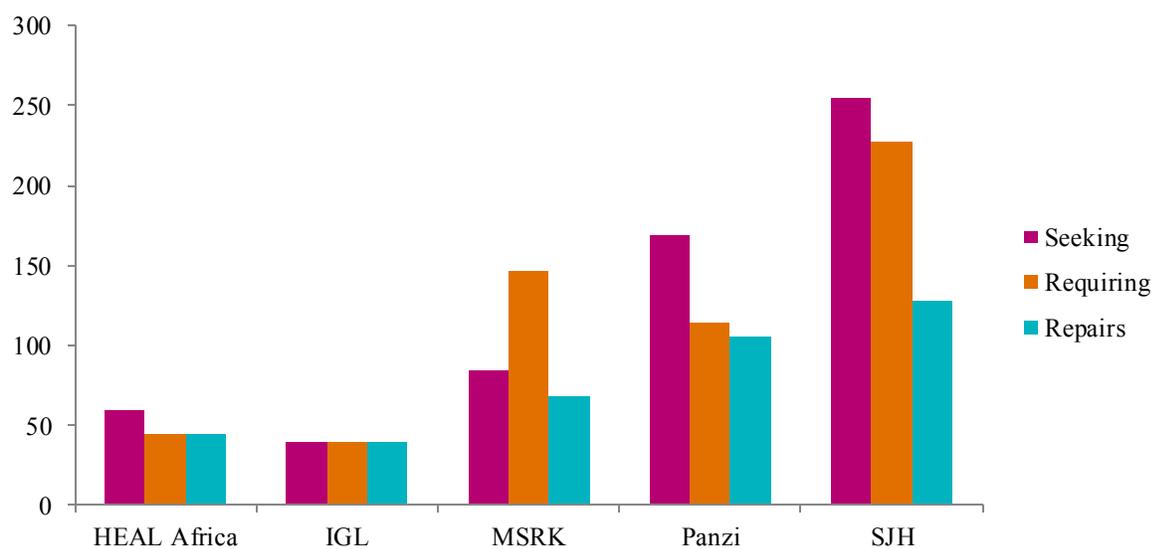
In October 2014, FC+ clinical staff conducted site assessments at SJH and Kisenso. In the third quarter of the fiscal year COPE quality assurance exercises were carried out at all supported sites except Panzi which awaited a client flow analysis prior to completing the exercise.

In the fourth quarter, HEAL and St. Joseph Hospital received supplies provided by Direct Relief, and equipment was purchased for MSRK and IGL (anesthesia vaporizers).

SJH has adapted several FC+ tools including the nurses training curriculum, the fistula counseling checklist, the protocol for post-operative monitoring and the death registration protocol. The Senior Clinical Associate of the FC+ Global team also met with surgeons and nurses at Panzi to discuss the possibility of further developing the Panzi staging system for fistula, POP, and incontinence.

During FY14/15, 608 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 572 were diagnosed with fistula and required treatment (94%). FC+ supported 385 fistula repair surgeries during this period. Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure DRC1 presents data on women seeking and requiring fistula treatment, and the number of fistula surgeries supported, by site.

Figure DRC1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY14/15.



These 385 fistula repair surgeries were conducted at five FC+ supported hospitals: HEAL Africa, IGL, MSRK, Panzi, and SJH, see Table DRC3 for detail by quarter. In addition to these FC+ supported repairs, Hôpital General de Référence (HGR) Kaziba provided 158 repairs during FY14/15 through the ProSani project, bilaterally funded by USAID. In addition to the surgical repairs reported here, a total of ten women received conservative treatment (catheterization) for fistula: six at FC+ supported sites and four through ProSani.

During FY14/15, supported sites in DRC identified a total of 84 women with iatrogenic fistula, representing 14% of all women diagnosed with fistula during that period. ProSani identified an additional 62 women whose fistula were iatrogenic, representing 39% of their reported diagnosed cases.

SJH experienced backlogs of clients waiting for surgery in both the first and second quarters, and as a result they referred a small number of clients to Biamba Marie Mutombo Hospital (HBMM) with funding from UNFPA for repair and scheduled all remaining clients for future concentrated repair efforts.

Table DRC3: USAID-Supported Surgical Fistula Repairs, by Site, FY 14/15.

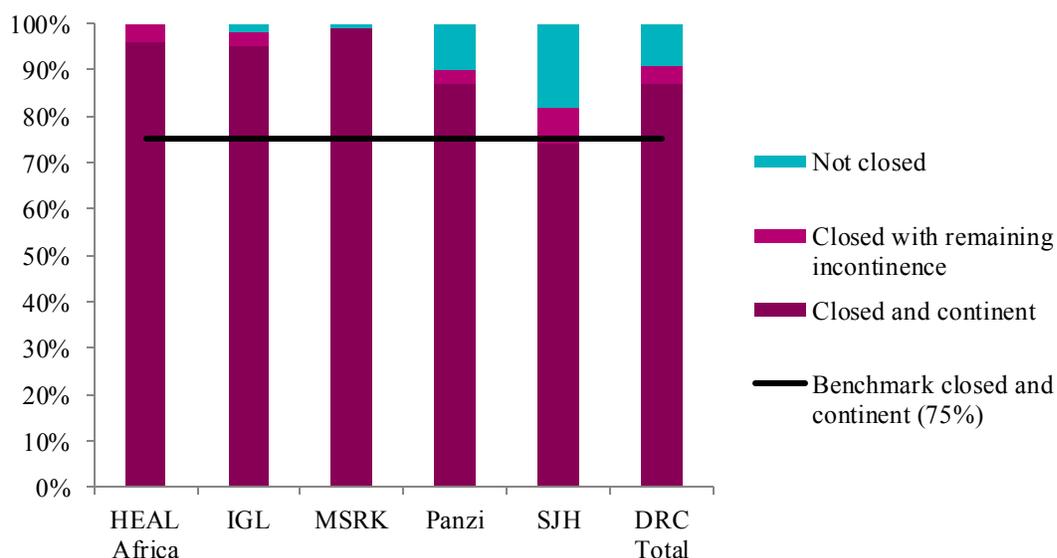
Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
HEAL Africa	29	0	15	0	44
IGL	NS	9	15	16	40
MSRK	NS	21	19	28	68
Panzi	NS	36	31	38	105
SJH	33	25	30	40	128
FC+ Total	62	91	110	122	385
HGR Kaziba (ProSani)	38	0	60	60	158
USAID-supported Total	100	91	170	182	543

HEAL Africa performed fistula repairs in the second and fourth quarters with non-USAID funding.

SJH experienced a decrease in the number of women receiving repairs during the first half of FY14/15 due to delays in funding, inadequate funding for client transportation reimbursement, and a reduction in efforts for raising client awareness and recruitment of fistula patients from other areas. As a result, they sought and obtained other funding for awareness-raising and recruitment efforts in neighboring provinces and carried them out in the second half of the year helping to raise the number of repairs provided. Funding delays proved difficult for multiple sites during the beginning of the fiscal year.

For FY14/15, 91% of all discharged fistula surgery cases were closed at time of discharge: 87% were closed and continent and 4% were closed and incontinent. Outcomes for discharged patients are presented, by site, in Figure DRC2. Reported complications were low at supported sites (3% overall) with a range of 0% (HEAL Africa, IGL, MSRK, and Panzi) to 10% (SJH). In the second quarter, SJH experienced high rates of women who were not closed and continent at discharge. The vast majority of those cases were women who had multiple previous repairs, particularly complex fistula.

Figure DRC2. Outcome Rates for Surgical Repairs, by Site, FY14/15.



During FY14/15, a total of four surgeons received training in surgical fistula repair, of which one participated in a training of trainers. Three surgeons from St. Joseph Hospital received training in the second quarter and the fourth quarter, see Table DRC4.

Table DRC4: Surgical Fistula Repair Training, Participants by Institution, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	1st	Cont	1st	Cont	1st	Cont	1 st	Cont	1st	Cont
St. Joseph Hospital	0	0	2	1	0	0	0	3	2	4

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	1st	Cont	1st	Cont	1st	Cont	1 st	Cont	1st	Cont
St. Joseph TOT	0	0	0	1	0	0	0	0	0	1
Total training sessions	0	0	2	2	0	0	0	3	2	5
Total number of surgeons who received training in FY14/15: 4¹⁶										

As part of fistula prevention and treatment efforts, FC+ in DRC has provided training to 270 health care providers during the fiscal year. Trainings in the first three quarters covered fistula prevention through proper use of the partograph, obstetric care, and family planning (see Table DRC5). In the fourth quarter, SJH and MSRK carried out trainings on community outreach and case identification. Panzi carried out training on quality assurance and SJH trained health facility staff on pre- and post-operative care.

Table DRC5: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
EmONC and labor monitoring	27	16	15	0	58
Partograph and family planning	0	0	38	0	38
Outreach and case identification	0	0	50	42	92
Fistula and FP counseling and methods	0	0	22	0	22
Pre- and post-operative care	0	0	0	10	10
Quality assurance	0	0	0	50	50
Total	27	16	125	102	270

FC+ supports FP counseling and service provision at five supported sites in DRC. During FY14/15, nearly 1,900 counseling sessions took place at supported sites and 4,694 CYP were provided (see Table DRC6 for detail, by site).

Table DRC6: Family Planning Counseling Sessions and CYP, by Site, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP
HEAL Africa	24	365	NS	NS	30	347	24	358	78	1,070
IGL	NS	NS	3	0	1	0	1	0	5	0
MSRK	NS	NS	3	0	0	0	7	113	10	113
Panzi	NS	NS	60	512	24	552	480	701	564	1,764

¹⁶ Three surgeons received training in both the second and fourth quarters and are only counted once in the total number of surgeons trained in the fiscal year.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
SJH	102	96	52	545	563	653	522	455	1,239	1,748
Total	126	460	118	1,056	618	1,551	1,034	1,626	1,896	4,694

FC+ supported sites reported an overall C-section rate of 34% in FY14/15, with a total of 9,682 deliveries. Information on number of deliveries, by site, is represented in Figure DRC3 and C-section rates, by site, are presented in Figure DRC4. 3% of reported deliveries were prolonged/obstructed labor and of those, 30% received catheterization for fistula prevention.

Figure DRC3. Number of Obstetric Deliveries, by Site, FY14/15 (n=9,682).

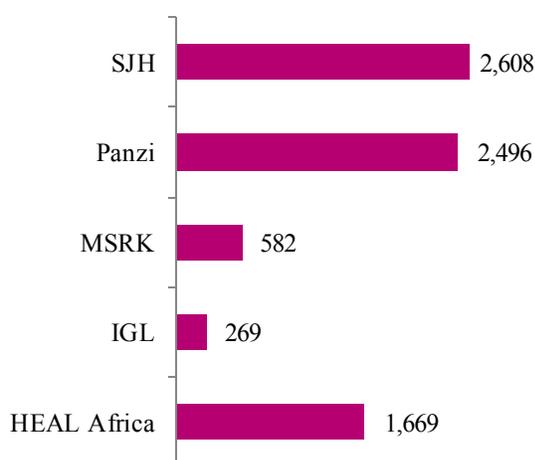
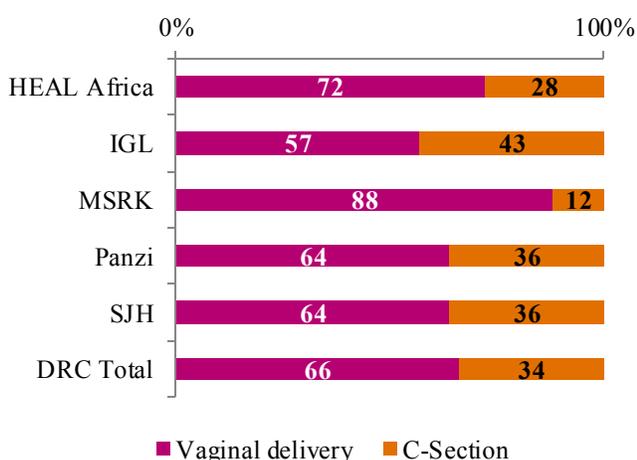


Figure DRC4. C-Section Rates, by Site, FY14/15.



All five supported sites in DRC reported providing conservative and surgical treatment for pelvic organ prolapse (POP) during FY14/15. During this period, 1,049 women sought treatment for possible POP symptoms with 788 women diagnosed with and requiring treatment for POP (75% of those seeking). A total of 662 women received POP treatment during this period (84% of those requiring). Across sites, 684 conservative POP treatments and 475 surgical POP treatments were provided (some women may receive both conservative and surgical treatment). All women receiving surgical POP treatment were cured at discharge and complications were only reported at St. Joseph Hospital (11% of discharged cases). POP treatment data is presented by site in Table DRC7.

Table DRC7. Number Seeking, Requiring and Receiving POP Treatment, by Site, FY14/15.

Site	#Seeking	#Requiring	% of Seeking	#Receiving	% of Requiring	% Cured Post-Surgery
HEAL Africa	443	277	63	277	100	100%
IGL	11	11	100	4	36	100%
MSRK	108	102	94	16	16	100%
Panzi	462	373	81	346	93	100%
SJH	25	25	100	19	76	100%
DRC Total	1,049	788	75%	662	84%	100%

The FC+/DRC Senior Project Manager and a provider from Panzi Hospital attended the FC+ convened POP/fistula integration meeting in New York in September 2015.

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

During FY14/15, two FC+ supported sites (SJH and IGL) were able to meet at least two times to review program data, and one (Panzi) was able to meet once. As a result of SJH data review meetings, the hospital made the decision to limit the number of clients operated upon during concentrated repair efforts to 25 women to ensure quality services, to begin providing group counseling sessions to try to ensure the availability of a female physical therapist for clients, and to send staff to the Kikwit area in Bandundu for fistula client identification efforts (funding is currently being sought for this activity).

SJH has begun to implement some of the clinical practices that were recommended from the RCT including removal of catheter seven days post-surgery for simple fistulas and the measurement of residual leakage following removal of the catheter.

Several FC+ partner staff attended and presented at conferences during the first quarters, including presentations at ISOFS in October 2014 and the 9th Annual Congress of the Congolese Urology Association. Presentations addressed the role of radio as a rural awareness raising tool in DRC and findings from a descriptive study about iatrogenic fistula.

Nigeria

USAID-supported fistula services in Nigeria began in 2007 through the previous FC project and continue through FC+ in 12 treatment and prevention sites and 237 prevention-only sites as of September 30, 2015. FC+ currently works in 11 states in Nigeria: Bauchi, Cross River, Ebonyi, Jigawa, Kano, Katsina, Kebbi, Kwara, Oyo, Sokoto, and Zamfara. In the fourth quarter of FY14/15, FC+ also provided technical support to 496 facilities that were formerly part of the TSHIP project which recently ended. Support to these sites is temporary until the new project is awarded. FC+ fistula prevention and treatment efforts in Nigeria have focused on support for repairs, clinical training, improving emergency and basic obstetric care, integration of family planning services, community awareness efforts, and advocacy at the national and state levels.

During the fiscal year, several new staff were hired in the FC+ Nigeria program including a Senior ME&R Advisor, Clinical Associate, FP Advisor, Finance Assistant and Finance and Admin Officer.

A national election in the third quarter of FY14/15 slowed activities during this period. Security remained fluid in some states throughout the year, particularly in the north, and some southern states like Ebonyi had temporary security issues due to election related violence. In addition, a workers strike in Oyo State negatively impacted program implementation there.

As part of efforts to develop the FY15/16 workplan, FC+ Nigeria held a planning meeting in Kaduna in the last week of June 2015. This process was supported by three staff from the FC+ global team as well as the Fistula Desk Officer from the Federal Ministry of Health (FMOH).

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

Throughout the fiscal year, FC+ has reached out to numerous key stakeholders at various levels of government and traditional institutions to advocate for more quality, attention and resource allocation for fistula prevention, treatment, and reintegration in Nigeria. These efforts have included advocacy and collaboration with the FMOH as well as many key national ministries and state level ministries in all supported states.

Advocacy and courtesy visits to government officials, ministries, and agencies in FY14/15 included:

- The FMOH Director of Family Health to discuss possible continuation of the GWIN initiative, FMOH's plans for a national fistula prevalence survey, and approval of a proposed protocol for conservative treatment of fistula with catheter.
- The Federal Ministry of Women Affairs and Social Development to organize a technical working group on ending early child marriage. Working group outcomes included development of Terms of Reference (TOR) and identification of strategies for moving forward.

- The Chief Medical Director of Murtala Mohammed Specialist Hospital (Laure VVF Center) in Kano State to follow up on issues identified during the Providers Network meeting regarding need for increased bed space and increasing iatrogenic fistula rates in Nigeria and how to address them.
- The Honorable Commissioner for Health and the Honorable Commissioner for Women Affairs in Kano State to discuss opportunities for improving EmOC, increasing manpower and bed space at MMSH, advocating for routine fistula repairs and discussing how to address the needs of WDI. As a result of persistent engagement by FC+ staff with the MOH and hospital management, a temporary ward of 16 additional beds was allocated to the center in March 2015, making a total of 28-30 beds for post-operative management of fistula clients.
- MOH representatives of the five states to be covered in the planned communications study (see Objective 2) to obtain necessary approvals for the study protocol.
- The wife of the immediate past Executive Governor of Ebonyi State, Her Excellency Chief Mrs. Josephine Elechi to introduce the new FC+ project and reaffirm commitment to collaboration with the state.
- The Vice Chairman of the Ebonyi State Maternal Mortality and Morbidity Monitoring Law Committee who reported that the state is facing challenges in client mobilization for the fistula center. He is preparing a proposal for FC+ to collaborate on possible community mobilization activities in the future.
- The Chair of Ogoja Local Government Area, Cross River State, Hon. Rita Agbo to seek the support of the local government for fistula activities at the Ogoja Fistula Center, particularly feeding of clients during pooled efforts repair. This meeting resulted in assistance provided at subsequent pooled effort repairs.
- Visits to the Oyo State Ministry of Health Ibadan, the Chief Medical Director of University College Hospital Ibadan and the Chief Medical Director of Adeoyo Maternity Hospital Ibadan as part of a joint FMOH, USAID, and FC+ team to affirm continued commitment to support state efforts. FMOH plans for a federal fistula center for the South-West were discussed.
- Visit to the Emir of Kano, Muhammad Sanusi II CON to introduce FC+ and invite the Emir to IDEFO events.
- Visit to the Executive Governor of Kebbi State and his wife, Her Excellency Dr. Zainab Atiku Bagudu, to seek support and collaboration for fistula clients in Kebbi. They have promised to develop an empowerment program for women and youth in the state and to work with FC+ to create fistula awareness through radio programs.
- Visits to the Ministries of Information, Women Affairs, and Religious Affairs as well as the Health Services Management Board and radio stations in Kebbi, Sokoto, and Zamfara States to advocate for sustained commitment for sensitization and awareness creation. These visits

resulted in several agreements including a 50% discount on all FC+ media activities on state radio and TV stations, participation in live radio programs, and inclusion of fistula and other related project messages in sermons. Religious leaders in Sokoto and Zamfara were very interested in fistula awareness creation and requested an orientation to better understand fistula issues, which resulted in an FC+ organized two-day orientation (see Objective 2).

FC+ also received commitments for sustained collaboration with various state governments. In Kebbi State, the Ministry of Women Affairs committed to support the expansion of the Gesse VF Center. In Zamfara State, the Hospital Services Management Board promised to ensure that the fistula center located at the Faridat General Hospital will remain as a stand-alone center when the General Hospital is relocated in the future.

Throughout the fiscal year, FC+ carried out multiple meetings with the Jigawa State government through the Ministry of Health. An MOU was discussed, drafted, reviewed, vetted, and finally signed in the fourth quarter of the fiscal year. Following this official confirmation, FC+ has begun quick implementation of project support in the state.

The FC+ project, as part of its efforts to address increasing number of WDI, in collaboration with FMOH, organized the Clinical Meeting on Women with Persistent Incontinence for fistula professionals in Nigeria. Held February 24-25, 2015, meeting participants included prominent fistula surgeons, representatives of FMOH, FMWASD, USAID, UNFPA, and the Society of Gynecology and Obstetrics of Nigeria (SOGON). During the meeting, a draft national guideline on management of WDI was adopted. Also, as a result of this meeting, new terminology was proposed for use in the Nigerian context: Women with Persistent Incontinence (WPI), defined as the incontinence of urine and or feces that is unlikely to be amenable to regular surgery. It is expected that after diagnosis, a second opinion is required before embarking on other surgical procedures for this category of clients. The use of this document should help in assessing or determining the prognostic outcome and selection for management at each level of competence. The draft guidelines will be presented to the National Fistula Working Group in FY15/16.

FC+ Nigeria staff attended many other meetings during FY14/15, providing ample opportunity to share information about the project as well as learn from the efforts of others. These meetings included the IOFWG and ISOFS meetings in Kampala as well as the FC+ Strategy and Technical Workshop and the EngenderHealth Program Managers meeting, described in Sections I and II. Staff also participated in a retreat organized by the Health, Population and Nutrition (HPN) department of USAID, an EmONC Baseline Assessment dissemination meeting organized by the Targeted States High Impact Project (TSHIP), a stakeholders' meeting on the 2013 National Demographic Health Survey (NDHS), and a meeting on Outcomes on Maternal and Newborn Care in Sokoto State organized by the Sokoto State MOH.

The project also co-sponsored and participated in the 3rd Nigerian Family Planning Conference in Abuja in November 2014. FC+ sponsored FP providers from supported states to attend the conference. Dr. Adamu Isah made a presentation titled, "The 5-Step Program Approach: Integration of Family Planning and Fistula Services in Nigeria."

FC+, in collaboration with Kano State Ministry of Women Affairs and Social Development, conducted a number of activities to mark IDEOF. The ceremony commenced with a pooled effort fistula repair, followed by a press conference with journalists in Kano, and a live phone-in radio program. The commemoration concluded with a graduation ceremony for 100 rehabilitated fistula clients who had been trained in income generation skills. The Executive Governor of Kano State was the guest of honor and presented empowerment packages to the clients including take-off grants and items like knitting and sewing machines.

During the third quarter, FC+ convened a Providers Network Meeting, where over 60 partners and key stakeholders were invited to share experiences, discuss challenges, and collectively plan a way forward. The meeting was attended by key project partners including fistula surgeons, nurses, FP coordinators, community partners, HMIS officers, and representatives from the FMOH, FMOWASD, MSF, and the media.

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

During the first half of FY14/15, in consultation with the USAID/Nigeria Mission, the project started the process of reviewing its communication strategy, to look at the effectiveness of the strategy used in the previous project and identify potential areas of improvement. FC+ developed a research protocol for a communications assessment to identify current knowledge, sources of information, and available communication channels for messages related to fistula, maternal health, and family planning. The findings of this assessment will guide the Nigeria communications strategy. The research protocol was finalized and approved by USAID, but FC+ received no response from the Nigeria IRB. After numerous attempts at communication with the IRB and several months of waiting, the project decided to seek approval directly from the relevant states. Approval has been received from all but one state and the study will take place in the first quarter of FY15/16. However, the delay had a strong negative impact on the project's level of community outreach activity, since these activities are to be based on the findings of the assessment.

Despite these delays in a significant element of FC+ community outreach activity, FC+ was able to conduct a total of 377 community outreach events in Nigeria in FY14/15, reaching over 180,000 people, see Table NGA1. Efforts to enhance community understanding and practices related to fistula prevention, treatment and reintegration have included community mobilization with CBOs, religious leaders, the Federation of Muslim Women Association of Nigeria (FOMWAN) and local governments. Highlights of these achievements are described below.

FC+ worked with CBOs in Sokoto, Zamfara, Kebbi, Ebonyi, and Cross River States to carry out health promotion and awareness creation activities and mobilization of clients for fistula treatment. Given low use of preventive maternal health services, including FP, in supported states, FC+ worked through CBOs to foster champions for social change within communities,

using community development structures such as Ward Development Committees (WDCs) and influential social leaders such as religious leaders, women's group leaders, and other community leaders. Community mobilization and sensitization activities included drama, sensitization, advocacy, dialogues, outreaches, reconciliations, sermons, referrals, and radio programs to promote community participation and ownership and increase knowledge about project intervention areas. Contents of messages included the importance of ANC and hospital delivery with skilled attendants and birth preparedness, danger signs and consequences of delay in accessing health care service during pregnancy and labor and the importance of child spacing. The CBOs have successfully established linkages with community groups, community leaders and religious leaders in the communities in which they work. In total, community partners have been able to reach over 100,000 people and conduct more than 200 events.

A large part of the CBO efforts include sensitization outreach efforts in collaboration with RLAC, the Network of Traditional and Religious Leaders Committee (NTRLCL) and the Federation of Muslim Women Association of Nigeria (FOMWAN). In Zamfara, Sokoto and Kebbi, Ebonyi and Cross River States, their efforts reached over 80,000 people. Message content was tailored to promote ANC and hospital delivery, fistula prevention and treatment, family planning, male involvement in maternal health, prompt health seeking behaviors, and demystifying myths and misconceptions around fistula.



Religious leaders' orientation in Kaduna (Credit: FC+ Nigeria)

The events were conducted through community dialogues, compound meetings, market places, mosques and churches, and women groups and associations. Traditional birth attendants (TBAs) were also invited for the activities and encouraged to make referrals to health facilities for deliveries. Identified fistula clients were immediately referred to a fistula treatment facility for treatment.

Building on activities carried out in FY13/14, the project visited Bungudu and Bakura LGAs in Zamfara State as well as PHC Birnin Yari in Kebbi State to explore the possibility of employing the "Site Walk Through" (SWT) strategy which consists of a guided tour of a health facility that provides an opportunity for community representatives to learn about the services that are available and the health problems in the community that the staff are trying to address so as to raise awareness among the community members to increase access to such services. PHC Birnin Yari in Kebbi State was selected to explore the introduction of SWT. This facility was suitable for the SWT because of the presence of community structures like the WDC in the LGA established by the National Primary Health Care Development Agency. The activity is planned for FY15/16 and will be implemented with the involvement of the LGA officials to foster sustained relationship between the facility and the community.

FC+ outreach has also focused on working to engage both print media and radio journalists in raising public awareness about fistula. A two-day orientation on fistula reportage was organized for 12 journalists from the print media, television, and radio. The orientation was held in Bauchi to coincide with a pooled repair effort in Ningi, Bauchi State. This setting provided a meaningful opportunity for the journalists to meet clients and interview them before and after their repairs.

FC+ also participated in various radio programs including the Federal Radio Corporation of Nigeria produced fistula awareness program “Health Watch” on the platform of Radio Nigeria network service. This program reaches over 14 million listeners in Nigeria and beyond. Listeners send text messages to seek clarification and help for fistula treatment. FC+ also took part in local radio station call-in programs about fistula, which provided an opportunity to discuss fistula prevention, treatment, and birth preparedness. Listeners were informed about available treatment sites and were encouraged to play a part in ensuring elimination of fistula in their communities. FC+ contributed to a total of 68 print and radio media reportages during the fiscal year.

Table NGA1: Community Outreach/Education/Advocacy Events, FY14/15.

Type of Event	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Education/ outreach/ advocacy at existing community activity	4	100	0	0	72	19,302	0	0	76	19,402
Maternal health/ fistula-focused	0	0	0	0	0	0	301	163,085	301	163,085
Total	4	100	0	0	72	19,302	301	163,085	377	182,487

FC+ has conducted training of 300 community volunteers and educators not formally affiliated with a health facility, see Table NGA2. Trainees included 27 community partners in five supported states (Ebonyi, Cross River, Sokoto, Zamfara, and Kebbi) who received training on fistula, FP, maternal health and community engagement. Ensuing step down trainings reached 273 Religious Leaders Advocacy Champions (RLACs), Ward Development Committees (WDCs), and other community based partners with the knowledge, skills, and tools they will need to promote healthy practices before, during, and after childbirth and to monitor maternal health care seeking and pregnancy outcomes in their communities.

Table NGA2: Community Volunteer/Educator Training, Participants by Topic, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
CBOs and RLAC TOT	27	0	0	0	27
CBO and Religious leaders orientation	0	28	245	0	273
Total	27	28	245	0	300

In the fourth quarter of the fiscal year, FC+ took part in the premiere of the movie DRY, a film about obstetric fistula. The movie premiered in Abuja on August 13, 2015 and features a storyline that prominently addresses issues related to fistula. FC+ has helped with development and promotion of the film. It is expected that the movie will help with overall advocacy for the prevention of obstructed labor and obstetric fistula in Nigeria.



Actress Stephanie Linus during the premiere of the film "Dry". (Credit: Habib Sadauki)

In November 2014, the project supported and participated at the 5th Annual Conference of the Institute of Social Works of Nigeria (ISOWN) held in Lagos with the theme: "Integrated Rehabilitation and Reintegration in Social Works Practice." At this conference a session was dedicated to the social aspects of fistula including rehabilitation of affected clients. Following this conference, FC+ collaborated with ISOWN in training of community-based partners.

In an effort to build the capacity of community partners for maternal health promotion and awareness-raising about fistula, the project organized a two day finance orientation for CBOs in five supported states (Cross River, Ebonyi, Zamfara, Sokoto, and Kebbi state). The capacity building exercise provided an orientation on requirements for preparing financial reports and documentations. The orientation also provided the CBOs with an understanding of the Standard Procurement Procedures for the project. The training was conducted in two batches in Ebonyi and Sokoto States, reaching a total of 18 CBO finance and program officers.

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

FC+ has been working with the Population Council to carry out research related to reduction of financial barriers to accessing fistula care services. Population Council has completed this research in Nigeria in FY14/15 and a report of research findings is expected in the beginning of FY15/16. The study was conducted in Kano and Ebonyi States. The protocol for the research was reviewed and approved by USAID/Washington and USAID/Nigeria. Findings from this study will inform research on interventions to address treatment barriers in FY15/16.

During FY14/15, FC+ began to reach out to organizations that have developed and used mHealth strategies to convey reproductive health messages to clients. We hope to learn from these organizations and explore collaboration in the future, particularly once findings from the planned communications assessment are available.

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

As part of FC+ commitments to ensure improved quality and standardization of fistula service delivery, the project has conducted facility needs assessments as well as clinical supervision and medical monitoring at all supported treatment sites in FY14/15, in collaboration with facility managers, heads of service delivery units and stakeholders from the supervising Ministries of Health and Women Affairs and Social Development. Some cross-cutting challenges have been identified at supported sites including:

- Inadequate number of fistula surgical repair sets across all sites.
- Inadequate and erratic supply of essential medical consumables to support routine fistula repairs at supported sites.
- Inadequate equipment at supported sites e.g. autoclave machine, theater beds.
- Knowledge gaps for healthcare providers regarding basic and comprehensive EmONC.
- Inadequate infrastructural upgrades.
- Poor medical waste management protocols across all sites visited.
- Nonexistent or suboptimal client rehabilitation programs.

FC+ has compiled findings from these visits and created action plans for each facility to address identified needs which are monitored during FC+ site visits.

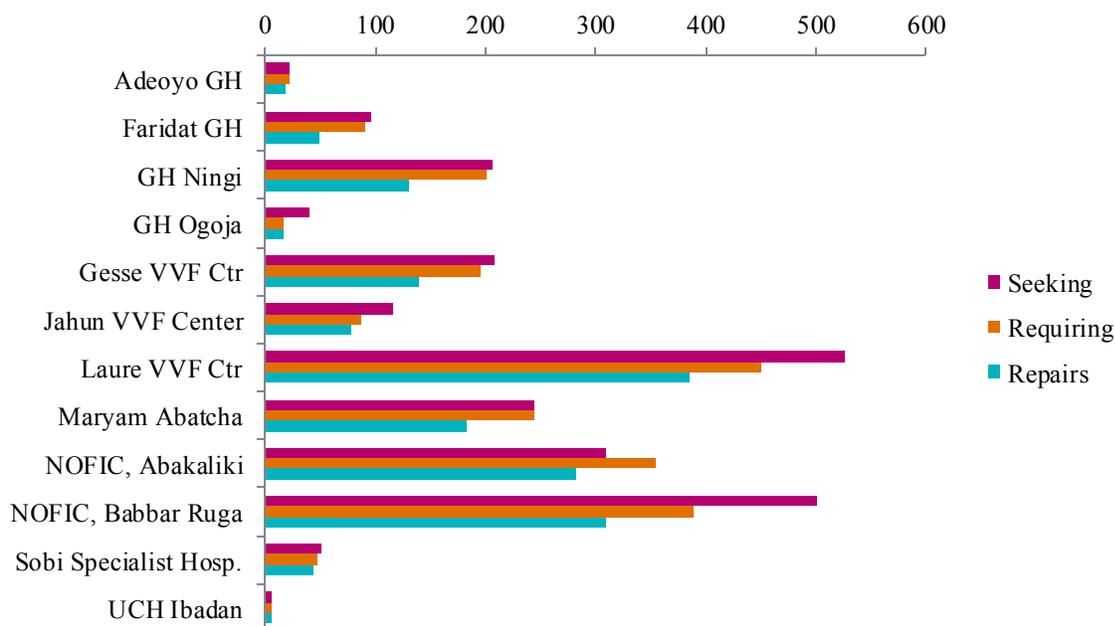
FC+ also visited Hajia Gambo Sawaba General Hospital Zaria to see their fistula center and assess the possibility of providing support for fistula repairs there. The center currently conducts fistula repair with support from Dr. Kees Waaldijk, UNFPA, and the Fistula Foundation and they have performed over 60 repairs since December 2014. They requested assistance in the areas of prevention in terms of training surgeons in remote areas who currently contribute to iatrogenic fistula and providing consumables for surgeries. FC+ will continue these discussions.

During FY14/15, 2331 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 2,108 were diagnosed with fistula and required treatment (90%). FC+ supported 1,645 fistula repair surgeries during this period. In addition to those fistula repair surgeries, 169 women received conservative treatment (catheterization) for fistula at supported sites. Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. See Figure NGA1 for data on women seeking and requiring fistula treatment and the number of repairs supported, by country. We are also unable to report the number of women repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

Two surgeons from Nigeria, one surgeon from Niger and a member of the global team participated in a neo-vagina workshop in Mozambique. This workshop was an important opportunity to position the project for future work especially for women with persistent pelvic floor disorders. This workshop focused on very complex surgeries specifically related to

restoring sexual function. Experiences and cases from this workshop will inform clinical guidelines.

Figure NGA1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY14/15¹⁷



These 1,645 fistula repair surgeries were conducted at 12 FC+ supported hospitals, see Table NGA3 for detail by quarter. This represents a nearly 200% increase over FY13/14 achievement (554 repairs).

Supported sites in Nigeria reported a total of 46 cases (2% of those diagnosed with fistula) identified as iatrogenic fistula in FY14/15. In Nigeria, the data on iatrogenic fistula diagnosis is sourced from operation notes across supported facilities where the assumption is that all ureteric fistulas are iatrogenic in origin. Because the surgeons are often absent at the time of reporting it has been difficult to confirm these data. FC+ is working to implement revised data capturing and reporting tools to ensure that such reporting is objective in nature and directly reported by surgeons at the time of surgery.

As part of the project’s ongoing strategy to use both routine and pooled efforts to reduce the backlog of fistula clients awaiting surgeries, 14 pooled efforts were supported during FY14/15, during which 380 repairs were performed. The national GWINN initiative provided feeding of clients; essential post-operative medications; and allowances for transportation, referral and linkages of identified fistula clients during these pooled efforts. Facility management was responsible for mobilizing clients and ensuring other logistics were in place. FC+ supported

¹⁷ NOFIC Abakaliki had an overall number of women requiring treatment that was higher than the number seeking care in FY14/15 due to women who presented in the last quarter of FY13/14.

facilities with routine supply of consumables, sponsorship of visiting surgeons, stipends to resident staff, and fueling of generators during pooled fistula repair efforts.

Both Ogoja and Ningi sites have struggled with staffing deficits and the pooled efforts have been an effective way of ensuring that repairs are provided for women visiting those facilities. The project continues to advocate for release of funds to these sites to enable them to have adequate staffing (an issue present since the transition last year of the centers from state to federal management) and has identified a medical officer at Ogoja who is interested in receiving surgical training, which will be provided by FC+.

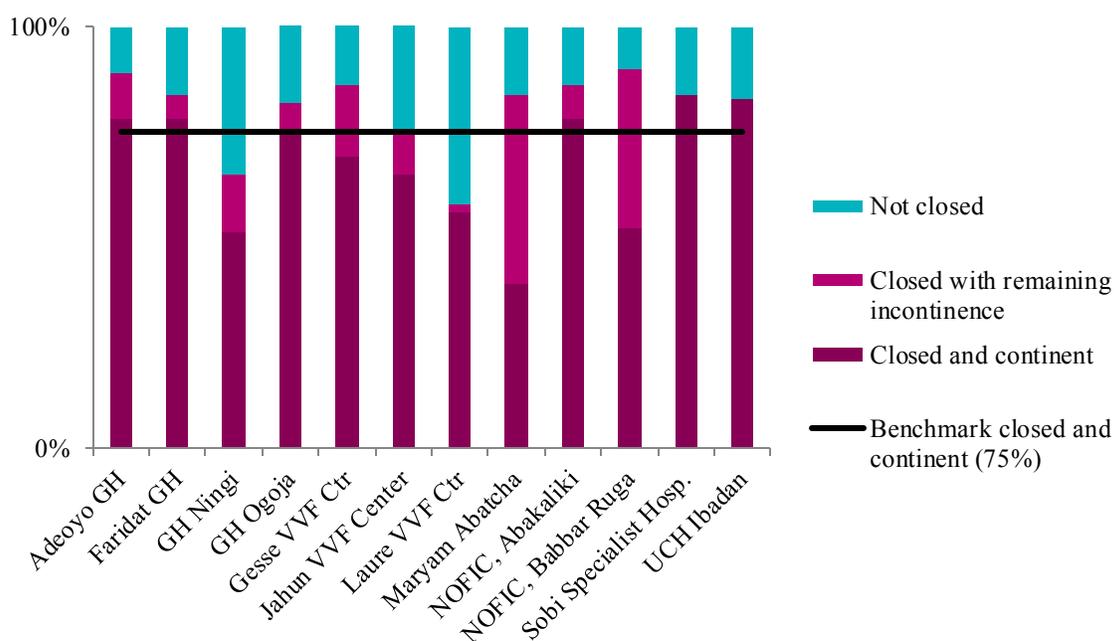
Additionally, health worker strike actions and security challenges, in particular those related to the national general elections, greatly hindered service provision and program implementation. The fourth quarter saw a general easing of security concerns throughout the county and had minimal interruption of activities.

Table NGA3: USAID-Supported Surgical Fistula Repairs, by Site, FY 14/15.

Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Adeoyo General Hospital, Ibadan	NS	NS	12	6	18
Faridat General Hospital, Gusau	0	26	12	11	49
General Hospital, Ningi	35	28	8	60	131
General Hospital, Ogoja	NS	17	0	0	17
Gesse WF Center, Birnin Kebbi	41	21	35	43	140
Jahun WF Center, Jigawa	NS	NS	NS	79	79
Laure WF Center	118	84	108	76	386
Maryam Abatcha Women and Children's Hospital, Sokoto	41	32	62	48	183
NOFIC, Abakaliki	76	75	64	68	283
NOFIC, Babbar Ruga, Katsina	89	62	99	59	309
Sobi Specialist Hospital, Ilorin	10	14	16	4	44
University College Hospital, Ibadan	NS	6	0	0	6
Total	410	365	416	454	1,645

Of all fistula repair surgeries discharged during FY14/15, 74% were closed at discharge: 59% were closed and continent and 15% were closed and incontinent. Those cases that were not closed at discharge are primarily considered to be women who have undergone multiple previous repairs. It is hoped that the ongoing efforts to ratify a national policy on WDI will help to ensure that these women receive appropriate treatment and support. Outcomes for discharged patients are presented, by site, in Figure NGA2. Clinical and program staff have designed a tool for follow up with relevant sites to gain clarity on the causes of low closed rates, and what steps, if any, are necessary to address the issue.

Figure NGA2. Outcome Rates for Surgical Repairs, by Site, FY14/15.



Reported complications were low at supported sites (2.4% overall) with a range of 0% (Adeoyo, GH Gusau, GH Ningi, UCH) to 53% (GH Ogoja). Project benchmarks define a complication rate of <20% as acceptable. The high complication rate at GH Ogoja was related to spinal anesthesia during a pooled repair effort. Project clinical staff investigated the situation and all affected patients were treated and recovered. As a measure to avert recurrence, the protocol has been reviewed to ensure that the first day of every pooled effort serves as refresher training for relevant staff, care, and management teams for the fistula patients. A curriculum for this is currently being revised by the clinical team.

A total of six surgeons participated in FC+ sponsored surgical fistula repair training during the fiscal year, see Table NGA4. Two surgeons received their first training in fistula repair and four surgeons received continuing training.

Table NGA4: Surgical Fistula Repair Training, Participants by Institution, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	1st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont
Maryam Abatcha Women and Children's Hospital	0	0	0	0	0	4	2	0	2	4
Total	0	0	0	0	0	4	2	0	2	4

As part of fistula prevention efforts, FC+ in Nigeria has provided training to 305 health care providers during the fiscal year, see Table NGA5. Trainings covered infection prevention, data for decision-making (DDM) (see Objective 5), fistula and FP counseling. Highlights of training activities are described below.

In the first quarter, providers from seven supported sites participated in infection prevention training at General Hospital Jahun, Jigawa State. In the second quarter, providers from four additional sites participated in infection prevention training in Abakaliki, Ebonyi State.

During the second quarter, training on FP counseling was conducted for 25 providers from Kano, Ebonyi, Kebbi, Cross River, Katsina, Jigawa, Sokoto, Oyo, Zamfara, Bauchi and Kwara States.



Infection Prevention training at General Hospital Jahun, Jigawa State (Credit: FC+ Nigeria)

In the third and fourth quarters, FC+ organized fistula counseling trainings for providers in facilities in the Northern part of Nigeria. FC+ commenced implementation of scaled up FP support in Ebonyi state, with a TOT in FP counseling and methods for 13 health staff in the third quarter. Also in the third quarter, an orientation to fistula identification, treatment and prevention was provided to 28 health workers.

In the fourth quarter, step down training in FP counseling was provided for 60 doctors and nurse/midwives. 22 doctors and nurse midwives participated in a FP service integration workshop that focused on fistula and family planning counseling.

Post-training supportive supervisory visits were carried out in the third quarter for nurse/midwives who had been recently trained in FP counseling in Kebbi, Katsina, Sokoto, Zamfara, Kano and Bauchi States. During these visits, FC+ provided technical assistance on-site, and monitored trainees for improvement of service quality while also tracking progress in implementation of their action plans to apply new skills/information in their working environment.

Keeping the future clinical workforce in mind, FC+ has also conducted educational outreach targeting medical/nursing students. This has included symposia at the schools of Nursing and Midwifery in Kebbi and Zamfara States covering topics related to fistula diagnosis, early treatment, referral and most importantly, its prevention; dangers of prolonged obstructed labor and use of the partograph. The concept of conservative treatment of fistula using catheter was also introduced to the students.

Table NGA5: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Data management	17	16	56	0	89
FP counseling	0	25	0	60	85
Infection Prevention	17	10	0	0	27
Orientation to fistula	0	0	28	0	28
FP counseling and methods TOT	0	0	13	0	13
Fistula counseling	0	0	16	10	26
FP counseling TOT	0	0	0	15	15
FP and fistula counseling	0	0	0	22	22
Total	34	51	113	107	305

As part of efforts to strengthen provider and facility capacity to provide and sustain fistula prevention services, FC+ has been carrying out assessments of prevention-only supported sites to assess staff strength, knowledge and skills for FP counseling and services, state of instruments and equipment, commodity supply system, service output data. The gap period between the end of the FC project and the beginning of the FC+ project resulted in the need to re-assess the current situation at all sites. During the first two quarters of FY14/15, 13 sites were assessed (seven in Ebonyi State and six in Kano State). Action plans were created to address identified needs and included:

- Capacity building of all service providers in all aspects of counseling, service provision, infection prevention, record keeping and data management.
- Creation of supportive supervisory mechanisms to routinely ensure compliance and improved service delivery.
- Re-explore long term facility advocacy strategy to improve, maintain and sustain the infrastructural set up of all focal sites to ensure quality in counseling and service delivery.
- Within the project's mandate, procure and distribute identified, needed equipment, instruments and consumables to family planning clinics.
- Production and distribution of adequate USAID FP requirements-including statutory information chart and other IEC materials and job aids to all supported FP sites.

Action plan implementation is monitored during FC+ clinical and programmatic monitoring visits to the sites.

In the third and fourth quarter, FC+ scaled-up FP services in the USAID priority states of Ebonyi, Sokoto, Bauchi, and Jigawa. Earlier in the fiscal year, the project carried out an exploration exercise in Ebonyi State with five LGAs using the newly developed FC+ LGA-based checklist for FP service scale up to gather baseline information. In the second quarter, the project conducted needs assessments of FP sites in the state and concluded plans for scale up of FP service statewide. An additional 70 FP sites have been selected for support in the state.

Assessments were carried out at 35 FP sites in Jigawa State using a simple needs assessment tool designed by the project, previously used in Ebonyi State.

Key findings included that many facilities have good staffing though many have had no in-service training on FP, and those trained have had no recent updates in FP service delivery. As a consequence, the majority of providers lack proper counseling skills. Many of the facilities have reasonable structures, including good client waiting areas with privacy. FP commodities were well stocked, however infection prevention is poor. Similarly, record keeping and data management in general require improvement.

With the end of the TSHIP project in July 2015, the USAID/Nigeria mission mandated FC+ to extend support to all former TSHIP sites in Sokoto and Bauchi until a new project is awarded. In anticipation of this, USAID/Nigeria raised the FC+ CYP target for FY14/15 to 29,000 (from 10,000). As of September 30, 2015, FC+ is providing support to 237 FP sites in Nigeria, as well as to 496 former TSHIP sites for a total of 733 sites in 11 states.

During FY14/15, nearly 94,000 counseling sessions took place at supported sites in nine states, and 59,702 CYP were provided, see Table NGA6 for detail, by state. The method mix includes injectables, implants, Copper T IUD, oral pills, and male and female condoms.

Table NGA6: Family Planning Counseling Sessions and CYP, by State, FY 14/15.

State	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP
Bauchi	NS	NS	NS	NS	NS	NS	25579	10540	25579	10540
Cross River	NS	NS	515	697	796	1106	0	0	1311	1803
Ebonyi	NS	NS	874	452	1074	648	10346	4373	12294	5472
Jigawa	430	117	471	114	331	138	5067	1181	6299	1550
Kano	1614	689	1225	720	1946	1309	2157	1609	6942	4327
Katsina	13	2	37	4	27	3	23	3	100	12
Kebbi	1078	522	1362	954	1210	622	702	471	4352	2569
Kwara	NS	NS	67	38	131	52	1758	2665	1956	2755
Oyo	NS	NS	NS	NS	NS	NS	6402	6715	6402	6715
Sokoto	828	782	646	498	776	560	23927	20246	26177	22085
Zamfara	733	499	455	392	722	582	608	401	2518	1873
Total¹⁸	4,696	2,610	5,652	3,870	7,013	5,019	76,569	48,204	93,930	59,702

Due to pending staff training, supported sites providing obstetric services have not yet begun to report data on deliveries to the project.

¹⁸ Totals may be higher than the sum of the state totals in the table due to rounding.

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

Throughout the fiscal year, FC+ carried out data verification and validation meetings at supported sites. Data were verified using two different approaches: direct visits to facilities with hands on review of site registers and/or organized regional data verification meetings with HMIS Officers and FP Coordinators who bring their registers to the meetings. Each approach has advantages: the former is most productive with opportunities to directly correct errors and interface with service providers while the latter is more cost- and time-efficient. The data verification process also provided opportunities for all supported sites currently providing treatment and prevention services to have internal data reviews whereby program data was analyzed, issues identified and action plans developed. Quarterly internal DDMs are also being conducted within FC+ Nigeria to routinely monitor and discuss clinical and programmatic data.

Additionally, working towards the goal of ensuring accurate and useful data collection, the project updated data collection tools together with supported states from the Northern and Southern parts of the country and conducted DDM training for a total of 104 health staff (see Table NGA4), including surgeons, HMIS officers, fistula center matrons, and medical directors. Participants went through each register (Pre-Operative, Theatre, Post-Operative, Catheter Ward Register, Catheter Theatre Register, FP Register, Counseling Registers, and Monthly Reporting forms) and critically reviewed each data element.

During the second quarter, a meeting was convened in Ebonyi attended by monitoring and evaluation experts for fistula prevention and treatment from Oyo, Kwara, Cross Rivers and Ebonyi states as well as FMOH staff. Participants worked together to revise fistula data management tools. FMOH involvement has contributed to sustainable change as the FMOH is now moving towards their adoption as national tools for documenting and reporting on fistula care and management. This process is in an advanced stage and currently being coordinated by the fistula desk office of the FMOH.

The FMOH has indicated very strong interest in the use of electronic medical records (EMR) for tracking its efforts across all levels. They feel strongly that this will improve quality of reporting and foster much needed sustainability. This is also an area of strong interest for the FC+ project and staff have commenced exploration for a secure, easy to manage, and highly affordable software for this purpose. FC+ anticipates piloting this system in the first half of FY15/16.

After attending the EngenderHealth CDDM meeting in Istanbul team members were able to conduct step-down training for the rest of the FC+ Nigeria team in September 2015.

As noted in Objective 4, internal DDM identified low repair success rates at several supported sites that warranted follow up investigation and action planning. A combined team of M&E and Clinical staff carried out this follow-up by visiting the facilities in the third quarter and using an assessment tool developed for this process. Three sites with the lowest closure rates were selected and their data were reviewed for any error that may have occurred during data

verification and validation. The review specifically focused on the time period when lower rates were first reported (the second quarter of FY14/15). The data have been analyzed; the findings and follow-up actions will be ready for reporting in the first quarter of FY15/16.

FC+ emphasizes the need to contribute to, disseminate, and stay abreast of global trends and best practices in topics related to fistula care. To this end, during the first quarter of FY14/15, the project sponsored five fistula surgeons and an FMOH representative to attend the 5th ISOFS Conference held in Kampala, Uganda. A sponsored surgeon made two presentations at the conference, addressing average urethral length for continence and catheter treatment as a means of managing obstetric fistula. As noted above, FC+ in Nigeria has also supported research on barriers to fistula treatment and has designed a communications assessment on fistula and maternal health.

Additional Objective: Sexual and gender-based violence – Addressing the needs of the girls abducted in Chibok, Nigeria

The Health Support for Survivors of Sexual and Gender Based Violence (SGBV) Group continued to hold weekly meetings in Abuja during the first half of FY14/15. FC+ is a member of this group which also includes the Federal and State Governments of Nigeria, international and local organizations, and health implementing organizations. This group began meeting as a result of the abduction of over 200 girls from Chibok Community by the Boko Haram group in April 2014. Following their abduction, the Nigerian government and development partners have been working together to providing guidance and assistance to the abducted girls, affected families and the community in general.

During the first quarter, EngenderHealth finalized two key documents as of part of its commitment to support survivors of SGBV: the Algorithm and Demographic and Tracking tool for capturing client profiles, care, treatment and referrals in response to the health needs of survivors of SGBV in a conflict environment in Nigeria. These two tools have received extensive review internally and externally and have been adopted by the Chibok Support Group members for inclusion in the National Guideline for Supporting Survivors of SGBV, produced by the Federal Ministry of Women Affairs and Social Development. 1000 copies of the algorithm were printed and given to the Chibok Support Group for use in the Northeast. Healthcare providers from selected facilities in Northeast Nigeria, the area most affected by the insurgency, will be trained on how to use the tools in FY15/16.

In January 2015, the project submitted an abstract to the Fifteenth Annual Meeting of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises on FC+ work developing support for the girls abducted by Boko Haram in Chibok. Though there was no space in the program for the presentation, based on the abstract, the organizers invited Dr. Adamu Isah of the Nigeria team to take part in a panel/interactive session on SGBV, with full financial support from the organizers. The meeting was held February 25-27, 2015 in Amman, Jordan.

Delays in rescue, administrative issues, and other challenges may prevent the timely implementation of these tools to support the needs of the girls abducted from Chibok; however, the FC+ project will continue to seek opportunities to disseminate these tools so that they may help other survivors of SGBV.

Uganda

USAID-supported fistula services in Uganda began in 2004 through the previous FC project and continue through FC+ in two treatment and prevention sites and 14 prevention-only sites as of September 30, 2015.

In Uganda, FC+ supports fistula repair services, clinical training, efforts to improve the quality of obstetric care and FP services, and building community awareness. The project is increasing emphasis on the integration of FP services with fistula and maternal health care and piloting efforts to meet the reintegration needs of women who have undergone fistula repair.

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

During the first quarter of FY14/15, FC+, in partnership with the MOH, successfully hosted the ISOFS and IOFWG meetings in Kampala with delegates coming from many countries around the world. See Objective 5 for additional details.

FC+ has also partnered with the MOH to print various tools adapted from the previous FC project. These include 300 copies of fistula support supervision tools, 2000 copies of fistula client cards, 2,000 copies of fistula registration forms, 300 copies of fistula death reporting forms, 300 copies of site assessment tools, 300 copies of fistula training guidelines, 300 copies of the minimum package for fistula camps, and 50 copies of fistula theatre registers. The project will support the MOH to orient fistula teams at different fistula repair facilities on how to use the new tools and also distribute copies for use at each site.

During FY14/15, FC+ worked with the MOH to update maps of the location of fistula surgeons and repair and reintegration services in Uganda, initially developed in 2010 under the FC project. In the second half of FY14/15, FC+ developed a map showing the spatial distribution of FC+ supported health facilities in Masaka, Kasese, Kalungu, Jinja, Kamuli, and Hoima districts using ArcGIS software. These facilities are divided into two categories i.e. treatment and prevention only sites. These maps will be used to visually display the geographical coverage of FC+ project in Uganda, the communities served and underserved, as well as to foster advocacy and decision making at different levels.

During the first half of the fiscal year, FC+ received support (in kind) through donation of FP posters from Reproductive Health Uganda (a local affiliate of IPPF) that were used as teaching aides while training village health workers at Buseruka Health Centre III. A number of implementing partners including Kalungu and Kasese Districts, Karambi Health Centre III, Kagando Mission Hospital and St. John Mary Kibingo Catholic Church provided venues for different trainings and meetings..

During the second quarter of FY14/15, FC+ implementing partner TERREWODE convened the first consultative meeting with the National Fistula Technical Working Group (NFTWG) to kick start the process of defining WDI. Among the key issues discussed were the social and medical dimensions of what constitutes incurable fistula, strategies for meeting the social and medical

needs of affected women, challenges involved and the rights based guidelines for supporting affected women. The group observed that using the word WDI was stigmatizing and it was unanimously agreed to change to women with incurable fistula (WIF). Incurable fistula, according to the workshop participants, was defined as “cases of fistula in which restoration of functional anatomy aimed at achieving urinary or fecal continence is not possible through surgery by the most skilled surgical team working in an enabling environment.”

A second consultative meeting on WIF was held in April 2015 in Jinja, convened by TERREWODE with members of the NFTWG. The meeting discussed the need to create a database for WIF and outlined actions that would support the development of the database and tools for collecting data on individualized care for WIF in Uganda. The participants discussed a number of medical and social issues that caretakers must address to provide this care. TERREWODE will continue efforts in Uganda and globally to continue this discussion as well as develop a reintegration strategy for women post-repair. See Objective 5 for additional work on this topic.

As a reflection of the government’s investment in and commitment to fistula treatment, in Uganda’s FY14/15 (July 2014 – June 2015, starting during the FC+ project’s first fiscal year), the national government allocated funds specifically for fistula services for the first time. This support of \$50,000 USD targets fistula repairs through camps at large hospitals.

In order to ensure support from all levels of the community, in the second quarter FC+ held meetings with Chief Administrative Officers (CAOs - executive heads of districts) of Hoima and Masaka districts to orient them to the FC+ project and planned advocacy meetings with political leaders in their respective districts. These meetings were meant to promote buy in, particularly to have CAOs champion efforts aimed at raising awareness about obstetric fistula among district political leaders and promote efforts aimed at allocating more resources, i.e. human, financial, and physical, to maternal health services.

During the third quarter of the fiscal year, FC+, with MOH and UNFPA, hosted IDEOF events in Hoima district, western Uganda – the region with the highest prevalence of obstetric fistula in Uganda (DHS 2011). FC+ was involved in a community sensitization about obstetric fistula using local radio stations, community volunteers, political and religious leaders; printing and distribution of various IEC materials; and hosting a one week fistula repair camp at Hoima Regional Referral Hospital (Hoima RRH) in which 49 women accessed free fistula and POP repair services. FC+ also organized a march through the town during which stakeholders held banners that showcased the services they provide. The network of village health teams (VHTs) and religious leaders participated through giving speeches, helping with outreach, and mobilizing women in need of fistula/POP services. The chief guest at the event, the Minister of State for Health Ms. Sarah Opendi, and a host of other government, local and community leaders visited the camp to view fistula services being provided. In her remarks, the Minister thanked FC+ for playing a key role in treatment of fistula and prevention efforts in Uganda. FC+ was selected to make remarks on behalf of all fistula partners including UNFPA. FC+ staff in Uganda also

contributed four of the photos and quotations that were featured in the EndFistula communications toolkit that was developed as part of online materials for commemorating this year's IDEOF (<https://www.engenderhealth.org/media/2015/05-21-end-fistula-toolkit.php>).

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 efforts to increase public awareness of fistula prevention and treatment, FC+ carried out 1,099 community outreach/education/advocacy events reaching over 67,000 participants during FY14/15, see Table UGA1.

During the first quarter, religious leaders previously trained by FC+ engaged in awareness raising activities including household visits and community sensitization on a wide range of topics including FP, male involvement, birth preparedness, utilization of ANC, and maternity services among others. Muslim, Catholic, and Protestant religious leaders reached 9,699 people with messages on these topics during the first quarter. In the third quarter, religious leaders in Hoima reached 2,628 people through awareness raising sessions in their congregations.

Table UGA1: Uganda Community Outreach/Education Events, FY14/15.

Type of Event	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Education/ outreach/ advocacy at existing community activity	54	9,699	0	0	15	7,726	4	291	73	17,716
Education/ outreach/ advocacy at health facility	1	73	0	0	0	0	0	0	1	73
Education/ outreach/ advocacy with policy makers	0	0	0	0	2	38	0	0	2	38
Maternal health/fistula focused education/ outreach/ advocacy event	589	20,833	414	21,708	20	7,000	0	0	1,023	49,541
Total	644	30,605	414	21,708	37	14,764	4	291	1,099	67,368

Also in the first quarter of FY14/15, outreach sessions were conducted by village health workers, trained previously by FC+, around Buseruka and Bururu health facilities in Hoima district reaching 6,920 community members in the first quarter and 7,236 in the second quarter. In the third quarter, activities reached 5,098 community members in 18 villages around Bururu. Follow

up meetings were held with the VHWs in the second and fourth quarters to review progress made to date in mobilizing communities in the health facility catchment areas and to support them technically to address challenges within their work. Data for the two health facilities focusing on ANC, maternity, FP and postnatal service utilization was reviewed and increases in clients coming for ANC1 visits were observed. ANC4 visits and deliveries at the facilities remained areas to focus upon. Activities carried out in support IDEOF in Hoima are described under Objective 1.



Muslim religious leaders attending fistula orientation.
(Credit: Molly Tumusiime)

A Site Walk-Through event was conducted at Buseruka HC III, in which 73 community representatives participated in a guided tour of the health facility to learn about the health services provided and held focused discussions on how to improve the quality of services, mobilize clients for services, and mobilize resources for the facility. Participants included district officials, health workers, local politicians, VHTs and clients. Participants worked in groups to identify some of the barriers to service utilization and action plans were developed. Prominent among the barriers identified were the unfriendly nature of health workers, lack of an ambulance, limited supply of running water and electricity, and a small maternity ward. The Buseruka Sub-County Local Councilor was the chief guest. FC+ will work closely with the Hoima district office to follow up on the action plans in the next quarter.

In addition to outreach efforts focused on the general community, FC+ has worked in the second half of the fiscal year to advocate among political leaders who are key stakeholders in improving maternal health and RH in their areas of jurisdiction, as they are not only held in high esteem by the communities they represent but can also influence decision making and resource allocation at different levels of government. FC+ held a one day advocacy meeting with 25 Hoima District Councilors drawn from 16 sub counties and a one day advocacy meeting with 13 Masaka District political leaders drawn from 13 sub counties. The meetings were convened to create awareness and discuss RH and maternal issues (including obstetric fistula) that affect the districts, ways of addressing them and the key roles and responsibilities of councilors in addressing those issues. The meeting also focused on generating specific priority actions for strengthening the advocacy strategy aimed at increased access and utilization of obstetric fistula prevention and repair services in Hoima and Masaka.

During the second quarter, FC+ held meetings with a representative of the Bishop of West Buganda Catholic Diocese to orient him to the FC+ project and discuss plans to train selected Catholic priests and other church leaders on maternal health issues so that they can integrate those issues and key messages into their community sensitization and church work. A similar

meeting was held with the District Khadi (head of Muslims) and both individuals expressed interest in collaborating with FC+. Trainings for selected Catholic and Muslim leaders will be held in the third quarter. During the third quarter, two separate trainings were conducted targeting Catholic and Muslim religious leaders to equip them with knowledge and skills in sensitizing their congregations about maternal and RH issues including causes of obstetric fistula, prevention and treatment, danger signs of pregnancy, family planning, antenatal and postnatal care. 23 Catholic leaders (majority priests) from Masaka, Kalungu, Sembabule, Rakai, Lyantonde, Bukomansimbi, and Lwengo districts attended the training as well as 25 Muslim leaders (majority Sheikhs) from mosques in Masaka, Kalungu, Sembabule, and Lwengo districts, see Table UGA2. All participants developed and shared with FC+ copies of action plans listing the activities they intend to carry out based on the knowledge and skills acquired. These action plans will be used for following up with the participants and providing field support based on their individual needs and circumstances.

In the fourth quarter, FC+ held a half day meeting with religious leaders in Hoima to update them about maternal health issues in the district, re-emphasize their role in addressing key maternal health issues and document the work they had achieved. The District RH and HMIS focal persons presented performance data for key maternal health indicators and highlighted areas where there was consistent poor performance and under achievement of set targets. Participants committed to reaching out to their respective congregations with maternal health messages and documenting their activities.

Table UGA2: Community Volunteer/Educator Training, Participants by Topic, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Religious Leaders	0	0	48	0	48
Total	0	0	48	0	48

In the fourth quarter, FC+ procured and distributed 154 bicycles to VHTs affiliated with Buraru. FC+ plans to compare the numbers of community members reached by these VHTs and Buseruka HC IIIs in Hoima District. It is hoped that the bicycles will increase the ease of mobility of VHTs in the villages around the facility catchment areas. In the past, VHTs had indicated inability to reach some of villages in their areas of jurisdiction because of long distances before and after receiving bicycles as well as conduct some interviews with them to find out whether/how the bicycles have transformed their work.

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

As noted above, FC+ has been working with the Population Council as they develop a barriers assessment research study protocol to be carried out in Nigeria and Uganda. The protocol has received USAID approval. Study tools have been translated into local languages (Luganda and Runyoro) and submitted together with the research protocol to the local IRB: Makerere

University School of Medicine Research Ethics Committee. Ethical approval was secured from the local IRB in the fourth quarter. The approved protocol and tools have been submitted to the Uganda National Council for Science and Technology. Eight research assistants were recruited and trained. Data collection in Masaka district has begun and will be complete at the end of October 2015, after which data collection will commence in Hoima district in November 2015.

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

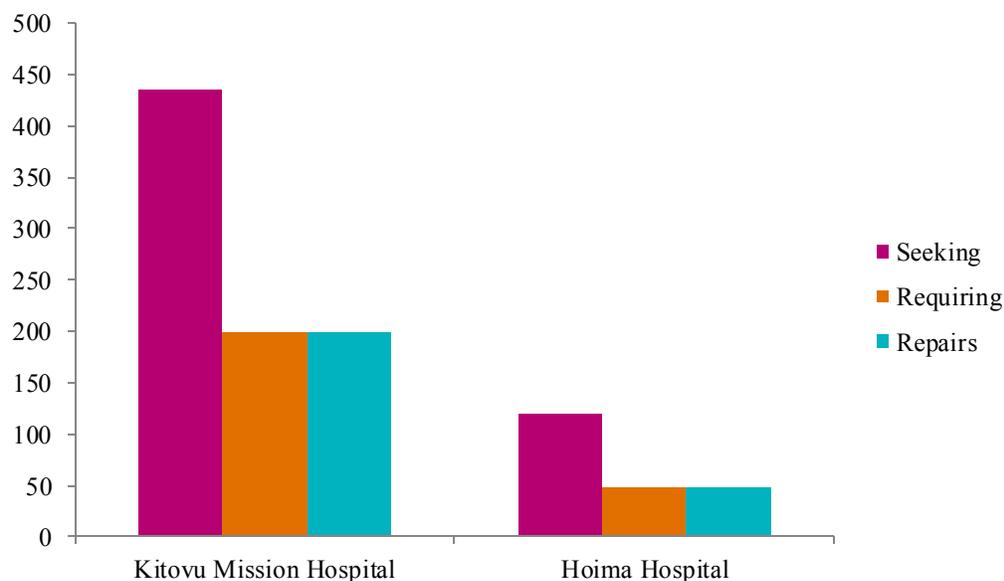
In the second quarter of FY14/15, following guidance from the MOH and Kasese District Health Office, Rwesande HC IV, a faith-based health facility, was added as a supported site for FC+. FC+ carried out a site assessment to determine site capacity to provide fistula prevention and repair services. Many staff at the health facility were interviewed, including the facility manager, heads of units/departments including the maternity ward, family planning; laboratory; pharmacy and stores. Observations were made to assess infection prevention and control practices and availability of equipment; data for the last three years on key indicators were collected to assess past performance.

FC+ currently supports two fistula treatment sites in Uganda: Kitovu Mission Hospital and Hoima Hospital. Both Kitovu and Hoima currently provide fistula and prolapse repair through concentrated repair efforts. Kamuli Hospital is a planned treatment site that is not yet supported due to delays in subaward processing related to USAID approval and release of funds. In addition to the one concentrated repair effort supported at Hoima this fiscal year, three other concentrated efforts were conducted there with MOH/UNFPA funding. Kagando Hospital is currently supported for prevention-only services, but its treatment capacity is being monitored on an on-going basis with the potential to begin support for fistula treatment in the future.

In addition to FC+ activities in Uganda, EngenderHealth has embarked on a two year, \$3 million BMGF grant project, ExpandFP. 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.

During FY14/15, 556 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 249 were diagnosed with fistula and required treatment (45%). FC+ supported 249 fistula repair surgeries during this fiscal year (100% of those requiring surgery) through concentrated repair efforts at Kitovu and Hoima hospitals. Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. See Figure UGA1 for data on women seeking and requiring fistula treatment and the number of repairs supported, by country. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

Figure UGA1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY14/15.



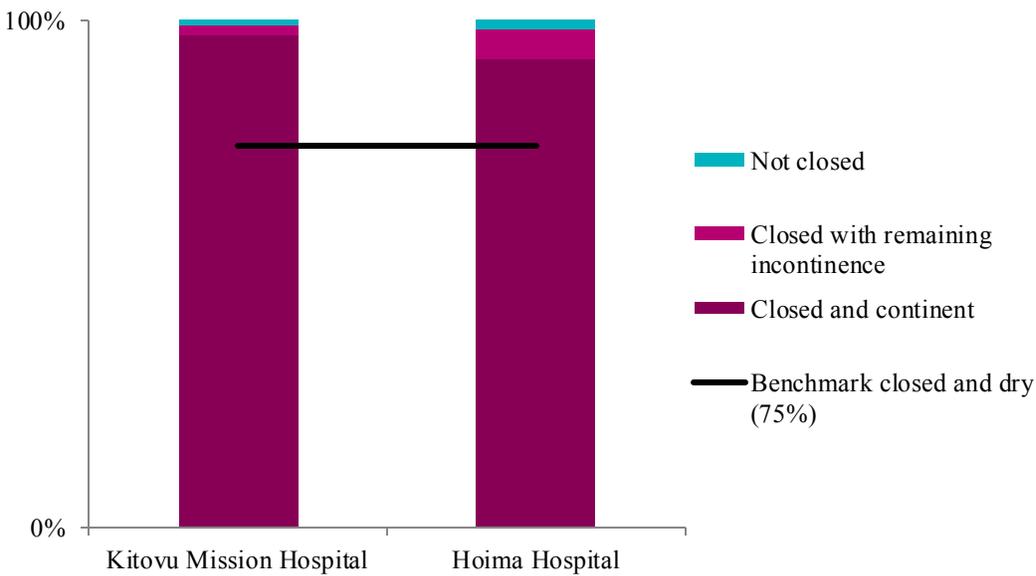
These 249 fistula repair were conducted primarily at Kitovu Mission Hospital (200 repairs) through a total of five concentrated repair efforts; the 49 remaining surgical repairs took place via two concentrated efforts at Hoima Hospital (see Table UGA3 for detail by quarter).

Table UGA3: USAID-Supported Surgical Fistula Repairs, by Site, FY 14/15.

Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Kitovu Mission Hospital	73	62	0	65	200
Hoima Hospital	0	0	49	0	49
Total	73	62	49	65	249

During FY14/15, 99% of all fistula repair surgeries were reported as closed at time of discharge; 96% were closed and continent and 3% were closed and incontinent. This very high rate of optimal outcome (closed *and* continent) is believed to reflect excellent surgical skills, but also warrants clinical review in FY15/16. Outcomes for discharged patients are presented in Figure UGA2. Reported complications were low (2.8%).

Figure UGA2. Outcome Rates for Surgical Repairs, by Site, FY14/15.



Supported sites in Uganda reported a total of 28 cases identified as iatrogenic fistula (5% of all diagnosed fistula) in FY14/15. According to the head of the Fistula Unit at Kitovu Mission Hospital, these women delivered from other health facilities and the probable cause of the fistula was poorly developed surgical skills of doctors (particularly inexperienced doctors). Other factors, such as staffing, supply and infrastructure inadequacy may also be factors. A clinical review of iatrogenic fistula will be undertaken in FY15/16.

A challenge noted at the concentrated efforts performed in quarter three at Hoima Hospital was a shortage of theater space for conducting repairs due to renovations taking place at the facility. FC+ worked with the MOH and UNFPA to procure an additional operating table and coordinate with other wards for space. In addition to the surgical repairs reported, 31 women received conservative treatment (catheterization) for fistula at Kitovu Hospital throughout the fiscal year.

Though not currently funded by FC+, it is relevant to note that Masaka Regional Referral Hospital is providing repairs (since December 2013) with repair equipment provided by the FC project and a fistula surgeon who was trained under the FC project.

In conjunction with concentrated repair efforts at Hoima and Kitovu, two surgeons participated in surgical fistula repair training during this fiscal year. One surgeon received his first training in surgical fistula repair and another continued his training through two USAID-funded training sessions, see Table UGA4. The surgeon participating in continuing training has graduated to advanced skills capacity and FC+ is working to identify an opportunity in Nigeria, Ethiopia or via Mercy Ships to further enhance his surgical skills.

Table UGA4: Surgical Fistula Repair Training, Participants by Institution, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr–Jun 2015		Jul-Sep 2015		Total FY 14/15	
	1 st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont
Hoima Regional Referral Hospital	0	1	0	0	0	0	0	1	0	1 ¹⁹
Kitovu Hospital	0	0	0	0	0	0	1	0	1	0
Total	0	1	0	0	0	0	1	1	1	1

As part of efforts to enhance South to South cooperation and capacity building, during the fourth quarter, FC+ Uganda sent a team of two Ugandan Ministry of Health expert fistula surgeons (Dr. Justus Barageine and Dr. Fred Kirya) to provide technical support in fistula treatment and capacity building to FC+ Bangladesh. The two surgeons participated in fistula repair camps organized at three different hospitals in Dhaka (Kumudini Hospital, Ad-Din Khulna, and BSMMU Hospital). They performed surgery on many women with simple fistula and women with complex recurrent fistula, and mentored and coached ten fistula surgeons over a combined period of four weeks. Dr. Justus delivered two lectures to faculty and postgraduate students at the Department of Obstetrics and Gynecology of BSMMU, covering topics including management of childbirth related injuries with a focus on obstetric fistula and perineal tears and the role of nurses in management of female genital fistula.

As part of fistula prevention efforts, FC+ in Uganda provided four trainings during FY14/15 to 136 health care providers. Trainings covered: family planning integration; EmONC and partograph use; and community outreach and advocacy. Table UGA5 provides totals for non-surgical trainings of health system personnel.

During the first quarter of FY14/15, FC+, in collaboration with Kalungu District Health Office, conducted a four day onsite FP integration training at Kalungu HC III. This training is part of FC+'s efforts to strengthen the capacity of FC+ supported prevention and treatment sites to provide quality FP services and promote provision of comprehensive services relevant to clients' desires/needs. The 25 participants came from maternity, MCH and antenatal units of seven health facilities: Kalungu HC III, Kyamulibwa HC III, Bukulula HC IV, Kasambya HC III, Kiti HC III, Lukaya and Lusangu HC IIIs. Participants included nurses, midwives, clinical officers, laboratory and medical records personnel.

Additionally in the first quarter, in collaboration with MOH, FC+ conducted a training on EmOC and partograph that focused on midwives and midwifery tutors from FC+ supported facilities in five districts: Masaka, Kalungu, Kasese, Hoima, and Kamuli. The 30 participants were trained in the management of normal labor, prolonged labor, and obstructed labor including immediate interventions, management of third stage of labor, immediate care of the baby and mother, and partograph use in labor monitoring.

¹⁹ The same surgeon participated in two continuing trainings during the fiscal year and is only counted once in the annual total.

FC+ trained 68 village health team volunteers (VHTs) in Uganda in topics related to maternal health, see Table UGA2. FC+ collaborated with the Hoima District Health Office to identify and train 68 VHTs selected from within the catchment area of Buseruka Health Centre III. The training was aimed at equipping them with knowledge and skills in promoting healthy practices during pregnancy, childbirth, and after childbirth and monitoring maternal health seeking behaviors and pregnancy outcomes in their communities. The VHTs are expected to sensitize their communities about a wide range of maternal health related topics and to refer individuals to health facilities to access quality health services and compile monitoring data on specific indicators every quarter. Supportive supervision and follow up will be provided by FC+ staff and district partners.

In the third quarter, fistula counseling training was conducted at Kitovu Hospital for 13 health staff representing the operating theatre, medical, surgical and maternity wards. Training was client-focused, including caring behaviors, counseling women and family members, addressing psychosocial issues, and effective communication strategies for conducting health talks.

Table UGA5: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Community outreach and advocacy	68	0	0	0	68
FP methods	25	0	0	0	25
EmONC and labor monitoring	30	0	0	0	30
Fistula counseling	0	0	13	0	13
Total	123	0	13	0	136

FC+ supported FP counseling and service provision at 17 sites in Uganda (this includes Kamuli Hospital in the fourth quarter, even though their official subaward is still pending) during FY14/15. Over 23,000 counseling sessions took place at supported sites and 21,370 CYP were provided, see Table UGA6 for detail, by site. Method mix in Uganda was primarily Implanon, Depo Provera and Copper T IUDs, with a smaller component including condoms (male and female), oral pills, and male and female sterilization.

Table UGA6: Family Planning Counseling Sessions and CYP, by Site, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15 ²⁰	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP
Azur HCIV	193	439	231	238	793	776	364	584	1581	2037
Bururu HCIII	290	142	101	259	432	224	419	307	1242	931
Buseruka HCIII	126	131	135	122	197	99	188	130	646	482

²⁰ Please note: aggregated CYP totals may not equal the sum of all presented components due to rounding.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15 ²⁰	
Bwera GH	591	821	504	498	926	679	868	1301	2889	3299
Hoima RH	279	291	342	526	520	229	592	550	1733	1596
Jinja RRH	NS	NS	NS	NS	NS	NS	3423	1244	3423	1244
Kagando	394	794	544	517	446	670	696	950	2080	2930
Kalungu HCIII	114	28	148	42	160	91	129	158	551	319
Kamuli	NS	NS	NS	NS	NS	NS	39	59	39	59
Karambi HCIII	75	34	140	38	491	792	204	483	910	1347
Kigorobya HCIV	335	318	298	252	394	198	524	372	1551	1141
Kikuube HCIV	352	125	315	111	343	271	287	96	1297	603
Kitovu	0	0	0	0	0	0	66	99	66	99
Kiyumba HCIV	168	143	75	113	291	163	84	82	618	502
Kyanamukaka HCIV	79	90	54	95	265	214	159	193	557	592
Masaka RRH	542	629	1243	908	706	1079	637	999	3128	3614
Rwesande HCIV	80	117	101	52	327	207	221	200	729	575
Total	3,618	4,102	4,231	3,771	6,291	5692	8,900	7,806	23,040	21,370

NS indicates site not supported during that time period.

FC+ supported sites in Uganda reported an overall C-section rate of 22% during FY14/15, based on 30,034 reported deliveries. Information on number of deliveries, by site, is represented in Figure UGA3 and C-section rates, by site, are presented in Figure UGA4. Sites reported that 1.5% of all labors were prolonged/obstructed, none of which received catheterization for fistula prevention.

Figure UGA3. Number of Obstetric Deliveries, by Site, FY14/15 (n=30,034).

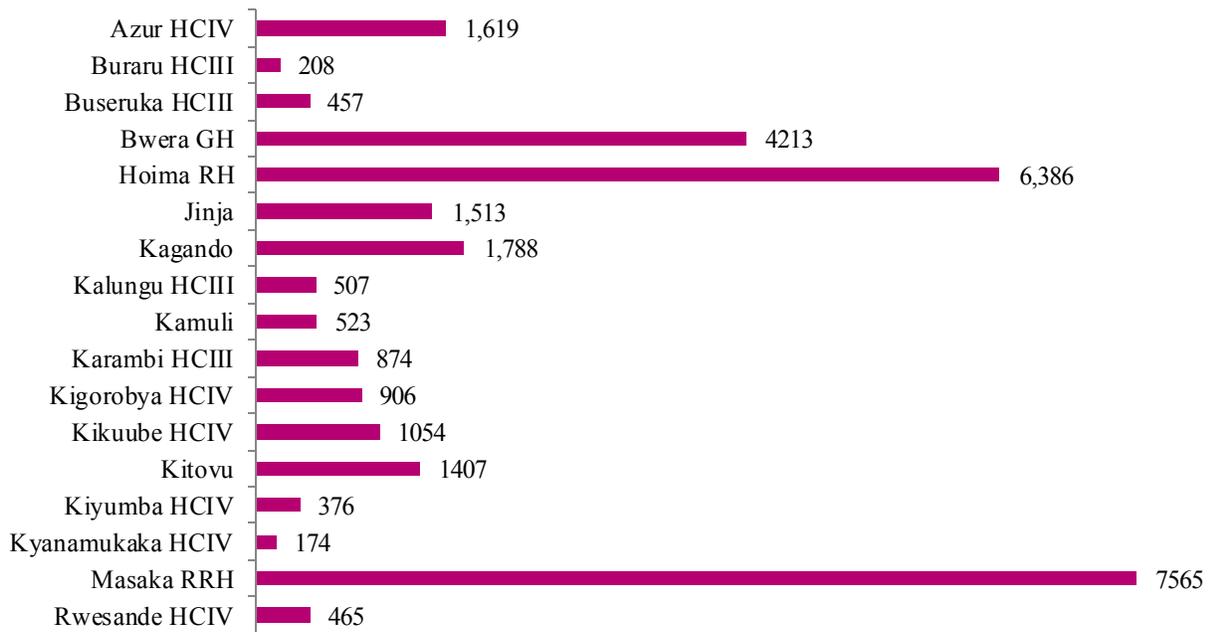
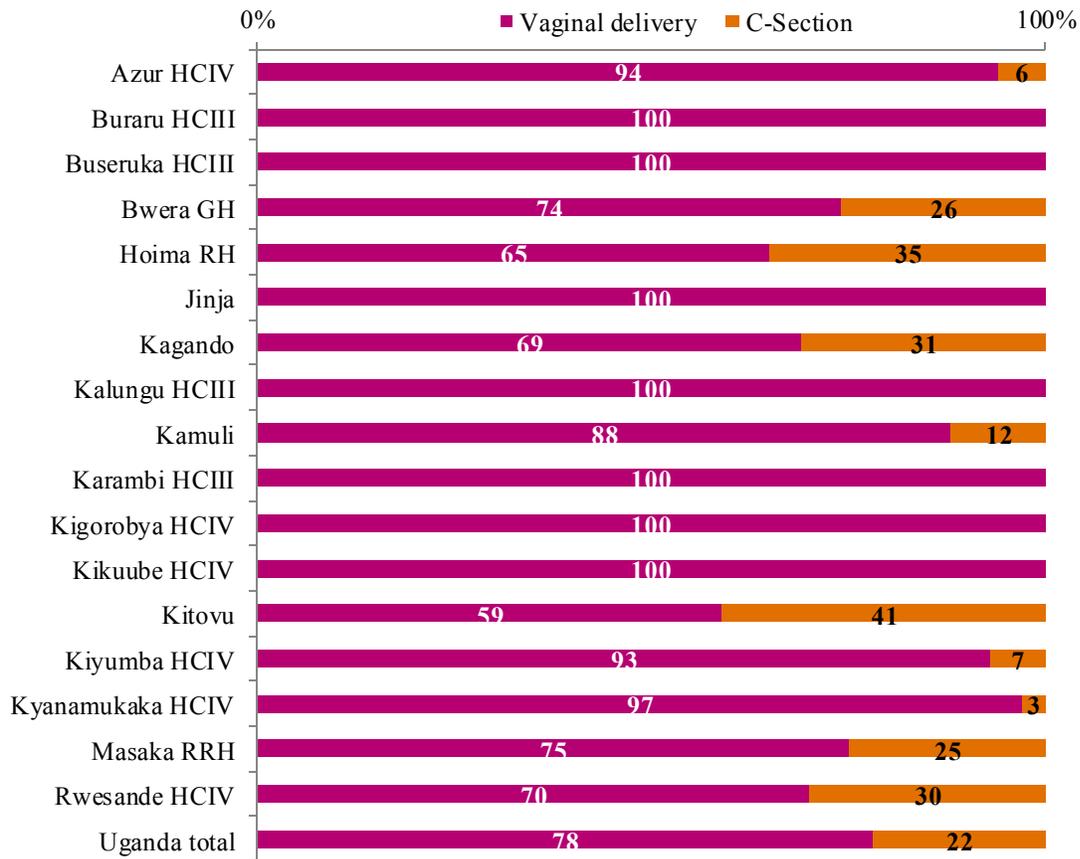


Figure UGA4. C-Section Rates, by Site, FY14/15.



Both Hoima and Kitovu Hospitals reported provision of conservative and surgical treatment for pelvic organ prolapse (POP) during FY14/15. This POP treatment was provided through the concentrated repair efforts that also addressed fistula repairs. During FY14/15, 73 women sought treatment for possible POP symptoms with 57 women diagnosed with and requiring treatment for POP (78% of those seeking). All 57 women received POP treatment during this period (100% of those requiring). At Kitovu, 21 conservative POP treatments and 35 surgical POP treatments were provided (some women may receive both conservative and surgical treatment), and at Hoima one conservative POP treatment and 17 surgical POP treatments were provided. All women receiving surgical POP treatment were cured at discharge and there were no reported complications. POP treatment data is presented, by site, in Table UGA7.

Table UGA7. Number Seeking, Requiring and Receiving POP Treatment, by Site, FY14/15.

Site	#Seeking	#Requiring	% of Seeking	#Receiving	# of Requiring	% Cured Post-Surgery
Hoima	34	18	53%	18	100%	100%
Kitovu	39	39	100%	39	100%	100%
Total	73	57	78%	57	100%	100%

In the third quarter, an assessment was carried out at 14 supported sites spread across Hoima, Kasese Masaka and Kalungu districts to establish the current status of partograph use in labor monitoring. This activity was also meant to assess gaps and training needs before beginning capacity building activities. Findings revealed many new staff at all the sites who are not trained in partograph use and are not up to date regarding new guidelines for managing eclampsia and early rupture of membranes. Shortage of partographs, lack of photocopying facilities, and poor provider attitudes were identified as key barriers to partograph compliance. The assessment also found that too few deliveries were occurring at lower level health facilities to facilitate adequate hands on experience for staff during onsite training and, therefore, that it will be important to train staff from lower units at higher level facilities (regional referral and district hospitals) going forward.

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

During the first quarter, Masaka Regional Referral Hospital held a data review meeting to discuss obstetrics cases and review staffing levels. This exercise was conducted in the fourth quarter with Azur HCIV. This is a promising practice that FC+ will seek to support at other prevention sites.

After attending the EngenderHealth CDDM meeting in February/March 2015, a follow-up CDDM orientation session was conducted in Uganda by M&E and clinical staff. Seven Uganda office staff including managers and project officers attended the session. Participants were introduced to the CDDM framework that was developed in Istanbul to support EngenderHealth

staff in developing strong systems for data collection and use including establishing clear roles and responsibilities for all people involved in CDDM. The data flow process was also discussed and the participants came up with five commitments that will help to strengthen CDDM at the country level. Some of the commitments include forming a country level CDDM steering committee co-chaired by MER and the clinical staff, ensuring that data collected is of high quality, ensuring timely data use at different levels, conducting joint supportive supervision exercises to project sites and sub grantees and holding quarterly data review meetings to assess program performance. See Appendix Z for a brief resulting from this meeting.

In March 2015, EngenderHealth Uganda hosted a four day training workshop that brought together selected M&E and program staff drawn from six FC+ project countries to introduce them to the project's DHIS2 platform designed to collect, analyze and store data for the project, and to train field-based monitoring and evaluation staff in its use. Four FC+ Uganda staff were able to participate in the training.

As noted above, FC+, in partnership with the MOH, successfully hosted the ISOFS and IOFWG meetings in Kampala in October 2015, with delegates coming from many countries around the world. FC+ also sponsored fistula teams, health workers and district officials from FC+ supported districts and health facilities in Uganda. As part of the meetings, FC+ sponsored a one-day research methods training attended by 80 participants from various countries, addressing the basic knowledge and skills needed to conduct health research, data analysis and publication.

Ugandan FC+ staff prepared, submitted and had accepted four abstracts for presentation at the upcoming 2015 FIGO conference and the 2015 International Conference on Family Planning.

Members of the FC+ Uganda team were part of the strong FC+ presence at the ECOWAS/WAHO Good Practices Forum in Ouagadougou, see Appendix L for details on presentations and posters. The Uganda Country Program Manager and several providers from supported sites in Uganda attended the FC+ convened POP/Fistula integration workshop in September 2015, see Appendix M for details.

FC+/EngenderHealth was one of the key sponsors of the annual Association of Obstetricians and Gynecologists of Uganda (AOGU) scientific conference held in Kampala, Uganda under the theme "Professionalism and partnerships in reproductive health: the key to sustainable development" (Sept 2015). The conference brought together stakeholders from the Ministry of Health, obstetricians and gynecologists, fistula surgeons from major hospitals around the country, Makerere and other national universities, and international and local NGOs. This event provided an opportunity for FC+ to chair and showcase its work through presentation of five abstracts on a range of topics including mentoring and coaching of fistula surgeons, maternal health data management and use, the role of religious leaders in community mobilization and family planning.

In the fourth quarter, data collection tools for a joint study with project partner TERREWODE addressing the needs of women with incurable fistula (WIF) were finalized and are currently

being translated into five local languages (Luganda, Lusoga, Runyoro, Ateso, and Langi). A research protocol is also being developed for submission to a local IRB for ethical approval. Once ethical approval is secured, TERREWODE will start enrolling WIF into the study. The study will help to understand the needs of WIF so as to provide them with individualized social reintegration services, evaluate their perceptions of reintegration interventions, and assess their quality of life before and after social reintegration. Based on the findings, guidelines for social reintegration of WIFs will be developed and provided to the MOH and fistula partnerships to guide future interventions. It is also expected that these guidelines will benefit south-to-south learning across FC+ countries.

FC+ collaborated with Makerere University, Department of Population Studies, to apply for a research grant aimed at funding a study on iatrogenic fistula (fistula arising from surgical errors during obstetric and gynecological procedures), in response to a WHO call for proposals. Unfortunately, the research project did not receive funding and we continue to seek out other research opportunities in collaboration with Makerere University.

West Africa Region/Niger

EngenderHealth began its support for fistula services in the West Africa Region in Niger in 2005 through a BMGF grant. USAID-supported fistula services in the region began in 2007 through the AWARE and FC projects and continue through FC+ in Niger in three treatment and prevention sites and two prevention-only sites as of September 30, 2015. FC+ efforts in Niger are part of a larger West Africa regional focus with the goal of continuing to build Niger as a regional hub for learning and a model for FP/Fistula integration activities, education, research, advocacy, and best practices. Emphasis is on collaboration with regional partners to strengthen fistula prevention, treatment, and reintegration efforts throughout West Africa.

Key activities during FY14/15 included support for fistula treatment services, community outreach activity, facility audits, site assessments, training and conference/meeting participation. Funding delays at the start of FY14/15 related to allocation of PRH funds resulted in delays and limited achievement of program implementation.

During FY14/15, FC+ also initiated activities in Togo. Niger-based and regional project efforts are reported here; activities in Togo are reported in a separate country report, below.

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

The “Réseau pour l'éradication de la fistule” (REF) is an important partner for FC+ in West Africa/Niger. The REF was jointly established by the Ministry of Health and the Ministry for Women and Children's Protection and includes representatives from civil society. It brings technical support and human resources in the prevention, management, and socioeconomic reintegration of women suffering from fistula. Under the previous FC project, activities were primarily implemented by REF. Under FC+, a project management structure has been established and as a result, there was an identified need to draft a MoU describing the partnership between FC+ and REF. This was developed during the second quarter of this fiscal year and has not yet been approved by REF, which has caused a delay in some project-related activities.

FC+ has supported REF's efforts to mobilize obstetric fistula specialists and involve them in the revision of a National Obstetric Fistula Strategy. The goal is to use this strategy, once it is adopted, as a guide for a regional strategy and planning for this is ongoing. In December 2014, a committee composed of twenty health and fistula specialists undertook the revision of the national strategy under the direction of the General Director of Health, President of REF. The new strategy has taken into account the principles of rights and choice for women suffering from fistula, similar to the approach articulated in the rights-based family planning framework co-developed by EngenderHealth. This national strategy includes the management of all forms of obstetric fistula, including traumatic fistula, as well as uterine prolapse and WDI. The technical committee established by REF finished revision of the strategy in the third quarter. Validation is expected to take place in the first quarter of FY15/16; the strategy will then be disseminated to all in-country stakeholders via a national workshop.

Talks were initiated with the MOH and REF in the second quarter of FY14/15 to develop a regional policy for fistula prevention with the authorities of the Organization of African States (OAS). A concept note was developed and REF is taking the lead in moving discussions forward. FC+ West Africa/Niger and REF are facilitating discussion and planning between the MOH and WAHO to plan for upcoming exchanges and to advocate for the finalization of a regional strategy for addressing obstetric fistula. The MOH of Niger has officially requested permission to visit WAHO headquarters (Bobo Dioulasso, Burkina Faso) as part of a national joint advocacy mission composed of representatives of the MOH and field partners. A formal advocacy strategy will be planned once the national strategy has been finalized.

During the second quarter of FY14/15, FC+ West Africa/Niger initiated discussions with Orange France and Orange Niger (telecommunications companies) on the possibility of implementing an mHealth project in collaboration with the Strengthening Health Outcomes through the Private Sector (SHOPS) project. Discussions are ongoing and collaboration is planned to address follow up and reintegration of fistula clients as well as the needs of WDI.

International Day to End Obstetric Fistula was celebrated in Niger on June 15, 2015, under the leadership of First Lady Dr. Malika and Minister of Health Aghali. The ceremony was hosted at the CNRFO, at the new fistula center under construction with financing from the Turkish cooperation. An estimate 200 people were in attendance, see Table WAR/N2, and gifts were provided to fistula clients by the first lady's foundation "TATALI IYALI."

International Day to End Obstetric Fistula celebrations. (Credit: Aboubacar Garba)



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+ is employing a community engagement strategy in West Africa/Niger that builds on the success of the FC project's work with Village Safe Motherhood Committees. In October 2014, a meeting was organized by FC+ West Africa/Niger in Maradi, with 24 mayors of municipalities and district health officials, to identify Centres de Santé Intégrés (CSI) and target communities for activities. Seven mayors received information on the causes and consequences of obstetric fistula (see Table WAR/N2). This information was novel for and of great interest to participants, who committed themselves to supporting FC+ activities in their areas.

Identification of community volunteers began on December 23 and continued until January 2015. The leaders of the CSI, under the supervision of officials from the health districts and the Regional Health Directorate, identified 360 community volunteers from across all 50 villages

and ten CSI. During the second quarter, training modules for MNCH and communication techniques were reviewed and revised and 12 resource people were identified to train the trainers of community volunteers. This training of trainers took place in the third quarter for 14 trainers, see Table WAR/N5.

The community volunteers' training manual produced by REF (developed under the former FC Project) entitled "Informing and engaging communities in improving maternal health" was amended to include topics such as the use of REDI approach to promote childbirth preparation and use of maternal health care and data collection.

Following the TOT, training of community volunteers commenced in the fourth quarter of FY14/15 with 360 community volunteers trained in Madarounfa and Guidan Rumdji in the Maradi region, see Table WAR/N1. Additional community agents will be trained in the Guidan Rumdji area in the first quarter of FY15/16.

Table WAR/N1: Community Volunteer/Educator Training, Participants by Topic, FY14/15.

Type of Training	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Total FY14/15
Communityvolunteers in Guidan Rumdji and Madarounfa	0	0	0	360	360
Total	0	0	0	360	360

The trained volunteers have already begun to implement community outreach activities. In the fourth quarter, 165 activities took place in 60 villages, using door to door visits, small group conversations, and awareness raising at mosques, baptisms, and weddings to discuss topics related to obstetric fistula, safe motherhood and male involvement. These activities reached over 13,000 participants, see Table WAR/N2. Committee activity will continue in FY15/16 in each selected community, with the volunteers utilizing communications materials for community sensitization on fistula prevention.

Table WAR/N2: Community Outreach/Education/Advocacy Events, FY14/15.

Type of Event	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached
Education/outreach/ advocacy at existing community activity	0	0	0	0	1	200	165	13,100	166	13,300
Education/outreach/ advocacy with policy makers	2	24	0	0	0	0	0	0	2	24
Maternal health/fistula-focused education/ outreach/advocacy event	0	0	0	0	0	0	10	348	10	348
Total	2	24	0	0	1	200	175	13,448	178	13,672

Insecurity along the border with Nigeria delayed planned West Africa/Niger cross-border work related to fistula referral and community outreach efforts targeting early marriage. The situation will continue to be assessed to determine if/when activities can be implemented.

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

To address transportation and financial barriers, all women who received repair for fistula during this period in Niger were reimbursed for transportation costs to and from the repair hospital. Housing and accommodation was provided for the entire duration of the stay at the repair site.

Discussions have begun with the telecommunications company ORANGE-Niger and ORANGE-France to plan a health project implementation related to timely provision of transport for fistula clients identified through screening and to facilitate communication with community volunteers who will report all new cases.

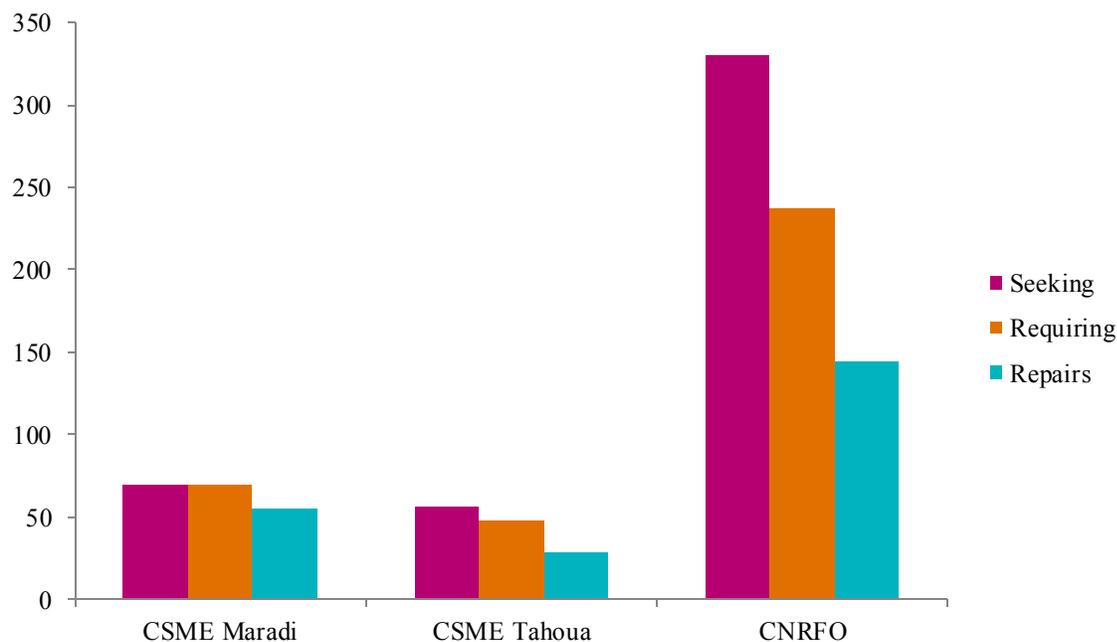
Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Throughout the fiscal year, FC+ and REF carried out facility audits and assessments at supported sites in Niger, as well as sites that may potentially receive support. During the first quarter of FY14/15, facility audits were carried out at three supported facilities: CSME Maradi, CSME Tahoua, and CNRFO. These audits help to identify site strengths and needs in order to inform programmatic support.

During FY14/15, 456 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites in Niger, of which 355 were diagnosed with fistula and required treatment (78%). FC+ supported 227 fistula repair surgeries during this reporting period. Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of women repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure WAR/N1 presents data on women seeking and requiring fistula treatment, and the number of fistula surgeries supported, by site.

Some delays in services for fistula repair occurred in Niger due to a higher than normal backlog of women waiting for surgical repair. Contributing factors were displacement of surgeons to the ISOFS conference in Uganda and end of year delays associated with administration at the hospitals. It is expected these cases will be repaired in the coming quarters. CNRFO reported being unable to repair a large number of women during the first quarter due to a stock-out of anesthetic drugs.

Figure WAR/N1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY14/15.



These 227 fistula repair surgeries were conducted at three FC+ supported hospitals in West Africa/Niger: CSME Maradi, CSME Tahoua, and CNRFO, see Table WAR/N3 for detail by quarter. Two concentrated repair efforts were carried out in the second quarter at CSME Maradi and CSME Tahoua to address women with complex fistula cases who had been waiting for repair due a work stoppage. The efforts resulted in an increase in the number of repairs carried out at those facilities. The third quarter had a decrease in repairs at the CSMEs due to a national physician strike and the fourth quarter coincides with the rainy/growing season which is thought to negatively impact women's ability to seek out services. UNFPA also provides support to some of the sites in Niger 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.

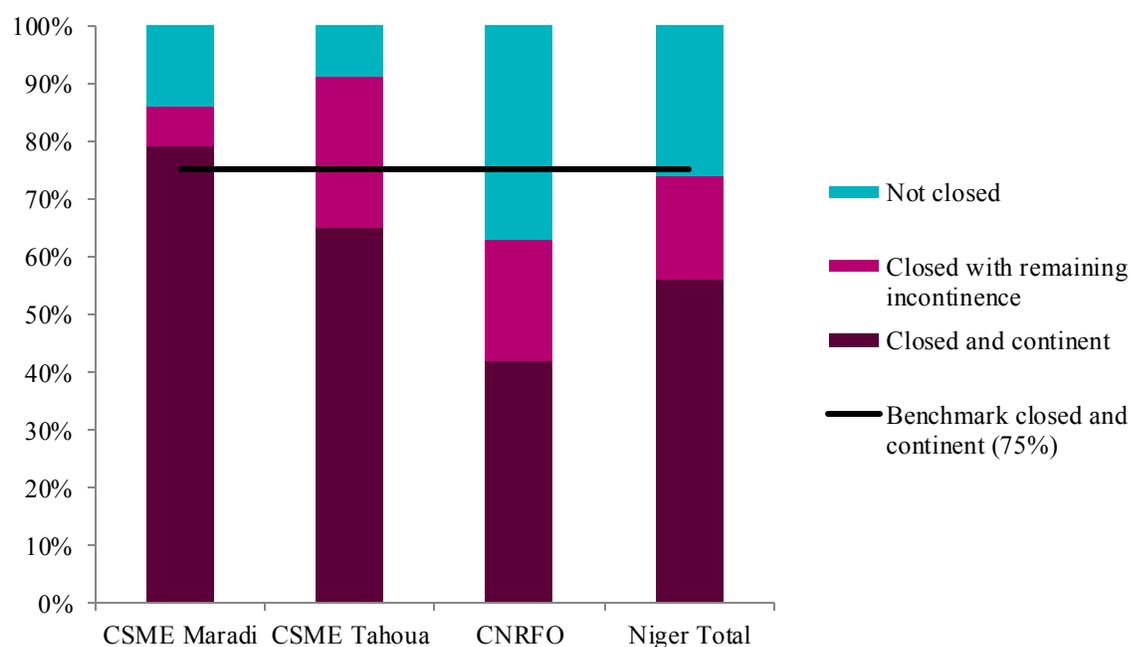
Table WAR/N3: USAID-Supported Surgical Fistula Repairs, by Site, FY 14/15.

Site	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
WA/Niger					
CSME Tahoua	0	22	5	1	28
CSME Maradi	11	22	5	17	55
CNRFO	10	19	73	42	144
Total	21	63	83	60	227

During FY14/15, Niger had a total of eight cases identified as iatrogenic fistula, representing 2% of all diagnosed fistula cases.

During FY14/15, 74% of all fistula surgery cases were closed at time of discharge; 56% were closed and continent and 18% were closed and incontinent. Outcomes for discharged patients are presented, by site, in Figure WAR2. CNRFO in Niamey reported 60% of their cases were repeat repairs (i.e. not first repairs), as well as seeing an uptake in more complicated fistula cases which this likely contributed to the proportion of repairs that were not closed. Additionally, the CNRFO routinely discharges all patients after 21 days, to create bed space for other patients. The low closed and continent rates are being investigated by FC+ global and West Africa/Niger clinical staff and the solutions will be identified. Reported complications were low at supported sites (1% overall) with a range of 0% (CSME Tahoua and CNRFO) to 3.5% (CSME Maradi).

Figure WAR/N2. Outcome Rates for Surgical Repairs, by Site, FY14/15.



During FY14/15, four surgeons in Niger received training in surgical fistula repair (all attending their first training) see Table WAR4.

Table WAR/N4: Surgical Fistula Repair Training, Participants by Institution, FY 14/15.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	1 st	Cont								
WA/Niger										
CSME Tahoua	0	0	2	0	0	0	0	0	2	0
CSME Maradi	0	0	2	0	0	0	0	0	2	0
Total	0	0	4	0	0	0	0	0	4	0

As part of fistula prevention efforts, FC+ West Africa/Niger has supported training for 120 health care providers during the fiscal year. During the first quarter, training of contraceptive technology trainers was held at the CNRFO, CSME Tahoua, HD Guidan Rounji, and HD Madarounfa for 29 health providers (midwives and nurses). Four nurses were trained in fistula diagnosis. In the second quarter, facilitative supervision training was carried out for 30 health agents from CSME Maradi, Guidan Rounji, and Madaroufa. In the third quarter, partograph training took place at CSME Maradi, along with the TOT for community outreach described in Objective 2.

A workshop on gender was held in Niamey from September 14-18, 2015 which included participants from Niger and DRC and covered topics related to gender, sexuality, and SGBV. Also in the fourth quarter, training was held at CNRFO on the use of data for decision-making. Table WAR/N5 provides information on non-surgical trainings for health system personnel

Table WAR/N5: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
FP methods	29	0	0	0	29
Pre- and Post-Operative Care	4	0	0	0	4
Quality Assurance	0	30	0	0	30
Partograph	0	0	20	0	20
Community outreach and education	0	0	14	0	14
Data for decision making	0	0	0	16	16
Gender	0	0	0	7	7
Total	33	30	34	23	120

AgirPF and FC+ have agreed to support ten selected health centers in Madarounfa and Guidan Rounji Health districts in Niger for FP provision. During the first two quarters of FY14/15, 833 counseling sessions took place at supported sites and 3,056 CYP were provided, see Table WAR/N6 for detail, by site. Method mix at supported sites in Niger primarily consists of implants and injectables, oral pills, tubal ligation, male condoms and IUDs.

Table WAR/N6: Family Planning Counseling Sessions and CYP, by Site, FY 14/15²¹.

Site	Oct-Dec 2014		Jan-Mar 2015		Apr-Jun 2015		Jul-Sep 2015		Total FY 14/15	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP
WA/Niger										
CSME Tahoua	116	525	NA	139	154	167	85	153	355	984
CSME Maradi	260	456	60	659	59	634	70	319	449	2,067
CNRFO	29	5	NA	NA	NA	NA	NA	NA	29	5
Total	405	986	60	798	213	800	155	471	833	3056

Please note: totals in table may differ slightly from the sum of site totals due to rounding.

FC+ supported sites in Niger reported an overall C-section rate of 41% (n=4,854 deliveries) in FY14/15. Information on number of deliveries, by site, is represented in Figure WAR/N3 and C-section rates, by site, are presented in Figure WAR/N4. Sites reported 16% of all labors were prolonged/obstructed and 7.5% of those labors received catheterization for fistula prevention.

Figure WAR/N3. Number of Obstetric Deliveries, by Site, FY14/15 (n=4,854).

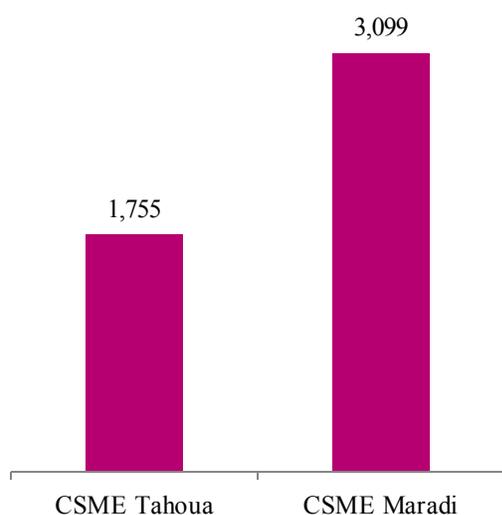
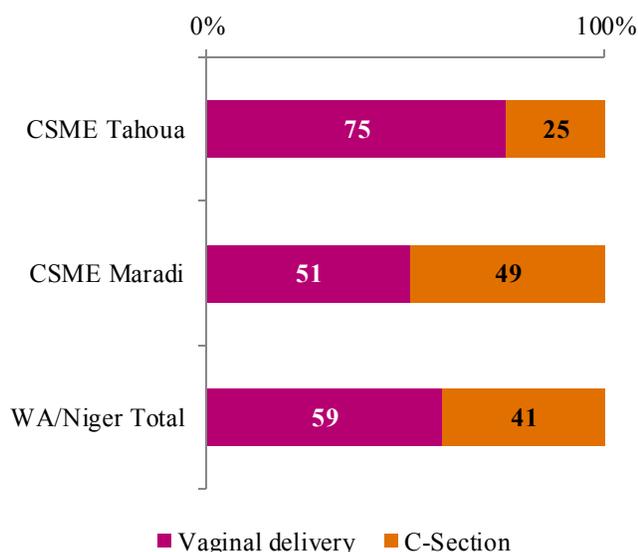


Figure WAR/N4. C-Section Rates, by Site, FY14/15.



Two sites in West Africa/Niger reported providing conservative and surgical treatment for pelvic organ prolapse (POP) during FY14/15. During this period, 129 women sought treatment for possible POP symptoms with 119 women diagnosed with and requiring treatment for POP (92% of those seeking). A total of 86 women received POP treatment during this period (72% of those requiring). Across sites, 28 conservative POP treatments and 73 surgical POP treatments were provided (some women may receive both conservative and surgical treatment). All women

²¹ CYP numbers may vary slightly from the aggregate of their parts due to rounding.

receiving surgical POP treatment were cured at discharge and there were no reported complications. POP treatment data is presented by site in Table WAR/N7.

Table WAR/N7. Number Seeking, Requiring and Receiving POP Treatment, by Site, FY14/15.

Site	#Seeking	#Requiring	% of Seeking	#Receiving	# of Requiring	% Cured Post-Surgery
WA/Niger						
CSME Tahoua	58	58	100%	58	100%	100%
CSME Maradi	71	61	86%	28	46%	100%
Total	129	119	92%	86	72%	100%

The West Africa/Niger Country Program Manager attended the FC+ convened POP/fistula integration meeting held in New York in September 2015.

One surgeon from Niger attended a neo-vagina workshop in Mozambique. For more details, please see Nigeria country section, Objective 4.

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

The West Africa/Niger team held an internal country level DDM in July 2015. Also in the fourth quarter, the Project M&E Officer conducted a site level data for decision making training, with a focus on learning how to review site level data to improve services. Routine data collection was conducted at supported sites and for project activities.

Use of clinical data for decision making training.
(Credit: Aboubacar Garba)



During the first quarter, the new West Africa/Niger Project Manager received orientation training in the use of FC+ data collection tools and disseminated them to the project supported sites. The Project Manager participated in a meeting discussing the implementation of a DHIS2 platform for the National Health Information System in Dosso.

During FY14/15, Nigerien staff participated in several international meetings and conferences. The Project Manager and Finance Manager participated in EngenderHealth's Country Program Managers' meeting in Abidjan. In October 2014, FC+ staff and partners from Niger were able to participate in the international ISOFS conference in Uganda (three fistula surgeons and the Project Manager). FC+ had a robust West Africa Region presence at the WAHO/ECOWAS Good Practices Forum, see Appendix L for details.

During FY14/15, FC+ M&E consultant Alex Delamou has published two articles in *Tropical Medicine and International Health* entitled "Good clinical outcomes from a 7-year holistic

programme of fistula repair in Guinea” (<http://www.ncbi.nlm.nih.gov/pubmed/25706671>) and “Factors associated with loss to follow up in women undergoing repair for obstetric fistula in Guinea” (<http://www.ncbi.nlm.nih.gov/pubmed/26250875>). Both articles analyze data collected under the Fistula Care project. FC+ has provided support to ensure the articles are available via open access. He also had a correspondence on Ebola in Health Care Workers in Guinea published in the Lancet (<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2960193-3/fulltext>).

West Africa Region/Togo

During FY14/15, FC+ initiated activities in Togo through site assessment, clinician training, and provision of support to a Guinean surgeon to participate in a UNFPA-sponsored fistula repair camps in Togo.

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

FC+ carried out three facility assessments in Togo: CHR Sokodé, CHR Dapaong, and CHU Sylvanus Olympio. During the first quarter of FY14/15, Dr. Sita Millimono from EngenderHealth Guinea, Bethany Cole from the FC+ global team, and Dr. Cyrille Guede from the AgirPF project were joined by counterparts from the Togo Ministry of Health and UNFPA to conduct needs assessments of three facilities in Togo: CHR Sokodé, CHR Dapaong, CHU Sylvanus Olympio. The purpose of the assessment was to understand current activities and capacity for prevention and repair activities using FC+ tools and to make recommendations for a national strategy. The team recommended concentrating efforts at sites best placed to continue with prevention and repair work. Support for this initiative in Togo is ongoing. Discussion is ongoing with partners in Togo for continued support for repair efforts organized by the ministry and UNFPA.

In the fourth quarter, as shown in Table WAR/T1, FC+ carried out training for 18 nurses and midwives in Togo in fistula pre- and post-operative care, particularly infection prevention, using the FC/ECSA curriculum for nurses and midwives.

Table WAR/T1: Non-Surgical Health System Personnel Training, Participants by Topic, FY 14/15.

Topic	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Total FY 14/15
Pre- and Post-Operative Care	0	0	0	18	18
Total	0	0	0	18	18

In the first and third quarters, FC+ supported one surgeon from Guinea, Dr. Kindy Diallo, to attend and lead UNFPA-sponsored fistula repair camps at CHR Sokodé in Togo. These repairs were supported by UNFPA and are therefore not included in the report of USAID-supported repairs. However, CHR Sokodé is considered an FC+ supported site, as shown in Appendix A.

FC+ was highlighted in USAID's West Africa Regional Office Newsletter, *ParlerHealth*. This post from former Project Director, Karen Beattie, highlights the fistula care surgery campaign in Togo in December 2015, and was included in the April 2015 newsletter. The newsletter can be read here: <http://us10.campaign-archive2.com/?u=0aefc5129112726a2eb7858af&id=87306e7abf>

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

Country/Site	Sector	Planned FY14/15 T: Treatment & Prevention P: Prevention-only	Actual FY14/15 (As of Sept 30, 2015)
Bangladesh: 8 sites		10T, 3P	8T
Ad-Din Dhaka	Private	T	T
Ad-Din Jessore	Private	T	T
Ad-Din Khulna	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	
Faridpur Medical College	Government	T	
Moulvibazar District Hospital	Government	P	
Patuakhali District General Hospital	Government	P	
Gaibandah District Hospital	Government	P	
Dr. Muttalib Community Hospital	Private	T	T
Mamm's Institute of Fistula & Women's Health	Private	T	T
DRC: 5 sites		3T, 2P	5T
St. Joseph's Hospital/Satellite Maternity Kinshasa	FBO	T	T
Panzi Hospital	Government	T	T
HEAL Africa	FBO	T	T
Imageri Des Grands-Lacs	Private	P	T
Maternité Sans Risque Kindu	Private	P	T
WA/Niger: 5 sites		3T, 2P	3T, 2P
Centre de Santé Mère / Enfant (CSME) Maradi	Government	T	T
Centre National de Référence des Fistules Obstétricales (CNRFO), Niamey	Government	T	T
Centre de Santé Mère /Enfant (CSME) Tahoua	Government	T	T
Madarounfa District Hospital, Maradi	Government	P	P
Guidan Roumji District Hospital, Maradi	Government	P	P
Nigeria: 745 sites		12T, 19P	12T, 733P
General Hospital, Ningi	Government	T	T

Country/Site	Sector	Planned FY14/15 T: Treatment & Prevention P: Prevention-only	Actual FY14/15 (As of Sept 30, 2015)
General Hospital, Ogoja	Government	T	T
National Fistula Center, Abakaliki	Government	T	T
Laure WF Center	Government	T	T
National Fistula Center, Babbar Ruga, Katsina	Government	T	T
Gesse WF Center, Birnin Kebbi	Government	T	T
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
University College Hospital, Ibadan	Government	T	T
Jahun WF Center, Jigawa State	Government	T	T
Adeoyo General Hospital, Ibadan	Government	T	T
Prevention only sites	Government	19P	237T
Former TSHIP facilities	Government	-	496T
WA/Togo: 1 site			1T
CHR Sokodé	Government		T
Uganda: 16 sites		4T, 13P	2T, 14P
Kitovu Mission Hospital	FBO	T	T
Kamuli Mission Hospital	FBO	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	P
Kyanamukaka HC IV	Government	P	P
Kalungu HC III	Government	P	P
Karambi HC III	Government	P	P
Kigoroby HC IV	Government	P	P
Azur HC IV	FBO	P	P
Buseruka HCIII	Government	P	P
Kikuube HCIV	Government	P	P
Buraru HCIII	Government	P	P
Rwesande HCIV	FBO	P	P
Kagando Hospital	FBO	T	P
USAID Supported, Non Fistula Care Plus			9T, 1P

Country/Site	Sector	Planned FY14/15 T: Treatment & Prevention P: Prevention-only	Actual FY14/15 (As of Sept 30, 2015)
IntraHealth (Mali) Jinnah Post Graduate Medical Center (Pakistan) Pathfinder (Ethiopia) PROSANI (DRC) Vodafone/CCBRT (Tanzania)			NA 1T NA 1T 7T, 1P
TOTAL USAID supported FC+ = 6 Countries		32T, 39P = 71 sites	31T, 749P = 780 sites
TOTAL USAID supported, bilateral (non FC+) = 5 Countries			9T, 1P = 10 sites
TOTAL <u>USAID supported, All Projects</u> = 7 countries			40T, 750P = 790 sites
Non-USAID Supported, EngenderHealth Guinea: Kissidougou District Hospital Labe Regional Hospital Jean Paul II Hospital	Government Government Government	3T T T T	3T T T T
TOTAL EngenderHealth supported, All Funds= 7 countries		35T, 39P = 74 sites	34T, 749P = 783 sites

T: Treatment and Prevention, P: Prevention-only

APPENDIX B: FC+ USAID MANAGEMENT REVIEW RESPONSES DECEMBER 2014

I. Financial Management

1. *Please provide a pipeline analysis for core and field support, POP and MCH funds; show burn rate trends and projected expenditures through Sep 30, 2015. Is the pipeline appropriate at this time in the project cycle?*

Fistula Care *Plus* (FC+) was awarded on December 12, 2013 with a ceiling of \$74,490,086. Funds obligated in December 2013 amounted to \$3,903,672. The second obligation of 2014 funds was received on May 21, 2014 in the amount of \$3,456,328, bringing the total for the fiscal year to \$7,360,000.

Table 1: Obligation of Funds in December 2013-September 2014

Country	Obligated December 12 2013	Obligated May 21 2014	Total funding
Bangladesh	\$280,000 (MCH) \$220,000 (POP)		\$500,000
DR Congo	\$200,000 (MCH) \$850,000 (POP)		\$1,050,000
Nigeria	\$990,000 (POP)	\$2,310,000 (MCH)	\$3,300,000
Uganda	\$300,000 (POP)	\$700,000 (MCH)	\$1,000,000
West Africa/Niger	\$263,672 (MCH)	\$376,328 (POP)	\$640,000
Core	\$530,000 (MCH) \$270,000 (POP)	\$70,000 (PPP)	\$870,000

Annex 1 indicates Core and Field Support, by FY14 POP and MCH funds available to spend, and their respective pipelines to carry forward to FY15 as well as the monthly burn rate for the fiscal year. It is too early in the project to delineate trends. The following are some notes regarding spending in this time period.

In three countries, where funds were delayed until May 2014, we received one type of funding (either POP or MCH). There was some misunderstanding at the Mission level in two instances about how expenses for obstetric fistula could be charged. As a consequence, some activities were delayed, and one fund bore more operational costs than would have been the case. For example, in the September 2015 pipeline, you will note that Uganda had a \$59,000 cost-overrun in POP funds. There was a delay in obligating subawards and the following are not reflected in the September 2014 pipeline. Table 2 summarizes the current and pending subawards.

Table 2: Active or Pending Subawards

Institution	Start Date	End Date	Subaward Number	Obligated Amount or anticipated amount	Status: Active or pending
Population Council	1-Oct-14	30-Sep-15	SUBA094	\$202,244	Active
Bangladesh					
Ad-din Hospital	1-Sep-14	31-Aug-15	SUBA094	\$31,710	Active
Kumudini Hospital	1-Sep-14	31-Aug-15	SABD003	\$9,582	Active
LAMB Hospital	1-Sep-14	31-Aug-15		\$57,140	Pending
BRAC	1-Jan-15	31-Dec-16		\$114,762	In preparation
DR Congo					
St. Joseph Hospital	1-Sep-14	31-Aug-15	SUBA093	\$271,663	Active
HEAL Africa	1-Sep-14	31-Aug-15	SACD001	\$110,201	Active
Imagerie Des Grands Lacs (IGL)	1-Oct-14	30-Sep-15	SACD004	\$104,092	Pending
Maternité Sans Risque de Kindu (MSRK)	1-Oct-14	30-Sep-15	SACD005	\$131,110	Pending
PANZI Hospital	1-Sep-14	31-Aug-15	SACD003	\$107,906	Pending
Uganda					
Kitovu Hospital	1-Sep-14	30-Sep-15	SAUG001	\$249,930	Active
Terrewode	1-Sep-14	30-Sep-15	SAUG002	\$51,109	Pending

Some specific observations by country on expenditures over the past year:

Bangladesh: Bangladesh is carrying forward about 52% of funding obligated for the first year. However, as indicated in Table 2, three subawards have become active since October 1 and one is pending. A fifth subaward is in negotiation with the local partner. As USAID/W is aware, the USAID Mission in Dhaka has requested that the project focus its attention on the backlog of clients in Bangladesh and indicated its desire not to engage in planned research activities. (Under Mod. 2, the mission has provided \$700,000 in MCH and \$300,000 in POP funding.)

D.R. Congo: While the DRC carried forward a large pipeline relative to its FY14 funding, as you will see from the above summary of subawards, the total cost of active and pending subawards is \$724,972. (Mod 2 did not include funds for the D.R. Congo and we will need to delay formally awarding one or more of the pending subawards until funds are obligated by the Mission.)

Nigeria: The large amount of MCH funds to be carried forward is due to the obligation of funds in May 2014 and to the need to recruit 17 new staff for the offices in Nigeria. Nigeria will contribute to the Population Council subaward that will address financial challenges to accessing fistula treatment in Nigeria.

Uganda: As explained above, the delay in obligation of MCH funds resulted in over-expenditures in POP funds. Of the three subawards earmarked for FY14 (TERREWODE, Kitovu, and Kamuli Hospital), Kitovu Hospital and TERREWODE subaward have been approved and obligated for expenditures to start being incurred in FY15. Uganda will contribute to the Population Council subaward that will address challenges to accessing fistula treatment in Uganda. (Mod 2 did not include funds for Uganda and this is now urgent because funds will be exhausted by the end of December.)

West Africa/Niger: Initial FY14 activities were focused in Niger. During the year, the USAID Mission approved activities in Togo in collaboration with UNFPA and AgirPF, the regional family planning project supported by USAID and also managed by EngenderHealth. FY15 will see more regional initiatives and additional cooperation with AgirPF in West Africa.

FC+ Global: Core staff time is allocated to field programs for country-specific management and technical support. For FY14, only 3% of Core POP obligation of \$270,000 is left to carry forward to FY15, while for Core MCH obligation of 530K, 46% will be carried forward to FY15. The release of FY15 funding is needed to cover FY15 POP funds that are almost exhausted. FC+ Core also has 70K obligation from the Public-Private Partnership initiative that is yet to be expended.

Allocables: FC+ uses an "Allocables" system, whereby 10% of all funds obligated by USAID are set aside in a separate fund for use by key personnel and the project coordinator to cover the cost of project management and oversight. Of the 736K obligation set aside as "Allocables" in FY14, 603K has been expended and 133K representing 18% is being carried forward to FY15.

2. Identify any issues or problems with financial management in NY or in the field

Please see the notes above in response to question 1. In addition, as has been discussed with Mary Ellen Stanton and Erin Mielke the USAID West Africa mission has requested budgets and reports on a different timeframe and in a different format from those required by the cooperative agreement for the global project. With a small core and country staff (one person in Niger) this has posed challenges in the recent past and we are exploring avenues for meeting the Mission's needs while at the same time limiting the requirements for additional budgets and reports.

Project Management

1. *What is the status of project staffing and recruitment efforts?*

Core: USAID recently approved Mr. Joseph Osei as the Finance Specialist on the project. This is a key personnel position. Ms. Karen Beattie, Project Director, announced her intention to retire at the end of December 2014. She will work 60% of time in January and February to ensure coverage and a smooth transition to a new project director. The position has been posted on EngenderHealth's website. Dr. Yetnay et Asfaw will provide an update on plans for this recruitment during the management review. Ms. Vandana Tripathi will take a three month maternity leave beginning approximately January 1, 2015. Plans have been put in place for managing ME&R activities in her absence.

Under FC+, the project has fewer global staff than under the previous project. Currently, the global staff consists of the project director, deputy, clinical director, a global projects manager, senior clinical associate, program associate M&E, and project coordinator. We rely on short-term technical assistance from other EngenderHealth staff.

Field: Although the Fistula Care project was formally extended to December 31, 2013, the project's resources were exhausted by the end of October 2013. This resulted in terminations of staff in both Nigeria and Uganda where the organization kept a skeleton staff to support its activities. The project is now almost fully staffed and operational. Table 3 is a summary of filled and open positions at the field level.

Table 3: Filled and Open Staff Positions

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
WA/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)	MER Advisor (Abuja – to start January 1) Clinical Associate (Sokoto – to start Jan 1) RH&FP Advisor (Abuja) Finance Assistant (Abuja)

Country	Filled Positions	Open Positions
	Administrative and Logistics Officer (Sokoto) Program Assistant (Sokoto)	
Uganda	M&E Program Associate Community Engagement Program Associate Accountants (2) Assistant Driver	Senior Clinical Associate FY14/15

2. Please provide a brief update of international collaboration activities and upcoming plans

WHO: FC+ collaborated with the World Health Organization HRP in completing the analysis of data from the randomized controlled trial (RCT) on duration of catheterization after fistula surgery. A manuscript was prepared jointly and submitted to the Lancet. We responded to two rounds of questions and are awaiting a final decision on publication. As noted in the project results section, FC+ and the WHO have also begun a secondary analysis of data from the RCT and the earlier observational prospective cohort study on determinants of repair outcomes. The analysis aims to generate a fistula classification system based on cluster analysis and prognostic value.

FIGO: In June 2014, project staff presented findings from the RCT to master trainers and managers of training centers for fistula surgery organized by FIGO. During that meeting it was agreed that next steps included further dissemination of findings at multiple forums and national health system levels (through national fistula technical working groups), updating training guidelines, and supporting health facilities with clinical algorithms, job aids, and training materials. The formal publication of the manuscript will facilitate a wider dissemination and WHO and project staff are actively following up with the journal editors. We are further pursuing ideas for the FIGO meeting to be held in Vancouver in October 2015.

UNFPA: Project staff collaborated with UNFPA to organize the recent meeting of the International Obstetric Fistula Working Group held in Kampala, Uganda. Approximately 200 individuals were present from Africa, Asia, Europe and the Americas. The meeting was held in conjunction with the International Society of Obstetric Fistula Surgeons. A total of six presentations were made at these two meetings by project staff and partners. In addition, the project sponsored a half-day workshop on research methodology led by Dr. Ambreen Sleemi. Approximately 200 people attended the workshop on the final day of the ISOFS meeting.

Project staff has also collaborated with UNFPA to begin the process of reviving and publishing the compendium of indicators for obstetric fistula prevention, treatment and reintegration.

In September, prompted by a request in the report of the United Nations Secretary General, the United Nations General Assembly passed a resolution that obstetric fistula should become a notifiable condition. This was announced at the IOFWG and ISOFS meetings in Kampala in October 2014. Some members, including the former President of ISOFS, expressed dissent at this idea. The project director has contacted UNFPA and we have been invited to discuss this further to determine what this actually means. There is definitely merit in some kind of register of women deemed incurable to (a) determine if the condition is truly incurable or whether another surgeon might be able to provide a repair; and (b) to ensure that for women whose condition is deemed incurable, resources for their support can be made available. The merits and feasibility of a broader registration of women with fistula are definitely issues

that require further in-depth discussion with stakeholders. Hopefully, the proposed FC+ template to gather information on HMIS surveillance and reporting protocols could provide some support if a “notifiable condition initiative” were to be undertaken.

3. *Are there any management issues or constraints that should be discussed and resolved to improve program effectiveness in coming years? (ie, NY, country, Mission, USAID/W, International organizations)*

As briefly discussed above, 2015 will bring a transition to new project leadership. EngenderHealth will submit the selected applicant to USAID for review and approval, as required for key personnel in the cooperative agreement. We anticipate that the new project director will be in place by end February 2015. Dr. Yetnay et Asfaw, Vice President for Strategy and Impact, will communicate with USAID/Washington and the USAID Missions in this regard.

The project is appreciative that in 2014-2015 core funding has been made available in the total amount of \$1,015,000, an increase of approximately \$200,000. While there are fewer countries (5) than under the previous project, the requirements for management and programming remain the same. As a consequence, field support is being used to support some global initiatives. For example, in order to carry out work with the Population Council considering financial and other constraints to fistula prevention and treatment, the subaward will be funded solely with field support from Nigeria and Uganda, and this will continue to be the case going forward for this initiative. In the case of Bangladesh, the Mission declined to participate in this study because of its priority for addressing the backlog of cases. Core resources are being spent on improving our ability to capture, record and report data, collaborations with groups like the DHS, UNFPA, CDC, FIGO, improving medical monitoring systems, etc.

Another issue, not restricted to this project, is the delay in receipt of funding for the fiscal year. USAID/W has been extremely proactive on assisting project staff to manage this situation, but delays in obligations from the Contracts Office continue and hamper our ability to implement the project’s workplan in a timely fashion.

Progress Towards Results and New Activities

1. *Please provide a brief status update of activities from the last year's workplan, and plans for activities that are still outstanding*

Planned activities that were not completed in year one due to recruitment, project start up, or delays in funding and subaward approval will be completed by quarter 2 of year two. An aggressive implementation schedule is in place for DRC and Niger and is under development for Bangladesh, Nigeria, and Uganda. Broad descriptions of the outstanding activities are below and major completed activities for year one are briefly described in Table 4. Please refer to the annual report country section for more details on country-level activities.

Bangladesh

Outstanding activities include community awareness and advocacy to reduce stigma. At the facility level, EmOC training and advancing use of the FIGO competency-based curriculum will help to strengthen services at supported sites. Under objective 3, the planned work with the Population Council to address barriers has been removed but is on-going as planned in Nigeria and Uganda.

DRC

Year one workplan activities will be completed by the end of year two quarter 2. MCH funds were not received until late May, 2014 resulting in delays in subawards. In addition, because of a misunderstanding with the Mission about the use of POP and MCH funds for fistula services, the proportion of MCH funding was lower than anticipated. Subawards for implementation at five partner sites to strengthen prevention and treatment service, integrate FP, and follow up support to quality improvement (QI) activities will be in place by the end of quarter 2. Additionally FC+ DRC will hold an annual meeting for the Community of Practice.

Niger

To strengthen the enabling environment, the FC+ Niger will work to advance the Levels of Care Framework. This work will be included in the continued effort to advance the national strategy. Expanded LoC Level One facilities will strengthen referral and a data for decision making will be conducted.

Nigeria

Efforts to adopt recommendations from a consultative meeting on catheterization and the LoC framework are on-going but not yet finalized. Planning for strengthening family planning services, training for nurses and doctors in repair, counseling, and quality improvement are underway. A pooled effort campaign at Gombe State was postponed due to insecurity and dates have not yet been confirmed for a reschedule.

Uganda

In the first two quarters of 2014/2015, the Uganda program will begin full implementation of subawards and printing and disseminating Ministry of Health fistula guidelines and data collection tools, supporting the Ministry of Health to gather, analyze and utilize fistula data for decision making, mentoring and coaching of health care workers on partograph use and EmOC, advocacy meetings with Ugandan parliamentarians, district level politicians and religious leaders.

Table 4: Major Completed Activities in Year One

	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
Bangladesh	Advancing the national strategy			Site assessments, repairs, surgical training, FP training, counseling training	Reporting on indicators in PMP
DRC	Task force meetings to advance national action plan	Media campaign to disseminate information on prevention and treatment		Site assessments	Reporting on indicators in PMP
Niger	Advancing the national strategy; coordination with AgirPF	Community engagement strategy; community selection		Site assessments; repairs; ToT for EmOC and FS; coordination with AgirPF for FP	Reporting on indicators in PMP
Nigeria	Coordination for the National Fistula Center in Bauchi State	Commenced consultation with community partners; conducted outreach and media events	Working with the Population Council to address barriers	Site assessments; repairs; provider network meeting	Reporting on indicators in PMP
Uganda	National Technical Working Group; planning IFOWG and ISOFS	Developed community engagement strategy; trained VHTs and conducted site walk through	Working with the Population Council to address barriers	Site assessments; repairs; training to increase site capacity	Reporting on indicators in PMP

2. *What is the status of the plans for new research?*

International Research Advisory Group (IRAG): On July 8-9, FC+ convened the first meeting of 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. There was broad agreement on important issues and illustrative research questions within each category.

Consultation on the quantification of the burden of fistula: On July 10-11, FC+ convened this consultation to build a consensus on FC+ priorities related to the measurement and estimation of the prevalence and incidence of obstetric fistula. The discussions and materials presented were used to develop FC+ talking points about measurement of the global fistula burden (See Appendix I of the annual report). These talking points have been circulated to FC+ staff and are shared with partners as needed.

Research agenda: Key recommendations and research priorities from these meetings were discussed with USAID; based on these discussions FC+ has developed a research agenda and incorporated selected research activities into its Y2 core workplan.

Research on barriers to fistula treatment: The Population Council completed a literature review on barriers to fistula treatment. After screening 3,972 articles, the review included 110 articles in analysis, resulting in nine categories of barriers to fistula treatment. FC+ and Population Council have discussed the findings to identify gaps in information that can be targeted through formative research in FY 14/15 Q2, and to guide the development of a research strategy to respond to these barriers in Nigeria and Uganda. FC+ and the Population Council will develop a concept paper, summarizing the findings of the desk review and formative research and presenting options for a research agenda over the next three years of FC+. Following a review of the concept paper with USAID, FC+ and the Population Council will write a protocol for a three-year operations research (OR) strategy and meet with partners in planned study countries (e.g., USAID missions and MOHs) to lay the foundation for OR activities.

Development and validation of an interview-based diagnostic tool: FC+ has begun compiling an inventory of materials used in surveys to measure fistula prevalence, including the DHS fistula module, interview guides, survey questionnaires, and sampling/outreach/ enrollment/recruitment tools. Analysis of these tools will guide the design of a validation study. FC+ will conduct a content analysis of materials, summarize inventory findings and use these to guide the development of a research protocol for a multi-arm validation study to identify an optimal interview-based diagnostic tool for fistula. FC+ will explore the possibility of partnering with Johns Hopkins University to conduct this validation study (or one arm of the study), building on Dr. Grace Chen's work validating a new fistula and prolapse questionnaire in South Asia.

Improved global and country-specific data on fistula: FC+ has made a special request for secondary analysis of data from countries that have used the Demographic and Health Survey (DHS) fistula module. This request will be reviewed by USAID; if accepted, FC+ will provide any support needed to the analysis. More than a dozen surveys using the module have been implemented since the previous comparative analysis in 2008.

HMIS Surveillance: FC+ has begun to develop a template for use in countries where fistula indicators have been added to national Health Management Information Systems (HMIS) and/or a fistula surveillance/reporting protocol has been established. This documentation will gather information on the implementation of HMIS/surveillance and the report and use of fistula data on an ongoing basis.

Secondary analysis of Fistula Care studies: FC+ and the WHO have begun a secondary analysis of data from the FC randomized-controlled trial (RCT) on shorter duration catheterization and observational prospective cohort study on determinants of repair outcomes. The analysis aims to generate a fistula classification system based on cluster analysis and prognostic value.

Improved global and country-specific data on fistula: FC+ will draft a fistula research toolkit document, summarizing known advantages and disadvantages of existing approaches to measurement and estimation of fistula prevalence and evidence.

Country-specific research: In Nigeria, the USAID Mission and FC+ staff have identified a need for improved information on current channels of information about, and patterns of access to, maternal health and fistula services, in order to design a more effective communication strategy. Nigeria staff, in consultation with FC+ global staff and the Senior Technical Advisor for community engagement, have developed a research concept paper for a rapid assessment to gather this information. FC+ will submit a research protocol for the Nigeria communications assessment to IRBs in Nigeria and the United States, and conduct this assessment to guide the future communications strategy.

FC+ will develop research protocols related to up to three priority research topics identified in consultation with USAID and the FC+ IRAG:

- Catheterization for prevention of fistula following obstructed labor.
- Testing outreach models to evaluate their reach for different types of women, case finding effectiveness (including for calculation of prevalence), and effectiveness at getting women into care.
- Evaluation of barriers to and enablers of provision of quality fistula services after training.

3. *What are the plans for documenting program models?*

FC+ has several resources to draw on to document program models. The FC+ conceptual model for research, the ExpandNet approach for scale up (<http://www.expandnet.net/tools.htm>), and EH/FC+ materials developed for integration all have specific steps for documentation. The multistep ExpandNet provides several products for assessing effectiveness and acceptability of pilot design during the implementation phase and the accompanying checklist is a thorough assessment with documentation prior to scale up. The Scaling Up Strategy contains recommendations about strategic choices related to type of scale up, organizational processes, costs and resource mobilization, and monitoring and evaluation. Step three of the five step approach for integration FP into fistula services details what needs to happen to build or strengthen systems to support new or expanded services which can include documenting experiences for continued improvement.

Additionally, the project is working on a Knowledge Management Plan that will support the use of data for programmatic and policy decision-making and seeks to consolidate and disseminate knowledge gained through the project, as well as external findings relevant to the broader fistula community.

4. *What are the plans for developing a gender equality strategy, vision or plan of action for Fistula Care Plus?*

Addressing obstetric fistula is, by its very nature, a strategy to address gender inequality. Obstetric fistula derives from a lack of attention and resources to the basic and emergency needs of girls and women from their earliest days – poor nutrition, inequities in educational opportunities, early marriage, poor maternal health services, including access to emergency obstetric care, poor post-delivery care. In addition, in

conflict areas, in addition to these challenges, women also experience sexual and gender-based violence that can result in traumatic genital fistula. These are the root causes of the gender inequity that leads to fistula. The international field of obstetric fistula has organized its work around addressing a continuum of care: prevention, treatment and reintegration and FC+ is engaged in all these activities.

Under the previous project, the majority of effort was spent establishing or strengthening existing treatment services, and increasing awareness at the policy, community and individual levels of the causes of fistula and addressing myths and misunderstandings. Gender was integrated into specific activities. For example, *Counseling the Obstetric Fistula Client: A Training Curriculum* and its accompanying *Counseling the Traumatic Fistula Client: A supplement to the Obstetric Fistula Counseling Curriculum* were both developed through a gender lens.

Under the FC+ project, two countries (Niger and Nigeria) have included plans to address early marriage in their workplans. In Nigeria, at the request of the USAID Mission, and with assistance from a consultant on gender, the project developed an algorithm for addressing the psychosocial and health needs of the girls abducted from Chibok and have also developed a tracking tool to document the support provided to women who experience sexual and/or gender-based violence (SGBV).

The FC+ strategy for the immediate future consists of the following five elements:

- To educate EngenderHealth staff and partners on gender equality and how to integrate it into programming for obstetric fistula. This will begin with workplanning workshops in 2015 at which a gender specialist will conduct a training and explore how gender can be effectively integrated into proposed workplans. EngenderHealth has new staff at the field level in Nigeria, Uganda, Niger and the D.R. Congo for whom this would be beneficial. (A gender 101 training has already taken place in Bangladesh.)
- FC+ partner Terrewode, is a Ugandan NGO working to support community engagement on gender issues and the reintegration of women with fistula. They have received a subaward to enhance community understanding and practices to prevent fistula, improve access to treatment, reduce stigma and support reintegration of women and girls with fistula, including those whose fistula is deemed incurable and those whose fistula is the result of sexual violence. Ultimately, our goal is that this Ugandan NGO will provide south-to-south support for these issues.
- Continued support to the Nigeria and D.R. Congo programs for work addressing the needs of women who have experienced SGBV.
- Support for the Niger and Nigeria programs in collaboration on addressing the issues of early marriage.
- A focus on moving from straightforward community engagement activities to gender transformative activities as described in Figure 3 below.

Figure 1: Framework for Design, Monitoring, and Evaluation of Community Engagement Approaches

	COMMUNITY ENGAGEMENT PROCESS & ACTIVITIES	OUTPUTS	OUTCOMES	IMPACT
	Are we engaging communities in addressing SRH issues of concern?	Are we enhancing community capacities and building community assets?	Are we influencing intentions and behaviors related to SRH among the population in general?	Are there measurable improvements in SRH outcomes?
COMMUNITY ENGAGEMENT	<ul style="list-style-type: none"> Communities (including representatives of most affected and/or marginalized groups) are involved in the process of: <ul style="list-style-type: none"> Defining priorities Identifying solutions Developing and implementing action plans Monitoring and evaluating results The problem exploration and action planning process is sustained over time. 	<ul style="list-style-type: none"> Capacities are developed—i.e., there are measurable changes in knowledge and skills among community partners: <ul style="list-style-type: none"> Knowledge about the issue Analytic and problem-solving skills Leadership skills Decision-making and planning skills Communication and conflict negotiation skills Resource identification and mobilization skills Social capital is developed—i.e., community networks and support systems are created or strengthened to improve health outcomes. 	<ul style="list-style-type: none"> Changes in knowledge of, awareness about, and attitudes toward SRH intentions and behaviors. Changes in care-seeking (preventive and curative services). Changes in access to or use of existing or new community resources. 	Changes in the incidence of SRH problems—among the general population, as well as among marginalized, vulnerable, and affected groups.
GENDER-TRANSFORMATIVE COMMUNITY ENGAGEMENT	<ul style="list-style-type: none"> Gender analysis informs the identification of key community partners and stakeholders. The community engagement approach and process takes gender into account in order to support and ensure participation of affected and/or marginalized groups. A problem exploration process guides community participants in exploring imbalances in power and the influence of gender norms. Community-defined vision/priorities reflect commitment to change identified gender norms and power imbalances that contribute to poor health. In developing, implementing, and evaluating community action plans, community partners take on roles that diverge from traditional gender norms. 	<ul style="list-style-type: none"> Social capital created among community partners (i.e. increased awareness, knowledge, skills, and capacities) falls outside traditional gender domains and norms. Marginalized or disadvantaged groups increase their participation and take on increased decision-making and leadership roles. Community support systems and services are developed or modified to better meet, serve, or benefit disadvantaged groups and enhance their access and participation. 	<ul style="list-style-type: none"> Changes in gender roles and norms and perceptions of rights related to women's and men's health and health behaviors. Reduced vulnerabilities (e.g., lack of decision-making power over health, lack of participation/ expression, discrimination, etc.) among marginalized and affected groups—both women and men. Increased access to new or existing community resources among marginalized and vulnerable groups. 	

5. What are the plans for establishing a “community of practice” to include bilateral programs?

FC+ is charged with gathering data from all projects supported by USAID, not just from FC+ supported countries/sites. The implementation of an obstetric fistula community of practice was specifically intended to engage those countries and projects supported by USAID to have an opportunity to share learnings and participate in joint activities. FC+ awaits instruction from USAID/Washington on how it should engage with the various bilateral projects following its communication with the USAID Missions. Project staff are providing inputs on indicators that might be gathered.

OF Community of Practice²²

The purpose of the OF CoP is to bring together a diverse group of professionals supported by USAID to address obstetric fistula and engage in a creative process to address important issues related to the preventive care, detection, treatment, and reintegration support for women, families, and communities impacted by obstetric fistula. Further, this CoP provides an important opportunity to strengthen learning, commitment, resources, and programming within the international community and local partners while potentially reaching out to women and communities. The intent is to advance global learning and collaboration related to OF service delivery among public health professionals, in an effort to strengthen commitment, support, and programming for these methods among key audiences - specifically, organizations and USAID-funded projects involved in OF service delivery (including research and training).

The OF CoP will contribute to advancing global learning and collaboration by:

<p>Quickly convening public health practitioners around the world to share experiences at low cost</p>	<ul style="list-style-type: none"> ● The OF CoP will serve as the regular venue for the exchange of learning and experience around the preventive care, detection, treatment, and reintegration support for women, families, and communities impacted by obstetric fistula. ● Initial outreach will request membership through relevant social media outlets (Facebook, Twitter, LinkedIn), listservs, and e-newsletters and via direct email invitation; see list of potential participants. This will be followed by a survey monkey questionnaire to determine the needs, gaps, and direction members want from the OF CoP.
<p>Facilitate the development and dissemination of evidence-based health information products</p>	<ul style="list-style-type: none"> ● The OF CoP will serve as the catalyst for advancing the knowledge base about best practices related to prevention and service delivery of OF by providing a space for technical experts and practitioners to develop, inform, and contribute to the ongoing knowledge base of OF materials and resources.
<p>Serves as a venue for disseminating the latest research and guidance</p>	<ul style="list-style-type: none"> ● The OF CoP will host a virtual forum on programming and service delivery related to the prevention and treatment of OF. Through an online forum, we will refer to newly published materials, research findings, and coordinate reporting indicators. ● Potential topics: in-depth look at country specific approaches; case studies; input from providers; how to develop champions; gain more robust data on women's needs. ● In FY 2015, FC+ will host a technical forum for members of the OF CoP to advocate for national strategies related to OF preventive care and treatment, and to demonstrate the potential impact preventive care on the sustainable development goals.

The OF CoP will achieve its goal through online forums, technical consultations, and on-going communications through the FC+ website.

²² Communities of practice are formed by people who engage in a process of collective learning and knowledge sharing in a shared domain of endeavor. **CoPs provide an opportunity for public health practitioners to develop a shared repertoire of resources over a sustained period of time.** This can include sharing: experiences, stories, tools, and problem solving in an effort to address the 'knowledge to practice' gap.

6. *What are the plans for addressing prolapse?*

With inputs from country program and community engagement colleagues, we have updated site needs assessment tools to include a Genital Prolapse supplement. The updated tool has been field tested and now used in actual assessments. The site needs assessments revealed that some sites have considerable backlog of genital prolapse cases. It will be important to balance care for these women without marginalizing women living with fistula.

We have also developed equipment lists for surgical and conservative management of genital prolapse, as well as a prolapse terminology guide. With inputs from M/E team, we have updated and defined indicators and reporting from quarterly summaries, clinical monitoring visits and training activities in genital prolapse management. We are developing a programming strategy for management of genital prolapse that will be in place by June 2015, to be piloted at select supported sites in select country programs, such as Nigeria and Bangladesh, depending on continued mission interest. We will engage with a group of key stakeholders to review the draft programming strategy before June 2015.

7. *What are the plans for addressing the needs of women with “incurable” fistula?*

As described above, FC+ partner Terrewode will work with project staff to develop a model for care of Women Deemed Incurable that can be used not only in Uganda but in south to south learning. We plan to work with ISOFS or other professional body to move recommendations on management of Women Deemed Incurable to program and clinical guidelines. During the ISOFS meeting, representatives from Nigeria posed the possibility of organizing a ‘tribunal’ of three very senior surgeons with the idea that the tribunal could arrange visits for outreach camps for Women Deemed Incurable, to make final determination on ‘incurability’ and/or last attempt at surgery. FC project staff will consider this, in collaboration with other stakeholders, in relation to the United Nations’ call for fistula to become a “notifiable condition.”

8. *What is the status of the development of a Public-Private Partnership for fistula?*

Project staff have been exploring opportunities for collaboration with Johnson & Johnson (J&J). Mr. Denis Robson, Director for African Affairs of J&J Medical (now retired), has met with the project team and facilitated connections to several institutions and individuals with potential for collaboration, including Becton Dickinson (BD). 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 consider an appropriate strategy for such partnerships at the global and/or country levels.

The country teams have established country-specific PPPs that include donations of air time for discussions related to fistula services in DRC, Nigeria, and Uganda and in Bangladesh, the project team has secured donations of drugs needed for repair surgeries from Nuvista Pharmaceuticals. Direct Relief is a FC+ partner and we are coordinating donations of supplies from U.S. and other pharmaceutical and medical supplies institutions for Bangladesh, DRC, Nigeria, and Uganda.

9. *Please provide a projection of fistula repairs for the next year and contrast this with the annual repairs under Fistula Care.*

Please see Annex 2 for a table and chart summarizing this issue. Note also that FY13/14 was actually a nine month time period (as opposed to 12 months for FYs in the previous Fistula Care (FC) Project. Because FY 13/14 was a start-up year, supported sites were not all providing repairs – some were preparing to start delivering repairs. See also Appendix D in the Annual Report – Number of USAID-supported fistula repair surgeries by country, site and year.

10. *Please highlight the progress, plans and issues in Bangladesh, the DRC, Niger, Nigeria and Uganda.*

Bangladesh

The USAID Mission has provided additional funding to the Bangladesh project in order to achieve 1,000 repairs with a focus on addressing the backlog established through a situational assessment conducted in 2003. At that time it was estimated that there were probably approximately 70,000 cases in Bangladesh. At the recent ISOFS meeting, it was announced that since that time, Bangladesh had managed to repair approximately 4,000 cases. FC was operating in three small NGO facilities, while UNFPA was supporting ten medical colleges. In the public sector, the majority of cases were being done at the Dhaka Medical College. As a consequence, there is significant effort required to strengthen existing and new supported sites in an environment of competing demands and limited resources. To assist in identification of cases and support prompt screening and referral, the FC+ team will collaborate with BRAC which has an extensive and well-trained outreach network.

DRC

Following sites assessments, in year two Q1, all five supported institutions will begin implementation of project activities and the team is ready to ramp up activities. In coordination with the USAID Mission and UNFPA, project staff will conduct site assessments at two new sites for potential support. The DRC Community of Practice will focus on developing an updated national action plan for the prevention and treatment of obstetric fistula.

West Africa/Niger

Three partner sites are performing OF repair and planned training will strengthen prevention and treatment efforts. Community-level interventions in Maradi will focus on building the capacity of community level cadres to promote maternal health care-seeking and use of family planning to prevent fistula. Project will continue to collaborate with other regional initiatives including the EH-led AgirPF project in Togo. In addition, the project has promoted collaboration between staff in Niger and Nigeria on addressing early marriage.

Nigeria

With recruitment nearly complete, the project is implementing planned activities. Coordination with the Federal and State Ministries of Health, as well as with UNFPA, continues to be an area of focus to ensure that project support contributes to sustainable implementation. The project has developed criteria for levels of support to sites, depending on their experience and expertise with a gradual move towards support from State and Federal level. While funds have been set aside at the Federal level, they have yet to be released which is having a negative impact on our ability to proceed with repairs. Focused efforts on research will begin in year two in collaboration with the Population Council to review financial and other constraints. In addition, research will be conducted to inform a communications strategy. Provider network meetings will continue and site assessments for sites are on-going. At the request of USAID Nigeria, the Project participated in efforts to address the needs of victims of SGBV in Nigeria.

Uganda

The project will work at two partner sites for repair and with TERREWODE for women deemed incurable. Site assessments were conducted at seven hospitals to determine capacity to provide fistula prevention and treatment services. Following an assessment of community engagement, village health workers and religious leaders were trained on maternal health issues and a site walk through event was conducted at one of the supported sites in western Uganda. The project staff will facilitate the dissemination of MOH fistula data collection tools and guidelines that were adapted from EngenderHealth materials.

Security

Security concerns remain for northern Nigeria, Niger, central and eastern Congo, and northern Uganda. Political and social unrest in Mali and Burkina Faso with continued Ebola cases in Guinea, Sierra Leone, and Liberia could impact travel and activities especially in the region of West Africa. While there are no specific travel restrictions currently affecting implementing sites, we continue to experience some delays that could affect implementation.

11. Please provide an update on the status of dissemination/information products

Since the launch of FC+, we have shared information on FC/FC+ project achievements, program models, study findings, and technical recommendations at a wide range of internal and external forums. Key dissemination opportunities include seven external meetings held by partners such as FIGO and ICM, and three FC+-convened meetings. Information products range from a brief analyzing media reporting on barriers to fistula treatment to seven peer-reviewed journal articles on research and evaluation findings. We have also used the FC+ and EngenderHealth websites and the Maternal Health Task Force blog and Buzz features as forums for sharing information about issues of importance to FC+. Annex 3 summarizes the status of information dissemination and products.

APPENDIX C: FC+ USAID MANAGEMENT REVIEW RESPONSES SEPTEMBER 2015

Progress towards results

1. What progress has the project made toward achieving its goal and objectives?

Please see **Table 1** for the updated FC+ benchmarks table, with results as of FY2 Q2. **Table 2** and **Figure 1** provide a summary of project-supported repairs.

Table 1: Benchmarks Table (through FY2 Q2)

Indicator	FY13/14		FY14/15	
	Benchmark	Achieved	Benchmark	Achieved through Q2
1: Number of countries supported by Fistula Care Plus (FC+)	5	5	5	6
2: Number of sites supported by FC+ for fistula repair and prevention	26	25	29	29
3: Number of prevention-only sites supported by FC+	43	16 ²³	37	35
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	5	NA	5	NA ²⁴
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	0	0	1	0 ²⁵
6: Number of countries receiving support from FC+ in which governments have budget line item for fistula care	2	2	2	NA ²⁶
7: Number of countries with fistula indicators included in the health management information system (HMIS)	4	3 ²⁷	4	NA ²⁸
8: Number of public/private partnerships established to address fistula prevention,	1	3	2	NA ²⁹

²³ Delays in funds release and subaward agreements negatively affected prevention-only site support in FY 13/14

²⁴ Indicator calculated annually, data will be available in FY 14/15 annual report

²⁵ Progress towards new guidance on WDI has been made in two countries (Nigeria and Uganda) but these have not yet been officially codified into national policy. This is expected in FY 15/16.

²⁶ Indicator calculated annually, data will be available in FY 14/15 annual report

²⁷ Along with Niger, Nigeria, and Uganda, indicators have also been approved in a 4th country (Bangladesh), but data collection has not yet begun.

²⁸ Indicator calculated annually, data will be available in FY 14/15 annual report

²⁹ Indicator calculated annually, data will be available in FY 14/15 annual report

Indicator	FY13/14		FY14/15	
	Benchmark	Achieved	Benchmark	Achieved through Q2
repair, or reintegration by country				
9: Number of community volunteers/educators trained in tools and approaches to raise awareness regarding fistulae prevention and repair	227	0 ³⁰	499	65
10: Number of community awareness-raising activities/events conducted by program partners	570	12 ³¹	586	624
11: Number of participants reached through community awareness-raising events/activities conducted by program partners	155,150	10,745	232,100	28,857
12: Number and type of transportation initiatives introduced, enhanced, and/or tested	0	0	2	0
13: Number and type of communication technologies introduced, enhanced, and/or tested for improving communication with patients and/or providers	0	0	1	0
14: Number of women requiring fistula repair surgery	2,131	908	4,000	1,545
15: Number of fistula repair surgeries	1,300	725 ³²	3,830	1,295
16: Outcomes of fistula repair (percentage closed and dry)³³	75%	76%	75%	70%
17: Complications of fistula repair (percent of repairs with complications)	<20%	<1%	<20%	4%
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)	526	354 ³⁴	925	472
19: Number of supported facilities that have introduced treatment for POP	0	0	1	³⁵ 8
20: Number of POP treatment services provided	0	0	30	398
21: Couple-years of protection in sites supported by FC+	28,430	40,039	81,500 ³⁶	28,085
22: Number of FP counseling sessions provided to clients	53,698	38,373	117,800	32,639
23: Completion of partographs and	NA	NA	50% of sites	NA ³⁷

³⁰ Delays in funds release and subaward approvals negatively affected ability to implement community outreach and education in FY13/14.

³¹ Delays in funds release and subaward approvals negatively affected ability to implement community outreach and education in FY13/14.

³² Delays in funds release and subaward approvals negatively affected ability to support fistula repairs during FY13/14.

³³ Going forward, we will be reporting on fistula cases that are closed as a more appropriate indicator of the success and quality of fistula repair. More detail will be provided in the annual report on the rationale for this change.

³⁴ Delays in funds release and subaward approvals negatively affected ability to implement training in FY13/14.

³⁵ These are sites currently providing prolapse services, not as a result of FC+ support.

³⁶ This target was revised upward at the request of the Nigeria mission, due to planned absorption of TSHIP sites.

Indicator	FY13/14		FY14/15	
	Benchmark	Achieved	Benchmark	Achieved through Q2
management of labor according to protocol at sites receiving support for strengthening partograph use			receiving a mean score of ≥ 4 on reviewed partographs; 60% of reviewed partographs responding appropriately action if action line reached	
24: Number of evaluation or research studies completed	0	0	1	0
25: % of supported sites reviewing fistula monitoring data bi-annually to improve fistula services	40%	NA	45%	NA ³⁸

Table 2: Annual Repairs by Country under FC and FC+³⁹

Bangladesh	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs	184	267	108	148
# supported sites (repair)	4	4	5	8
average # repairs/site	46	67	22	38

DRC	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs	1221	1356	0	153
# supported sites (repair)	6	7	3	3
average # repairs/site	204	194	0	102

Niger	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs	209	373	127	84
# supported sites (repair)	4	6	3	3
average # repairs/site	52	62	42	56

Nigeria	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs				
# supported sites (repair)				
average # repairs/site				

³⁷ Indicator calculated annually, data will be available in FY 14/15 annual report

³⁸ Indicator calculated annually, data will be available in FY 14/15 annual report

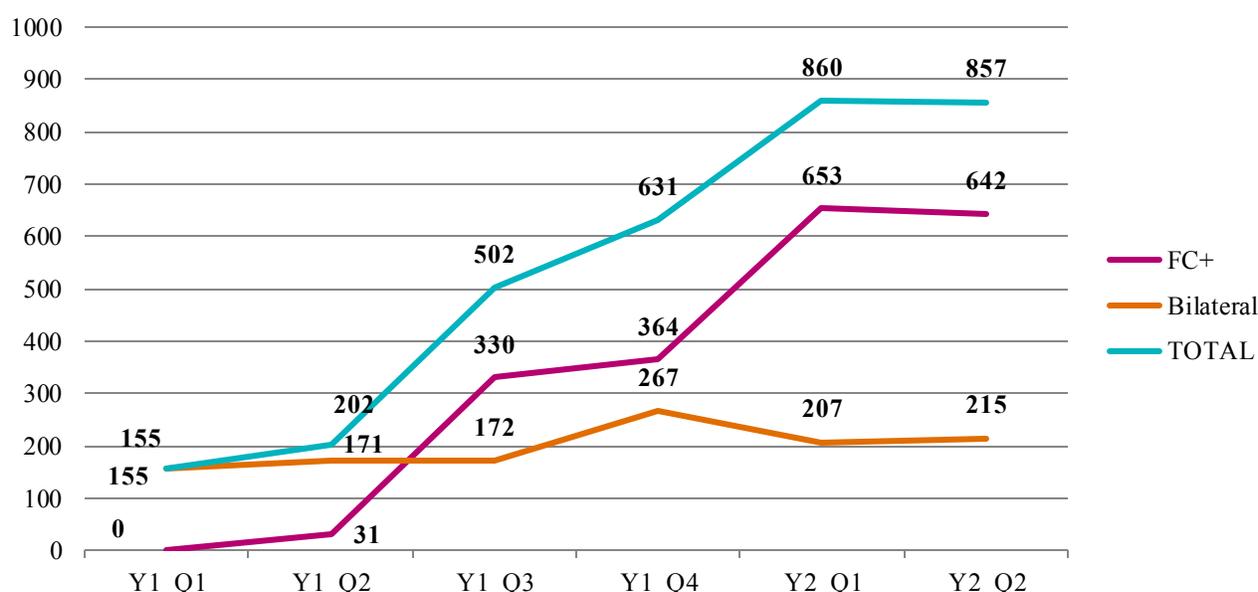
³⁹ FY 13/14 was a 9-month period and not all supported sites were providing repairs due to start-up phase. FY 14/15 average repairs/site are projected based on results from Q1-Q2.

# repairs	1720	1580	554	775
# supported sites (repair)	9	10	11	11
average # repairs/site	191	158	50	142

Uganda	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs	517	522	63	135
# supported sites (repair)	3	3	3	3
average # repairs/site	172	174	21	90

Global	FY 11/12 (FC)	FY 12/13 (FC)	FY 13/14 (FC+)	FY 14/15 (through Q2) (FC+)
# repairs (globally)	4759	4911	725	1295
# of countries	9	9	5	5
# supported sites (repair)	35	40	25	58

Figure 1: USAID-Supported Fistula Repairs, by Quarter, To Date (n=3,207)



2. Are there any actual/anticipated problems in meeting country and global expectations?

Late approval of sub-agreements resulted in delayed implementations of FY 1 and FY2 workplans. Consequently, unliquidated sub-partner obligated balances that were yet to be expended stood at about \$1.2M, as of June 30th, 2015. A large portion of these unliquidated balances are expected to be carried forward to FY3 and no-cost extensions will have to be executed for almost all the sub-agreements.

Additionally, we experienced significant delays in obligating funding to the FC+ program:

- In FY1, about 50% of the year-1 funding of \$7.36M was obligated only 4 months to the end of the fiscal year (obligation date of 5/31/2014).

- FY2, 68% of the total year-2 funding of \$\$9.065M was obligated 2 months into the year; 20% of the funding was obligated 5 months into the year; and 12% on 8 months into the fiscal year (Uganda).

At the country level, extremely long delays in securing IRB approval for planned studies have significantly delayed research activities in Nigeria and Uganda and delayed follow-up actions contingent on research findings. The affected studies include a communications assessment in Nigeria and formative research on barriers to fistula treatment in Uganda. The project has adjusted its strategy in Nigeria, now planning to proceed with a study with state administrative approval only. However, these delays significantly affected the project's ability to begin community outreach and training activities in Nigeria in FY2. Following an IRB meeting in Kampala in August 2015, provisional IRB approval was received in early September in Uganda, and FC+ will work with the Population Council on an accelerated formative-to-implementation research schedule to enable us to catch up in FY3 and the remainder of the project. A rapidly changing external environment has changed FC+ plans in relation to conducting a study to validate questions for interview/survey-based diagnosis of fistula. Please see the research agenda section below.

Additional country-specific challenges include:

Bangladesh

- Repair targets were doubled by the Mission; however, the supported sites are not on track to achieve this target. Diagnostic camps have been initiated to identify more cases, but have only found 24 cases out of several hundred screened as of August 2015.

DRC

- Insecurity in North Kivu has hindered supported sites activities.
- Pending elections may contribute to insecurity and/or delays in activities.

Nigeria

- CYP target increased from original 10,000 to 29,000 by the Mission in May of FY2; this will not be achieved by the end of FY2 given the ongoing integration of TSHIP sites.
- The roll-out of the newly harmonized tools to supported sites is currently under discussion at the fistula desk office of the FMOH. We hope it will be approved before the end of this project year. But there is still concern the process may take longer than we anticipate due to bureaucratic bottle necks.

Project Implementation

1. What progress has been made toward implementing the research agenda?

The FC+ research agenda was finalized in early FY2, following meetings and discussion in Q3-4 of FY1. Significant progress has been made towards implementing the priority research activities identified in this agenda and the FY2 workplan, including:

- Completion of the secondary analysis of all DHS surveys that have used the fistula module. The resulting report was published at the DHS and FC+ websites:
<http://dhsprogram.com/publications/publication-OD67-Other-Documents.cfm>. FC+ and DHS staff are co-writing a manuscript based on this analysis, in the context of several recent papers attempting to estimate the global fistula burden (Cowgill 2015, Maheu-Giroux 2015).
- Completion of an inventory of survey- and interview-based tools used to identify fistula cases in published studies. This has resulted in the collection of 10 tools, ranging from simple checklists to comprehensive assessments of incontinence. A content analysis and comparison of questions is underway.
- Completion of the Population Council literature review of barriers to accessing fistula treatment. This review was published at the Population Council and FC+ websites (http://www.popcouncil.org/uploads/pdfs/2014RH_ObstetricFistulaTreatmentSystematicReview.pdf) and has guided the design of subsequent formative research in Nigeria and Uganda. A manuscript based on this review is being drafted and will be shared with USAID shortly.
- Completion of the Population Council formative research in Nigeria, including focus groups and interviews in Kano and Ebonyi states. Analysis of these data is underway and will be shared with FC+ and USAID shortly.
- Completion of a concept and tools for documentation of the process of adoption and implementation of the HMIS fistula indicators developed under the Fistula Care Project (FCP). This process documentation will be completed in the countries that are currently part of FC+ in FY3.
- Convening of a consultation to consider whether and how FC+ can conduct or support research on the role of urinary catheterization after obstructed labor in preventing obstetric fistula. Research activities have been identified and discussed with USAID based on this discussion, and are included in the FY3 workplan.

FC+ is also collaborating with USAID-Bangladesh on the inclusion of maternal morbidity (particularly fistula and prolapse) questions in the upcoming Bangladesh Maternal and Mortality Survey (BMMS). A clinical validation study to estimate the sensitivity and specificity of fistula identification survey questions will be paired with the BMMS, advancing one of the highest priorities in the FC+ research agenda.

In Nigeria, planned research on current knowledge and communication channels for messages related to fistula prevention and treatment has been on hold due to an extremely delayed national IRB approval process. Following numerous unsuccessful attempts to move this process forward or to receive a timeline for review at the national level, FC+ has moved on to securing state-level administrative approvals and will initiate the study in Q1 of FY3.

FC+ has also continued to prioritize publication and dissemination of research findings. Please see **Annex 1** for an updated list of FC/FC+ publications and their readership where available. Please see the partnerships section below for an update on how FC+ is circulating research and other project findings through meetings and conferences convened by other CAs and international programs.

2. How is/can *Fistula Care Plus* disseminate results of the duration of catheterization trial to stimulate use of this research in country/institutional guidelines and in service delivery implementation?

FC+ started awareness raising about the RCT even before the official results were released: we published the research protocol in a peer-reviewed journal and by made presentations at the Prague confederation of midwives and at the Dar es Salaam FIGO Training Initiative assessment meetings.

The official findings of non-inferiority were eventually published in the *Lancet* this year and we used the event for a media campaign for wide dissemination in clinical and social media by our communications team as well as that of partner organizations. Because we realize that change can take time with clinical colleagues, some of whom are comfortable holding on to eminence-based medicine even when new evidence base is available, we have emphasized advocacy especially through professional associations and technical working groups and individual champions. One clinical team from a historically well-established fistula training institution written to the *Lancet*, with formal critique of the finding; the journal has availed us of the opportunity – which we have used- to make a point by point rebuttal. We are now awaiting the editor’s decision for publication. Meanwhile, we have been disseminating – and will continue to do so - at several venues and different audiences, such as presentations at ISOFS two- yearly congress in Kampala 2014, Nigeria Provider Network meeting June 2015, The WAHO Best Practices Forum in Ougadougou July 2015. Another presentation is planned for the upcoming FIGO triennial congress in October this year. Anecdotally, some of the senior fistula surgeons are already conducting short duration catheterization for simple fistula, in Nigeria, Kenya, Uganda – especially in the sites where the RCT was conducted. We have shared an adaptable draft guideline with select co-investigators for feedback and discussion at a program strategy meeting on September 28th, finalization and posting to our website. Ultimately, the goal is for eventual incorporation in training guidelines and service delivery standards and practices for doctors and nurse/midwives (in supported sites but also more widely), and have already started discussing the multiple steps to that end with National Technical Working groups and MOH, such as the ones in Nigeria. We will continue to advocate for incorporation of the guidelines into FIGO and other international fistula training manuals.

3. What has been the progress in developing a Public-Private Partnership (PPP)?
FC+ will continue to work with USAID to identify PPP opportunities within the project. The FC+ team will establish a game plan for acquiring new skills necessary for successful PPP engagement, including learning how to approach a private corporation towards successful interface with emerging markets within the FC+ project toward growing market share, rather than the traditional “corporate social responsibility” functions that are the traditional hallmark of for-profit corporate engagements in low-income countries. FC+ is learning from resources such as USAID’s analysis of Global Development Alliances PPP (https://www.usaid.gov/sites/default/files/documents/1880/GDA_Evaluation_reformatted_10.29.08.pdf) along with the proceeds of the Institute of Medicine’s 2015 two day workshop on PPP for Global Health and Safety held at the New York Academy of Medicine. FC+ will work with USAID/Washington and with no-cost corporate pharmacology and biomedical industry consultants to develop FC+ team skills for successful engagement of PPPs.
4. What additional/different strategy does the Project need to employ for the countries aiming to eliminate obstetric fistula (both prevent it and address the backlog of cases)? What is the status of current plans?

Global

- Recognizing the importance of addressing backlog in eliminating fistula, the project is accelerating clinical monitoring activities and tools to address backlog at FC+ supported

sites. This is underway with an assessment to better understand current processes related to documentation and care delivery strategies currently in use for backlog in treatment sites. FC+ has undertaken a survey on clinical monitoring methods in supported treatment sites that will illustrate awareness of current backlog volume and current client tracking and backlog documentation procedures; >80% of sites have responded to date. Please see http://www.surveymonkey.com/create/survey/preview?sm=7_2BvuihXVEFBdxmIIQ8_2BE2QuhMmqefeBYSLfBhAEgBtY_3D for the survey content. Based on preliminary analysis of response to date, three-quarters of sites rely on paper lists to track backlog. Only about half of the sites separate lists of women who are waiting 'in situ' (i.e., at waiting homes) and those who have returned to their communities. Of facilities that could estimate their fistula backlog, most reported that between 10 and 50 women are waiting for fistula repair.

Bangladesh

- A tool to track backlog has been developed, adapted from Fistula Foundation tools; it will be rolled out at supported sites with support from FC+ clinical consultants. See **Annex 2**.

Nigeria

- Currently, the National Strategic Framework for Elimination of Fistula will expire in 2015. FMOH, FC+, and other partners will collaborate to renew the framework and ensure it addresses salient issues.
- The Project will collaborate with the FMOH to conduct mapping of fistula services in Nigeria designed for application within Levels of Care Framework that classifies facilities according to the level of fistula services provided (prevention only, prevention and simple routine fistula care, prevention and complex routine fistula care, pooled effort sites) and ensures efficient, timely referral between levels of care.
- Significant emphasis on strategies for prevention of end-stage prolonged/obstructed labor, its early recognition and management in order to prevent obstetric fistula will include development and dissemination of community messaging.

DRC

- This year a task force will be convened to develop an action plan for eliminating fistula and to increase national coordination. Currently almost all of the sites (preventive and curative) are concentrated in the east.

Uganda

The delayed release of funds will cause spillover of some FY2 activities to FY3.

Prevention strategies to promote elimination

- Onsite Mentoring and coaching on consistent and accurate use of the partograph as well as its interpretation
- Collaborations with AOGU (Association of Obstetricians and Gynaecologists) to promote EMOC in facilities

Addressing backlog

- provide additional subawards to treatment centers (Private not for profit)
- Mentoring and coaching of fistula teams in government treatment centers to promote routine fistula repair in addition to camps.

5. What is the progress on addressing prolapse?

(Also see PPP activities from Question 3 in Project Implementation section above.)

FC+ will hold a consultative workshop on integration of prolapse evaluation and management into fistula care services in September 2015 to harmonize and standardize strategy and approaches to training and service delivery, including review of a draft curriculum for training and a skills matrix. In FY3, draft clinical manual and associated teaching/training tools will be finalized for POP integration into fistula service models in FY2. These will be informed by the findings of an ongoing online survey on prolapse service needs (see below) and the proceedings of this consultative workshop.

In addition to the prolapse integration meeting to be held at the end of Y2, FC+ has also surveyed all supported treatment sites to understand current demand and capacity for prolapse services. Questions related to prolapse were included in the online survey linked above (Question 4). Descriptive data analysis of responses regarding prolapse demand and services is underway, to be presented at the prolapse integration meeting. FC+ has also encouraged the team developing the Bangladesh maternal mortality survey (BMMS) to include questions about maternal morbidity, including prolapse, in the survey questionnaire. Please see response to Question 3 below.

In addition to the Integration Workshop and Survey of POP activities and needs, FC+ will participate in a MEASURE Evaluation Webinar in integrated service delivery strategies in Malawi and Senegal and review relevant publications.

In FY3, the project will use the workshop, program survey and published USAID integration reports from other programs to design and pilot a standardized and harmonized approach to integration to facilitate implementation (demonstration phase) including assessment, evaluation parameters with indicators to guide program planning and document the process for and outcomes of services integration. National and international academic standards for POP training will be synthesized into the project. POP Integration sites will include:

DRC: Integration consultant: Judith Goh or Suzy Elneil or Rene Genadry

- Panzi Hospital in Bukavu (definite)
- St. Joseph's Hospital in Kinshasa (pending site and needs assessment)

Nigeria: Integration consultant: Suzy Elneil

- Abakaliki Hospital Center in Ebonyi State

Uganda: Integration consultant: Judith Goh

- Kitovu Medical Center

West Africa: Integration consultant Rene Genadry

- CNRFO and Lamorde – both in Niamey

6. Describe how the project is working effectively with, and is responsive to, Missions in countries where the project is working

The Nigeria team and the WARP team are both required by their local missions to submit separate quarterly reports on project activities, in addition to the project's global semi-annual and annual reports. Country examples of mission collaboration include:

Bangladesh:

- FC+ has been responsive to USAID Mission concerns in Bangladesh, for example updating repair targets for FY2.

- An August 2015 country site visit with the Project Director, Global Clinical Director and USAID FC+ AOR resulted in a FC+ strategy to develop new fistula case identification strategies to address gaps in tracking treatment backlog and in-depth site-based clinical data review, compliance with clinical quality of care, methods of determining trainee skills acquisition, use of international trainer cost-benefit profiles prior to engagement, compliance with waste management training, family planning compliance and compliance with infection prevention training.
- FC+ has also provided suggestions for integrating fistula, non-fistula incontinence and prolapse measurement into the BMMS, and will provide TA from the Deputy Director in the finalization of the questionnaire and plans for a clinical validation study to be nested in the primary BMMS.
- At the request of the Mission office, FC+ will also engage our Bangladesh partner, BRAC, in assessment of care seeking behaviors among the many menopausal obstetric fistula clients in Bangladesh who refuse treatment even when identified by trained community health workers, living for decades with their condition.

Nigeria

- The Mission requested that FC+ absorb the TSHIP prevention-only sites in the wake of that project's closing.
 - Project has expanded to Jigawa and Oyo states with plan to expand to more states to increase access to fistula prevention/repair services in keeping with the mission request for scale up.
 - We responded to the Mission's request for a state-wide FP service delivery in Ebonyi State. On our own, we replicated the same strategy in Jigawa state without asking for additional funding.
 - We convened consultative meeting on management of WDI. When completed, the guidelines developed in that meeting could significantly improve diagnosis, management (or referral) of WDI in a more systemic way. A poster presentation on this strategy was made at WAHO conference in Ouagadougou in
 - We responded to the request of the Mission on addressing the needs of survivors of SGBV in Nigeria. Algorithm as well as tracking tools were developed and put to use in the Northeast of Nigeria.
 - The Project worked with Kano State Government, Kano Emirate Council, Print and Electronic press organizations in Kano to commemorate the International Fistula Day in 2015.
 - The Project reached out to the new administration in Kebbi State, establishing rapport with the state First Lady and her husband for expansion of opportunities in Kebbi.
 - The Mission requested that EH Nigeria adapt the global Fistula Care *Plus* indicators so that they are each "domesticated" to the Nigerian environment. This process involved a series of meetings with USAID Nigeria team, MEMS (M&E contracting project of USAID) and in consultation with our NY M&ER team. These efforts culminated in a domesticated set of indicators under review with MEMS. The approved indicators will be used to create online PRS (a data reporting and management platform of the Mission).
7. Describe and provide examples of how the project is collaborating with other CAs and international organizations working the same technical or complementary areas. What does the project plan to do to improve collaboration and coordination among CAs and other international organizations?

FC+ collaborated with the **World Health Organization (WHO)** on the manuscript that was published in the Lancet in early 2015. A manuscript was prepared jointly and submitted to the Lancet. FC+ and the WHO have also begun a secondary analysis of data from the RCT and the earlier observational prospective cohort study on determinants of repair outcomes. The analysis aims to generate a fistula classification system based on cluster analysis and prognostic value. WHO has presented initial results from this analysis to FC+ and we are discussing how best to move forward.

Continued partnerships will deepen and expand collaboration to work on rehabilitation, reintegration, and related issues. FC+ will continue to work to identify in-country and international organizations working in social reintegration to enhance in-country reintegration efficiencies, to promote south-south partnerships, and to integrate international groups such as ACOG Global Programs, RCOG, FIGO, U of Michigan's 1,000+ ObGyn, WACS, COSECSA, ECSA, WAHO, and specifically related to POP, IUGA (International Urogynecologic Association).

On 17th September, 2015 FC+ global team and FC+ Uganda Program Manager have a meeting with **ACOG Global Programs** to discuss collaboration on ACOG's cesarean skills program in Uganda.

FC+ will also work with stakeholder partners from academic urology and regenerative medicine along with partners including but not limited to Wake Forest University (<http://www.wakehealth.edu/WFIRM/>), FIGO and ACOG Global Programs to create a position statement on the equitable bridging of access to autologous stem cell (ASC) therapies for neo-bladder (a viable alternative for PFRD urinary diversion candidates) and urethral ASC injectables (PFRD/closed and incontinent see <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3218558/pdf/nihms335812.pdf>) for women with highly complex fistula whose ability to be cured is affected by inequitable resource constraints regarding access to ASC regenerative therapies.

In September 2015, FC+ Project Director represented FC+ at a meeting of FIGO fistula surgery training program trainers, trainees and partners to improve understanding of the working of the FIGO Fistula Training manual, its challenges, and devise a way forward for the fistula surgery training community. Among various conversations regarding improving and monitoring training goals, all trainees and trainers spoke of the evolution of prolapse and non-fistula incontinence care at the FIGO Accredited Training Centers and at each of the participating trainees home institutions. It was agreed that the FC+ Prolapse Integration Training Manual (to be developed pursuant to the September workshop and webinar) would best be designed as a partner manual to the FIGO Fistula Training Manual. Prof Suzy Elneil, author of the FIGO manual, agrees to participate in the editing of the FC+ POP manual. Both Gondar University fistula program and Hamlin Fistula Ethiopia are launching urogynecology fellowships. The directors of both programs are interested in reviewing the FC+ prolapse integration training manual as part of the curricula in their respective urogynecology training programs. The FC+ PD also met with the EngenderHealth Ethiopia staff. The EngenderHealth Senior Clinical Advisor, Dr. Dereje Negussie, is also the president of the Ethiopian Society of Obstetrics and Gynecology (ESOG), as well as a high-ranking member of the African Federation of Obstetrics and Gynecology (AFOG). He will facilitate both ESOG and AFOG involvement in the evolution of these two Ethiopian fistula centers as each develops its academic urogynecology fellowship training program that will, by definition, include fistula training

Conferences convened by international organizations and other CAs have also been an important avenue for collaboration and dissemination of FC+ findings and models. FC+ had an extensive presence at the first **West Africa Health Organization (WAHO) ECOWAS Best Practices in Health**, presenting findings from Guinea, Niger, and Nigeria, as well as multi-country research efforts and EngenderHealth program models. This meeting brought together researchers, regional experts, program managers and clinicians, focusing on the topic: "Ending Preventable Mother and Child Deaths in West Africa - What works in Reproductive Health and Family Planning." FC+ participation in the Forum is described at:

<http://www.fistulacare.org/pages/blog/2015/08/good-practices-shared-at-waho-forum-in-burkina-faso>. FC+ staff and partners will share research and program findings from each FC+ country at the upcoming **FIGO World Congress** in October 2015. Presentation topics include: community approaches to promote maternal health care utilization and improve fistula screening, findings related to post-operative care after fistula repair, and new approaches to fistula classification and maternal health data management. FC+ will host a panel on iatrogenic fistula at the October 2015 **Global Maternal and Newborn Health Conference** (GMNHC) in Mexico City, convened by numerous maternal and newborn health

organizations and led by the **Maternal Health Task Force**. The FC+ panel will be moderated by Project Director Lauri Romanzi and with speakers including Abu Jamil Faisal, Sanda Ganda, Dolorès Nembunzu, and Tom Raassen. Presentations will include a multi-country analysis of iatrogenic fistula cases, along with perspectives from fistula treatment sites in Bangladesh, DR Congo, and Niger. A full list of FC+-supported presentations and presentations at FIGO and other global conferences is available on the [FC+ website](#).

FC+ worked with partners including UNFPA, USAID, and the **Woodrow Wilson International Center for Scholars and UNFPA**, to co-convene a panel event on July 14, 2015 entitled “[Restoring Hope and Dignity: New Developments and Best Practices in Addressing Maternal Morbidities](#).” Congresswoman Carolyn Maloney (D-NY) also spoke at this event, which was moderated by Sandeep Bathala of the Wilson Center. Speakers highlighted both obstetric fistula and pelvic organ prolapse (POP), with USAID and UNFPA speakers describing the prevalence and clinical consequences of these conditions, as well as the social isolation and stigma they may cause. The discussion flagged the preventability of these maternal morbidities, particularly by ensuring that poor and rural women have adequate access to emergency obstetric care. FC+ Project Director Lauri Romanzi emphasized the crucial role of programs to screen for and rapidly respond to obstructed labor, which underlies these and other important maternal morbidities and adverse health outcomes. Conrad Person of **Johnson & Johnson** discussed current efforts to increase data on preventable maternal morbidities, including the [global fistula map](#).

FC+ is working with UNFPA to plan a workshop to finalize materials related to 12 indicators that have been selected as the most useful for fistula programming, addressing prevention, treatment, and reintegration. This workshop seeks to bring together USAID, CDC, UNFPA, AMDD, and FC+ to endorse a common definition and measures for these 12 “super-core” indicators.

FC+ continues a collaboration with the **Maternal and Child Survival Program (MCSP)** to publish and disseminate new tools for the measurement of the quality of intrapartum and immediate postpartum care in sub-Saharan Africa. FC+ Deputy Director Vandana Tripathi will present key findings at an MCSP-convened panel on quality of labor and delivery care at the GMNHC in Mexico City.

FC+ supported reporting of selected fistula indicators from projects supported with bilateral USAID funds, such as **PROSANI** in DRC. FC+ has also carried out several discussions/orientations with the **Fistula Foundation** to help them determine whether DHIS2 would be a useful platform for their data collection. They currently do not have a database system in place and have not been able to do larger analysis of their data. We are currently collaborating to establish a section within the FC+ DHIS2 database that will house Fistula Foundation data; this will greatly contribute to the global knowledge base on fistula procedures, characteristics and outcomes. Additionally, FC+ has presented its DHIS2 development at a global NGO symposium organized by the Non-Profit Organizations Knowledge Initiative (**NPOKI**) and the **University of Oslo** and has served as a resource to several other NGOs who are considering/in the process of developing their own DHIS2 instances.

In Bangladesh and Niger, FC+ shares office space with USAID-funded projects. In DRC and Uganda, FC+ shares office space with family planning projects funded by the Bill and Melinda Gates Project. Distributing office costs across projects maximizes funding and allows collaboration for shared goals when possible.

Country examples of collaboration include:

DRC

The project involves the Ministry of Health (MOH) as possible given limitations related to the project's activities in privately run facilities. The MOH has multiple exchanges and coordination frameworks such as MNCH task force through which we engage other organizations. The project has led the establishment of the national community of practitioners that brings together the sets of fistula surgeons and organizations involved in this field.

Nigeria

EH/FC+ collaborated with the Chibok Support Group members (WHO, UNFPA, UNICEF, FHI360, PATHS2, UN WOMEN, IPAS, NURHI) and collectively developed an algorithm and tracking tool for management of victims of SGBV. A presentation on this collaboration was made at the 15th annual meeting of the Inter-Agency Working Group on RH In Crises in Feb 2015 in Amman, Jordan. The Project collaborated with FMOH through G-WIN Project to conduct fistula surgeries in several supported facilities. We extended similar offer to UNFPA with limited success. We collaborated with the Institute of Social Works of Nigeria and conducted a national seminar in Nigeria. We are working with National Technical working group of the Fed Ministry of Women Affairs and Social Development to organize a conference on ending child marriage. The Project participated in state-level meetings of partners in Kano and Sokoto States. Joint action plans (largely advocacy with new administrations) were developed. We are working closely with MEMS to domesticate FC+ indicators and upload these on PRS reporting platform aimed at aiding sub-annual and annual portfolio reviews.

Uganda

The project is represented at key national technical working groups, e.g., FTW, MCH and FP at which harmonization, synergism and complementarity are addressed. Fistula treatment sites are supported by both FC+ and MoH with support from UNFPA. Plans have been clearly drawn to support repairs camps at these sites without necessarily duplicating resources and effort but rather build synergism to increase the number of repairs performed.

West Africa

To expand leadership in fistula prevention and treatment in the region, West Africa is working with WAHO for a regional policy on fistula elimination. This will be shared with relevant partners and ministries for adoption. In Niger, the Network for the Elimination of Fistula (REF) works closely with FC+ to pass a national strategy for the elimination of fistula. With UNFPA the project collaborates on activities to ensure complementarity.

Project Management

1. What issues or concerns related to staffing has the project identified, if any, and how is the project addressing them?

International fistula consultancy guidelines are under development for project-wide application in FY16. Collaboration with senior fistula surgeons visiting from other countries will be continued to the extent necessary to facilitate skills training goals that cannot be met by senior national fistula experts. In FY3, international fistula consultants will no longer be recruited only for service delivery/clearing backlog but to increase the clinical and surgical skills of trainees, who will not only observe and assist but will also perform appropriate portions of complex cases, and the majority of simple cases, under the trainers' tutelage. Pre-surgery preparation and post-surgery ward rounds, though implicit, will be specified in the consultancy SOW. Criteria will be set forth (see clinical tracking systems for client care and backlog monitoring above) to assure that South-South international consultants are not neglecting their own nation's fistula backlog and that no financial incentive is created to entice a consultant fistula surgeon from one country to neglect the fistula clients in his or her own country because of differences in consultancy day rates between home and consultancy countries. Continued tracking of trainees and trainers, and how training translates to skills acquisition and post-training unsupervised routine fistula care service delivery will be amended to meet a new, system-wide FC+ menu of clinical monitoring. In Bangladesh, this will include exploratory meetings regarding centralized collaboration with UNFPA and the National Fistula Task Force for a training database and other activities to monitor the comprehensive national picture regarding fistula training, fistula treatment, and clinical backlog of fistula cases. Emphasis on this joint effort will be on the quality and complexity of surgical training and how it translates to on job performance, but will not be on numbers of surgeons, nurses or midwives trained (quality over quantity). In a meeting with UNFPA, we agreed that, as outlined in FC training strategy, emphasis should be on training 'surgical teams' – including nurses and midwives for catheter-based nonsurgical treatment of fistula, adjunctive physiotherapy for pelvic floor rehabilitation and, as needed pelvic stabilization and foot-drop therapy, in addition to a goal of one or two Bangladeshi fistula surgeons independently active for simple-moderate complexity fistula by end of project. Sites where skills acquisition is focused on foreign nationals working full time on site will be augmented so that these resident foreign surgeons are training Bangladesh surgeons on site to the full extent of their skill set.

Concentrated efforts (CE) to be facilitated by platforms set forth in FC+

<http://www.fistulacare.org/pages/da/files/3/3.1/Fistula-Training-Strategy-Guidelines-Standards-English.pdf> and in the FIGO Competency Based Fistula Training Manual. National fistula experts and invited international surgeons follow a flexible guideline of:

- Minimum 30 cases per CE
- Minimum 15 cases per trainee
- National trainee(s) mandatory for every CE
- Trainees must perform surgical skills, in addition to pre-operative evaluation and post-op care, all supervised by the trainer
- International trainers engaged to the extent necessary for augmentation of the capacities of the competent core group of advanced-level national fistula trainers
- Trainee skills acquisition monitoring before and after every CE
- Trainee skills implementation after every CE
- Clients logged into a tracking system to document outcomes, staged repair management, and backlog related to high-complexity (or other factors)
- Two tables concurrently active for the entirety of every CE (two rooms, or two tables in a room)
- Adequate anesthesia and nursing staff, surgical instruments, high-intensity theater lighting, and disposable supplies to run two tables in each site per CE

FC+ has requested a change in the Finance Manager and Administration Specialist position, increasing the LOE to 100%. Since the launch of FC+, the EH corporate component of the FMAS responsibility no longer involves a single, large global project. Currently the EH corporate component of the FMAS role involves an ever-increasing roster of bilateral projects that are not global. The diversity and increasing scope of this component of the FMAS function is detracting from his ability to perform adequately as the Key Personnel Global Finance Manager for FC+. In response to FC+ project concerns regarding the FMAS, EngenderHealth recently offered to take on the full salary funding for and professional utilization of our current FMAS, so that FC+ can expand the scope of work for this position, add salary funds and hire a dedicated, fulltime FMAS. This new FMAS will be based in New York (as opposed to Washington DC), and will also pick up the Contracts and Compliance functions within FC+ that were never separately staffed as originally envisioned (see description of the Contracts & Compliance Coordinator, TBD, below). The Contracts and Compliance Coordinator position originally envisioned during the Request for Applications (RFA) process was never finalized in the human resource roster for FC+. In addition to the strain from the ever-increasing load of EngenderHealth bilateral projects, the current FMAS reviews budgets during subaward authorization process and reviews invoices from the subawards prior to payment. Ending the matrix management of the FMAS position is intended to restore the finance management function to a level commensurate to the FC+ FMAS post. The cost of this year three LOE increase is absorbed by year 2 global team salary overhead reductions, such that it will not impact global project deliverables.

2. Are the current mechanisms for communication between the USAID management team and project appropriate and effective?

The FC+ AORs have been extremely responsive to project staff needs, facilitating linkages to other resources within USAID (e.g., research and PPP advisors), participating in FC+ research and clinical consultations, and accompanying FC+ staff on field visits to address country-specific concerns as they arise. We have experienced delays related to contracts and finances; please see Question 2 under Section I.

3. How is the project ensuring compliance to legislative and policy requirements? Are there any issues? EngenderHealth has a compliance and contracts unit that is fully staffed with a cumulative of over 40 years of experience with applying USAID policies. The FC+ team is in daily email and direct verbal communication with the compliance and contracts unit to discuss various topics such as prime award management, restricted procurement, and subaward monitoring. EngenderHealth has an internal audit office that reports to the Board of Directors and since the award was made there have been no internal high risk audit findings for the FC+ project or country offices. Additionally, the director of the grants and contracts unit attends FC+ monthly pipeline meetings.

4. How is obtaining data from USAID bilateral programs with fistula activities working? Problems? Successes?

In February 2015, the FC+ M&E Associate conducted orientations for staff of bilateral fistula programs implemented by Vodafone/CCBRT and Pathfinder/IFHP. FC+ PMP indicators that are relevant for these bilateral projects were jointly selected. It was agreed that these projects would report data to FC+ quarterly, including backdata to the start of FY13/14 where possible (see data obtained to date in **Annex 4** below). It was mutually decided that attendance at the FC+ 2015 DHIS2 training in Kampala for FC+ was not necessary since the number of indicators both Pathfinder and Vodafone will be reporting is small, and both organizations preferred to complete a customized data collection form and send to FC+ for entry, rather entering data directly into DHIS2. The FC+ M&E Associate has offered to do a virtual DHIS2 orientation at any time in the future if the organizations are interested in learning how to use the platform. Email contact has been made with IntraHealth M&E staff in Mali several times but a discussion has not yet been held to select indicators; this is a

priority for the coming month. A discussion will also be held with USAID/Benin and their bilateral fistula partner when program activities begin there.

Several issues have arisen related to bilateral reporting: It is difficult to report information from bilaterals along with FC+ data in our reports without presenting copious amounts of data and generating potential confusion. In addition, the bilateral programs do not understand why data is to be reported directly to USAID and also reported/rolled up through FC+; there is concern that there will be double counting (or the perception of double-counting if the data are seen by external stakeholders without adequate context). Finally, it is a challenge to integrate bilateral data with FC+ numbers in some areas, given that the activities and background are different for the different programs.

Note: Pathfinder hopes to report on the following indicators going forward but has not yet been able to do so:

- Number of sites supported (*this will only represent the number of sites from which Pathfinder has trained health workers in fistula identification and referral.*)
- Number of fistula cases repaired and rehabilitated

Pathfinder's obstetric fistula work (and M&E) is integrated in the IFHP program, which covers the 4 largest and most populous (80+ million people) regions, with data collection starting at village level. Their agreement with the USAID mission in Ethiopia is a reporting deadline 45 days after the end of the quarter. Therefore, they cannot get data to FC+ in time for us to report on the current quarter and will be submitting data a quarter behind. Planned reporting deadlines are: Feb 15 (Oct-Dec), May 15 (Jan-Mar), Aug 15 (Apr-Jun), and Nov 15 (Jul-Sept).

APPENDIX D: GLOBAL MATERNAL AND NEWBORN HEALTH CONFERENCE PRE-FORMED PANEL CONCEPT

Prevention of Maternal Morbidity: Challenges and approaches – The case of iatrogenic fistula

OBJECTIVES

- To describe existing and emerging approaches to measuring and estimating the prevalence and incidence of iatrogenic fistula, regional.
- To share the results of recent studies examining the prevalence and incidence of iatrogenic fistula in sub-Saharan Africa and Southern Asia
- To share the recommendations of approaches that require further testing/research and those that should be scaled up and/or applied in additional settings

BACKGROUND

This panel will condense information presented/generated from several sources, including:

- Anchor presentation global and regional, overall picture definitions, criteria for diagnosis
- Country program specific
- Considerations and recommendations
- Issues with measurement, definition, country and regional trends and temporal trends

To link to the GMNHC audience, we will aim to frame this panel within the overall topic of maternal morbidity measurement, particularly the challenges in measuring rare(r) events that require data from both the community and the facility.

POSSIBLE PRESENTATIONS AND SPEAKERS

- Anchor presentation Thomas Raassen AMREF Kenya or regional or global or Mahendeka and Ngongo?)
- Case study Bangladesh – Abu Faisal, Farhana Akhter, SK Nazmul, LAMB rep or Bilqis Kumudini
- Case of DRC – Dolores Nembunzu, Michel Mpunga, Ahuka, Mukwege
- Case of Uganda – catastrophic injuries – Susan Obore, Harun Mwanja, others Rose Mukisa
- Case of Nigeria – Wazomis also cause fistula Adamu, Habib

Note:

- For each presentation, we would like to highlight both the actual findings and considerations regarding the validity/reliability of the method (e.g., effects of question wording, timing, data collector, etc.).
- If this panel is accepted, GMNHC will assign a moderator. However, we are allowed to propose a candidate as well.

APPENDIX E: FC+ PLANNED PARTNERSHIPS, BY COUNTRY⁴⁰

Country	Partners	Nature of Partnership
Bangladesh	Government of Bangladesh Ministry of Health and Family Welfare (MOHFW) Directorate General of Health Services (DGHS) Directorate General of Family Planning (DGFP) Ministry of Social Welfare (MOSW) and Ministry of Women and Children's Affairs (MCWC) Ministry of Local Government, Rural Development and Cooperatives (MOLGRD)	Endorsement and dissemination of National Fistula Strategy and National Action Plan, participation in National Task Force on Obstetric Fistula, Vouchers National Task Force and Action Plan development, Government Medical College and District Hospitals, partograph use, C-Section, strengthening HMIS, surgical training FP integration, community outreach Reintegration, WDI Community outreach
	Obstetrical and Gynecological Society of Bangladesh (OGSB)	Partograph use, C-Section
	UNFPA	National Task Force, strengthening HMIS, policy
	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
	DRC	Ministry of Health
Access to Primary Health Care Project (ASSP) (DFID)		Fistula treatment, Community outreach
UNFPA		Fistula prevention
Direct Relief International		Drugs and medical supplies
WA/Niger	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
	Community committees	Community outreach

⁴⁰ This list reflects partnerships planned at the start of FY 14/15. An updated list of partnerships and accomplishments will be provided with the next semi-annual report. This list does not include supported sites or other fistula projects supported by USAID bilateral funds.

Country	Partners	Nature of Partnership
Nigeria	Federal Ministry of Health	Coordination with G-WIN Initiative
	UNFPA	Coordination with ongoing activities
	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 treatment
	National Obstetric Fistula Working Group	National fistula prevalence study
	Dimagi	mHealth application
	Radio Nigeria (FRCN)	Public-private partnerships
WATogo	Ministry of Health	Fistula treatment
	UNFPA	Fistula treatment
Uganda	Ministry of Health	Fistula prevention and treatment, National technical working groups
	TERREWODE	Social reintegration, particularly with WDI/PFRD
	AMREF	Fistula prevention and treatment
	Population Council	Barriers to 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 F: 2014 INTERNATIONAL OBSTETRIC FISTULA WORKING GROUP (IOFWG) MEETING AGENDA

SUNDAY, OCTOBER 26, 2014		
17:00 - 19:00	Registration and pick up of meeting materials	Venue: Hotel Africana
18:00 - 21:00	Welcome Cocktail at the Venue overlooking the pool	
MONDAY, OCTOBER 27, 2014		
SESSION 1 - 8:30-10.15 – HOTEL AFRICANA CONFERENCE ROOM		Presenters
08:30 - 09:40	Opening ceremony (Including testimony from fistula survivors and their partners)	<ul style="list-style-type: none"> -Dr. Justus Barageine, Fistula Surgeon, Uganda (5 min.) -Ms. Esperance Fundira, Representative, Country Office, UNFPA, Uganda (10 min.) - Dr. Luc de Bernis, Senior Maternal Health Advisor, UNFPA, Geneva (5 min.) -Ms. Erin Anastasi, Interim Coordinator, Campaign to End Fistula, UNFPA, USA (5 min.) -Hon. Minister of Health, Uganda (10 min.) - Fistula survivors and their partners (TERREWODE), (20 min.) - Security briefing (15 min.)
09:40 – 10:10	Campaign to End fistula update/overview of CEF vision (Achievements/highlights from the past 2 years)	Ms. Erin Anastasi , Interim Coordinator, Campaign to End Fistula, UNFPA, USA
10:10 - 10:30	COFFEE BREAK	

SESSION 2 - 10:30-13.00 – THEMATIC UPDATES FROM PARTNERS		Chairperson: Dr. Amandua Jacinto (Chair, FTWG Uganda)
10:30 - 11:30	Prevention of obstetric fistula (Midwifery training; traditional birth attendants; task-shifting)	- Dr. Shershah Syed (Pakistan); - Dr. Luc de Bernis (UNFPA, Geneva)
11:30 - 12:30	Treatment & training: Fistula Repair Kits	- Dr. Justus Barageine (Fistula surgeon, Uganda) - Dr. Denis Robson (Johnson & Johnson)
12:30 - 13:00	Country update: Uganda (Fistula Technical Working Group Uganda)	Dr. Peter Mukasa (UNFPA/Uganda)
13:00 - 14:00	LUNCH	
SESSION 3 - 14:00-15.15 – THEMATIC UPDATES FROM PARTNERS (CONTINUED)		Chairperson: Dr Amone Jackson, Assistant Commissioner in Department of Clinical Services, FTWG Uganda
14:00 - 14:25	Country update: Ethiopia (National task force & national plan of action to eliminate OF by 2020)	Dr. Martin Andrews (Hamlin Fistula Ethiopia)
14:25 - 14:50	Country update: Bangladesh (National strategy for ending fistula)	Prof. Sayeba Akhter (Bangladesh)
14:50 - 15:15	Innovation (Short film: mobile phones & fistula)	Dr. Vindhya Pathirana (CCBRT/Tanzania)
15:15 - 15:30	COFFEE BREAK	
SESSION 4 - 15:30-16:45 – THEMATIC UPDATES FROM PARTNERS (CONTINUED)		Chairperson: Dr. Amone Jackson
15:30 - 16:50	Social Reintegration - Incurable fistula patients (20 min.); - First African conference of fistula survivors (20 min.); - Teenage pregnancy and reintegration of teen survivors of OF (20 min.); - Patient reintegration and empowerment (20 min.)	- Mr. Musa Isa , (Fistula Foundation Nigeria); - Dr. Gloria Esegbona & Ms. Fatima Aliyu (Institute of African Women’s Health); - Ms. Alice Emasu (TERREWODE/Uganda); - Ms. Sololia Amente (Healing Hands of Joy/ Ethiopia)

18:00 - 21:30	Evening meal and cultural performance at Kika Cultural Center	Transport leaves the reception of Africana Hotel at 17:30
TUESDAY, OCTOBER 28, 2014		
SESSION 1 - 8:30-10.30 – RESEARCH UPDATE, PARTNER-LED PRESENTATIONS		Chairperson: Dr. Rose Mukisa (EngenderHealth/Uganda)
08:30 - 09:15	Recap of Day 1	Presenter: Dr. Peter Mukasa (UNFPA/Uganda)
09:15 - 10:30	<p>Fistula Care <i>Plus</i> (FC+)-led presentations</p> <ul style="list-style-type: none"> -Overview of FC+ project objectives and scope (5 minutes) -Objectives 1/5: Results from global consultations on research priorities and measurement of fistula burden (15 minutes) - Objective 2: Findings from research on community engagement for fistula prevention/treatment in Guinea (15 minutes) - Objective 3: Findings from analysis of media coverage of fistula treatment and related barriers (10 minutes) - Objective 4: Findings from randomized controlled trial of shorter post-operative catheterization and implications for practice (10 minutes) - Q&A/Discussion (20 minutes) 	Dr. Karen Beattie, Project Director; Ms. Bethany Cole, Global Project Manager; Dr. Joseph Ruminjo, Clinical Director
10:30 - 10:45	COFFEE BREAK	

SESSION 2 - 10:45-13.15 – RESEARCH UPDATE, PARTNER-LED PRESENTATIONS (CONTINUED)		Chairperson: Dr. Rose Mukisa (EngenderHealth/Uganda)
10:45 - 11:15	Update on OF multi-country study and a new model for estimating fistula incidence and prevalence	Prof. Saifuddin Ahmed (Johns Hopkins University, USA); Dr. Rene Genadry (Johns Hopkins University, USA & University of Iowa)
11:15 – 11:45	Fistula indicators for improving program monitoring and quality	Dr. Luc de Bernis (UNFPA/Geneva)
11:45 - 12:15	Rapid prevention of obstetric fistula	Dr. Anders Seim (HDI) Dr. Alassoum Zeidou (HDI & MoH/Niger)
12:15 – 12:45	Global Fistula Map update	Ms. Lindsey Pollaczek (Direct Relief)
13:15 - 14:15	LUNCH	
SESSION 3 - 14:15-16:30 – RESEARCH UPDATE, PARTNER-LED PRESENTATIONS (CONTINUED) – WRAP UP		Chairperson: Dr. Opar Bernard, Principal Medical Officer of the Ugandan MOH
14:15 - 15:00	Analysis of fistula programming within MSF over a 5-year period	Dr. Geert Morren (MSF)
15:00 - 15:30	One-by-One/GynoCare model & data	Dr. Carolyn Anderman (One-By-One/Kenya)
15:30 – 16:00	Wrap up of the Meeting	- UNFPA/Uganda (Deputy) Representative; - Dr. Luc de Bernis (UNFPA/Geneva)
16:00 – 16:30	Closing Ceremony	Permanent Secretary, Ministry of Health (Uganda)

APPENDIX G: FC+ PRESENTATIONS AT THE 5TH INTERNATIONAL SOCIETY OF OBSTETRIC FISTULA SURGEONS (ISOFS) 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 H: FC+ TEAM STRATEGY AND TECHNICAL WORKSHOP AGENDA

Team Workshop | 5 – 6 February 2015

Pullman Abidjan Hotel | Rue Abdoulaye Fadiga

01 BP 2185 Abidjan 01 – Cote d'Ivoire | Telephone: 225 20 30 20 20

GOAL

To share technical updates and refine strategies for technical interventions across the global project

OBJECTIVES

- To refine strategies for key technical areas including
 - program interventions for bladder catheterization;
 - translating RCT to practice;
 - strategy for integration of genital prolapse into fistula programming
- To share potential strategies for elimination of fistula
- To learn from technical updates in the program
- To learn lessons from team members on core and country experiences

THURSDAY, 5 FEBRUARY 2015

Time	Session	Facilitator	Notes
	Registration	10 min	
	Welcome	Yetnayet Asfaw 30 min	<ul style="list-style-type: none"> • Welcoming remarks and introductions • Sharing progress of S&I team and upcoming EH initiatives
	Meeting context	Joseph Ruminjo 15 min	<ul style="list-style-type: none"> • Review of agenda, goals, objectives, expected results. Where and how are we going to focus our efforts <ul style="list-style-type: none"> ○ Reducing barriers to access ○ Elimination of fistula ○ Bladder catheterization, spectrum of indications ○ Genital prolapse integration strategy
9:45	Country program summaries:	Abu Faisel 5 min Country program representatives 40 min Habib Sadauki Michel Mpunga Rose Mukisa Balarabe Abu Faisel	<ul style="list-style-type: none"> • Progress at end of year one and plans for year two <p>Country program summaries: (interactive, using poster or flip chart 3 x 4 ft; highlight key strategies and what we are doing in country program</p>
	Barriers to Access of Services	Bethany Cole/Abu Faisel, 20 min Country program representatives 10 min each	<ul style="list-style-type: none"> • Treatment, prevention? • Information on Population councils work on reducing barriers. • Share with managers Pop council agenda for Nigeria, Uganda

		Uganda – Rose Mukisa Nigeria – Habib Sadauki Discussion 20 min	
12:30	Lunch		Provided onsite
	An approach to 'Elimination of Fistula' by a target date – Ethiopia and other models	Bethany synthesis from Ethiopia Rep 15 min Country program experiences: 12 min each Discussion – 15 min Bangladesh experience – Abu Faisal Nigeria – Habib Sadauki Uganda - Rose Mukisa DRC - Michel Mpunga Regional model WA- Moustapha Diallo	<ul style="list-style-type: none"> • Elimination /'eradication' of fistula in your country program • Have you had same or similar ASK from Mission or from Government? USAID Washington and Mission perspectives • What is your strategy to respond to the ASK, in the short term and project long? • What are the opportunities? • What are the challenges and how do you address them? • What is the current status/achievement • What is known about WDI, how it is being addressed • Any additional thoughts, caveats, contextual issues • Innovative approaches to management of client backlog, strategy/theory of elimination/eradication, ie plus and delta of current interventions • Maintaining and monitoring quality in the context of expansion • Community of Practice for Fistula Care Plus
3:00	Break		
	Pipeline review and cost share documentation	Joseph Osei	<ul style="list-style-type: none"> • Overview of Cost share processes and documentation; pipelines, burn rates, budget review
4:30	Review and close		

FRIDAY, 6 FEBRUARY 2015

Time	Session	Facilitator	Notes
	Logistics/housekeeping	Bethany Cole 10 min	Input from each program managers on what they are doing in the spectrum of bladder catheterization and how we evaluate the various interventions
	Bladder catheterization country program and site examples, experiences	Joseph Ruminjo 20 min Country Reps 60 min Michel Mpunga Issoufou Balarabe Adamu Isah Abu Faisal Rose Mukisa	<ul style="list-style-type: none"> • For prevention • For conservative treatment • Short duration catheterization post repair; RCT to practice

10:30	Break		
	Strategy for integration of POP into Fistula programming	Joseph Ruminjo, 20 min country program representatives, 70 min	What is the situation at country level in integration of POP services into fistula programming: numbers, systems, resources <ul style="list-style-type: none"> • What are the opportunities at individual country level? • What are the challenges? • What is the best way forward?
12:30	Lunch		Provided onsite
	Update session	Joseph Ruminjo	<ul style="list-style-type: none"> • Research priorities • Measurement and evaluation • Clinical Terminology questions/definitions regarding the database, • FP compliance monitoring • Select QI issues
	Country Program Teams: Intersect between FC Plus / Engender Health work and strategy in each country program	Isaac Achwal and country reps 30 min	Synergies, conflicts, opportunities
	Start Work-planning session	Abu Faisal / Bethany 30 min	
3:30	LATE pm break		
	Continue Work-planning	Abu Faisal / Bethany	Review upcoming work-planning workshop for year three
4:30	Closing	Yetnayet Asfaw	

APPENDIX I: FC+ DHIS2 TRAINING AGENDA

DHIS2 Training| March 10-13, 2015

Location: Protea Hotel, Kampala, Uganda

MEETING OBJECTIVE

- To introduce the DHIS2 platform designed to collect, analyze and store data for the Fistula Care *Plus* (FC+) project, and to train field-based monitoring and evaluation staff in its use.
 - Part I: M&E and reporting in FC+
 - Part II: Data organization and entry
 - Part III: Data visualization and reporting

TUESDAY, 10 MARCH 2015

Time	Session	Details	Facilitator
8:30am	Breakfast		
9:00am	Welcome, introductions, and review of agenda and expectations	<ul style="list-style-type: none"> - Welcome - Introductions (Names, role in relationship to DHIS2 & expectations from the workshop) - Walk-through agenda - Objectives of the training 	Rose/Karen/Simon
9:45am	Overview of Fistula Care <i>Plus</i>	<ul style="list-style-type: none"> - Goals/Objectives - Expansion from Fistula Care - "What's New?" 	Bethany / Rose
10:00am	Overview and review of Fistula Care <i>Plus</i> (FC+) project data processes	<ul style="list-style-type: none"> - Data collection, reporting, monitoring - Questions/discussion 	Karen / Simon
11:00 – 11:15am	Break		
11:15 am	Overview of FC+ DHIS2:	<ul style="list-style-type: none"> - Background on DHIS2 platform, why did we choose DHIS2 - Other EH/global health/govt. programs using DHIS2 - DHIS2 overview - Live demonstration (Features of DHIS2) 	Karen/ HISP
1:00pm	Lunch		
2:00pm	DHIS2 access, user roles and management	<ul style="list-style-type: none"> - User authorization and authentication in DHIS2 - Live demo of various accounts (2.16) 	HISP
2:30 pm	DHIS2 Concepts	<ul style="list-style-type: none"> - Basic terminologies - Core dimensions 	HISP
3:15 pm	Break		
3:30 pm	DHIS2 Concepts continued		HISP
4:45pm	Summary/ Plus-Delta		Simon

WEDNESDAY, 11 MARCH 2015

Time	Session	Details	Facilitator
8:30am	Breakfast		
9:00 am	Review of Day 1 / Housekeeping		Karen
9:30am	Data Entry Intro	- Introduction to data entry and programs	HISP
10:00am	Working with data (group)	- Log-in - Navigation - Data forms	HISP
11 am	Break		
11:15 am	DHIS2 data quality	- Best practices – DQ assurance - Validation rules - Data quality functionalities - Data approval - Live demo	HISP
12:30pm	Lunch		
1:30pm	Working with data (individual)	- Entry of Year 1 project data	
3:15pm	Break		
3:30 pm	Working with data (individual)	- Continue data entry, move to live entry on production server if participants feel comfortable	
4:45 pm	Summary/ Plus-Delta		Karen

THURSDAY, 12 MARCH 2015

Time	Session	Details	Facilitator
8:30am	Breakfast		
9:00 am	Review of Day 2 /Housekeeping		Simon
9:30am	Working with data (individual)	- Continue data entry, move to live entry on production server if participants feel comfortable	
10:30am	Break		
10:45am	Overview of Reporting in DHIS2	- Reporting rates - Dataset reports - Standard reports - Organization units reports - Resources - Sending/receiving messages	HISP
12:00pm	Lunch		
1:00pm	Pivot Tables	- Presentation and live demo - Practice and exercise	HISP
3:00pm	Break		
3:15pm	Data Visualization	- Presentation, - Demo, - Practice exercise - Terms/Parameters - Chart types - Exporting	HISP
5:00 pm	Summary / Plus-Delta		Simon

FRIDAY, 13 MARCH 2015

Time	Session	Details	Facilitator
8:30am	Breakfast		
9:00 am	Review of Day 3 /Housekeeping		Karen
9:15am	Visualizer: Practice		HISP
10:30am	Break		
10:45am	Dashboards: Presentation, Demo, Practice exercise	- Creating, editing dashboards - Sharing dashboards	HISP
12:00pm	Lunch		
1:00pm	GIS: Presentation, Live demo, Exercise	- Terms/Parameters - Creating maps - Sharing maps	HISP
2:45pm	Additional practice time for pivots, visualizer, dashboards, GIS		
4:15pm	Closing	Next steps Feedback/evaluation	Rose / Simon/ Karen

LIST OF PARTICIPANTS

1	Karen Levin	Program Associate, M&E
2	Bethany Cole	Global Projects Director
3	Prosper Behumbiize	HISP DHIS2 consultant, Uganda
4	Eric Munyambabazi	HISP DHIS2 consultant, Uganda
5	Michel Mpunga	DRC Program Manager
6	Rose Mukisa	Uganda Program Manager
7	Simon Ndizeye	Uganda Program Associate, M&E
8	Lucy Asaba	Uganda Program Associate, Medical
9	Mai Birni Garba Aboubacar	Niger M&E officer
10	Alex Delamou	Guinea M&E officer (consultant)
11	Nazmul Huda	Bangladesh Program Manager
12	Joseph Ringpon Gwamzhi	Nigeria M&E officer
13	Chidimma Ezenwa Anyanwu	Nigeria Senior M&ER Advisor
14	Leah Jarvis	EngenderHealth M&E Program Associate
15	Isaac Achwal	Senior Clinical Program Associate
16.	Molly Tumusiime	Uganda Program Associate, Community Engagement

APPENDIX J: ENGENDER HEALTH CLINICAL DATA FOR DECISION MAKING (CDDM) MEETING AGENDA

Clinical Data for Decision-Making:

A Meeting to Improve the Generation, Synthesis and Application of Clinical Program Data

March 23-27, 2015

Istanbul, Turkey

AGENDA

Background:

In recent years, evidence-based decision-making and programming has become the expected standard in the field of sexual and reproductive health (SRH), as in most fields of medicine and public health. Quality evidence is essential for producing the best outcomes with limited resources, by allowing program managers and policy-makers to make decisions supported by good quality data rather than on instinct or intuition (or limited/poor quality data). EngenderHealth has increasingly invested resources to capture, synthesize and disseminate data, in order to support evidence-based decision-making. Currently, we collect an enormous amount of clinical data. However, like many organizations, we sometimes collect too much data, we don't always collect the right data and we don't always make optimal use of the data we have. In addition, between Ensuring Clinical Quality (ECQ) and monitoring, evaluation and research (ME&R) activities, there are redundancies among the data collected, including duplicate data collection processes. By improving the way that we generate and use clinical data, we will be better able to improve our program development; to ensure program success; and, to contribute to global learning both within EngenderHealth and among the global SRH community, generally.

We have convened this three-day meeting to improve the way in which we capture and use clinical data which relates to service delivery and the implementation of ECQ and QI interventions such as counseling, clinical training, clinical monitoring and coaching (CMC), COPE, facilitative supervision, whole-site-training. The meeting will contribute to the broad organizational initiative to improve data quality and use. In the lead up to the meeting, the Clinical Support team (CST) is updating the CMC Toolkit and the Clinical Training Toolkit that are used for ECQ activities. On a parallel track and in collaboration with the CST, the HQ Monitoring, Evaluation & Research (ME&R) team has completed an extensive review of tools used for program monitoring and evaluation across our programs and projects. Following that review, the teams have worked to develop template tools and guidance documentation, for use in the ME&R of our programs activities.

The meeting will bring together Senior Clinical and ME&R staff from EngenderHealth field programs as well as key HQ staff. We aim to streamline data collection and improve clinical data usage through harmonization of tools and approaches used organization wide for ECQ and ME&R. In addition, we aim to facilitate greater and more effective cross-organizational learning and sharing.

Specific objectives are:

1. To assess current clinical data collection process
2. To assess the ways in which programs currently use data for decision-making (DDM)
3. To develop a road map for harmonizing data collection guidelines and tools between ME&R and ECQ
4. To develop a draft Framework for Clinical DDM (CDDM) at EngenderHealth
5. To create an action plan for finalizing and implementing the Framework for CDDM

DAY 1, MONDAY, MARCH 23RD		
Objectives 1&2—Taking stock of where we are and where we need/want to go		
Time	Activity/Presentation	Presenter
08:45–09:00	Arrive in meeting room	
09:00–10:00	Opening activities: <ul style="list-style-type: none"> • Welcome • Attendees Introduction & expectations • Review of objectives, agenda and discussion on expected outcomes • Logistics 	Levent Jared Caitlin/Carmela Elkin
10:00–10:15	Introduction to the Gallery Walk	Levent
10:15–11:15	Gallery Walk	All
11:15–11:30	BREAK	
11:30–12:30	Moderated discussion to identify issues and common trends emerging from the posters	Ghazaleh (moderator)
12:30–13:30	LUNCH	
13:30–13:45	Energizer	Sanjida
13:45–15:15	Group work: Part 1: Exploring root causes of the issues/gaps (30 min) Part 2: How to address the identified issues/gaps? (60 min)	Carmela – instructions Group work (each group assigned a resource person – Caitlin, Levent, Carmela, Ghazaleh, Mark)
15:15–15:30	BREAK	
15:30–16:00	Lightning presentations on group work (5 minutes each)	Shahana (moderator)
16:00–17:00	Group discussion: How do we strengthen our current efforts and address our current gaps (in data collection and use)	Caitlin (moderator)
17:00–17:15	Wrap-up (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Levent
DAY 2, TUESDAY, MARCH 24TH		
Objective 3—Developing a draft CDDM Framework		
Time	Activity/Presentation	Presenter
08:45–09:00	Arrive in meeting room	
09:00–09:15	Warm-up (Linking Day 1 to Day 2, energizer, housekeeping announcements)	Vandana
09:15–11:15	Developing a Clinical Data-for-Decision-Making (CDDM) Framework – mapping out where we want to go (Aim, Objectives, Levels of Decision-Making, Key Elements)	Caitlin/Annette
10:15–10:30	BREAK	
11:15–1:00	Group work to develop key elements of draft CDDM framework at each level <ul style="list-style-type: none"> • <i>Group 1: Data generation</i> – what data do we need & what tools & approaches do we use to collect it • <i>Group 2: Data synthesis</i> – what process, tools & approaches 	Group work (each group assigned a moderator – Caitlin, Levent, Carmela, Ghazaleh)

	<p>can we use to turn data into knowledge (analysis & interpretation)</p> <ul style="list-style-type: none"> • <i>Group 3: Knowledge dissemination/learning</i> – what processes, tools & approaches can we use for disseminating data & facilitating integrated learning/decision-making • <i>Group 4: Knowledge application</i> – what processes, tools & approaches can we use to apply our learning 	
13:00–14:00	LUNCH	
14:00–14:15	Energizer	Joseph Ruminjo
14:15–15:45	Group presentations on Key Elements of CDDM Framework (20 minutes each)	Diouratie (Moderator)
15:45–16:15	Presentation of clinical M&E tools (10 minutes each) <ul style="list-style-type: none"> • Overview (Caitlin, 5 minutes) • Event Smart (Nichelle) • Client interview (Caitlin) • Provider interview (Mark) • Facility audit (Ghazaleh) 	Ghazaleh (Moderator)
16:15–16:30	BREAK	
16:30–17:15	<ul style="list-style-type: none"> • Review of ECQ framework over the poster • Training and follow-up tools • CMC tools • Current CMC/ME data collection/use framework 	Jared Assefa Achola/Kanama Mark/Levent
17:15–17:30	Wrap-up (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Simon
DAY 3, WEDNESDAY, MARCH 25TH		
Objectives 4/5—Developing a roadmap to harmonize our M&E/ECQ tools & creating action plans for implementing the CDDM Framework		
Time	Activity/Presentation	Presenter
8:30–8:45	Warm-up (Linking Day 2 & 3, energizer, house-keeping, announcements)	Assefa
8:45–9:00	Brainstorm around key terms for DDM	Ghazaleh
9:00–10:15	Define our key terms for DDM <ul style="list-style-type: none"> • Group work (45 minutes) • Presentation (30 minutes) 	Ghazaleh (instructions & moderate)
10:15–10:30	BREAK	
10:30–11:45	Assess what tools we need and how the tools should be <ul style="list-style-type: none"> • Group work (45 minutes) • Presentation (30 minutes) 	Levent (instructions & moderate)
11:45–12:30	Refine data flow diagram into a unified team function and define roles & responsibilities to ensure operationalization (using the diagram) <ul style="list-style-type: none"> • Group work (45 minutes) 	Mark (instructions)
12:30–13:30	LUNCH	
13:30–13:45	Energizer	
13:45–14:15	Refine data flow diagram into a unified team function and define roles & responsibilities to ensure operationalization (using the diagram) <ul style="list-style-type: none"> • Presentation (30 minutes) 	(Mark, moderate)

14:15–15:15	Presentation of Draft CDDM Framework & Discussion 1. Present (5 minutes) 2. Discuss in groups (20 minutes) 3. Discuss in plenary (rest)	Ghazaleh (present framework & moderate)
15:15–15:30	BREAK	
15:30–16:45	Develop a road map for finalization, implementation and monitoring and framework	Caitlin (instructions)
16:45–17:00	Wrap-up (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Vandana

**Connecting the dots:
How do we better use evidence to support effective programming at EngenderHealth?**

**March 26-March 27, 2015
Istanbul, Turkey**

Objectives:

1. To explore opportunities for addressing gaps in evidence regarding EngenderHealth tools and approaches
2. To identify the role, challenges and needs of M&E and CST staff in implementing successful DDM (both for clinical data and beyond)
3. To explore the role, challenges and needs for data quality assurance (DQA) and to identify steps for improving DQA
4. To create action plans for improving collection, quality and use of routine monitoring data and for generating evidence regarding EngenderHealth tools and approaches

DAY 4/ THURSDAY, MARCH 26TH Objective 1-3; Action planning for DDM/DQA		
Time	Activity/Presentation	Presenter
08:30–08:45	Daily warm-up	Carmela
08:45–09:00	Where to go from here? Overview of objectives	Caitlin
09:00–09:45	Creating a robust M&E system for DDM <ul style="list-style-type: none"> • Why we need to strength M&E for better DDM? (Ghaz, 10 minutes) • What elements do we need to implement robust systems for DDM? (Annette, 10 minutes) • Sharing experience of establishing and improving DDM in M&E systems – FC+ and Mayer Hashi II (Shahana and Vandana, 10 minutes each) 	Annette/Ghazaleh
09:45–10:30	Getting from point A to point DDM: Identifying needs for ensuring effective DDM Group work (30 minutes) <ul style="list-style-type: none"> • What do you need to change about your M&E and your clinical program to better facilitate DDM? • What support do you need to get there (From program/ technical/ clinical team? from HQ? from budget? Staffing?) 	Pranjali (moderator)
10:30–10:45	BREAK	
10:45–11:30	Plenary discussion – action planning (45 minutes) What are the top five things we can do to support improved and effective DDM?	Pranjali
11:30–12:00	Connecting DQA to DDM: Understanding the whole M&E system <ul style="list-style-type: none"> • Why DQA? • What can DQA do for you? Experience from the field: implementing DQA in Mayer Hashi II (Shahana,	Caitlin Shahana

	15 minutes)	
12:00–13:00	LUNCH	
13:00–13:15	Energizer	Ayele
13:15–14:00	Group discussion & action-planning on DQA <ul style="list-style-type: none"> • Discussing DQA self-assessment tool • Sharing / discussing tips on implementing/improving DQA and DQA challenges/needs • What are the top five action steps we can take to ensure better DQA? 	Grace/Ghaz
14:00–14:45	Quality improvement and experience with ECQ <ul style="list-style-type: none"> • Where is the E (evidence) In QI? (15 m) • ECQ at EngenderHealth (Guided discussion – 30 m) <ul style="list-style-type: none"> ○ What we know? ○ What we need to know? 	Carmela/Levent
14:45–15:00	BREAK	
15:00–16:15	Getting started: Identifying opportunities to generate evidence around EngenderHealth tools and approaches Mark gives instructions on group work. Groups have 30 minutes to identify the top 5 priorities for evidence generation. <ul style="list-style-type: none"> • What do we need to be measuring that we are not? Thinking about QI tools (COPE, ECQ, Facilitative Supervision and other QI tools, rights and choice, gender, the SEED model, Reality Check, , etc. • Groups present their 5 ideas and discuss (30 m) • Everyone votes for their priorities (10 m) 	Mark (moderator)
16:15–16:30	Wrap-up	

DAY 5/ FRIDAY, MARCH 27TH		
Objective 4— Upcoming initiatives, miscellaneous M&E biz		
Time	Activity/Presentation	Presenter
08:00	Arrive in meeting room	
08:00–08:15	Warm up (Linking Day 4 to Day 5, energizer, housekeeping announcements)	Isaac
08:15–09:00	Clinical Standards and Practice & Clinical Care and Surgical Practice Policy <ul style="list-style-type: none"> • A brief presentation capturing what we want to emphasize or reinforce under each standard (15 minutes) • A brief presentation and discussion of its implications (15 minutes) • Discussion (15 minutes) 	Achola/Jared
09:00–10:00	New PP-IUD inserter <ul style="list-style-type: none"> • Demo of the inserter and the insertion procedure (20 minutes) • Discussion about evidence (40 minutes) <ul style="list-style-type: none"> ○ What safety/acceptability evidence is available? ○ Is there need for more evidence? 	Sunita/Sanjida Carmela
10:00–10:15	BREAK	
10:15–10:45	Global metrics (presentation and discussion)	Ghazaleh/Nichelle
10:45–11:30	Getting to quality research and evaluation (moderated discussion) <ul style="list-style-type: none"> • What do we need to improve planning/implementing evaluation/research? • How can we improve SOPs or other standard tools and process for better research and evaluation, including clinical research? 	Vandana/Andre
11:30–12:00	Wrap-up (next steps, action plans, follow-up) Workshop evaluation	Ayele/Simon
12:00–13:00	LUNCH	

APPENDIX K: FC+ PROTOCOL DEVELOPMENT CONSULTATION: CATHETERIZATION AFTER OBSTRUCTED LABOR

July 17, 2015 | EngenderHealth - New York

OBJECTIVE

- To discuss the parameters and feasibility of a proposed clinical research study to evaluate the effects of bladder catheterization after obstructed labor for the prevention of obstetric fistula and other adverse urogynecological outcomes

AGENDA

Time	Session	Presenter/Facilitator
8:30am	Breakfast	
9:00am	1. Welcome, introductions, and review of meeting aims	Lauri Romanzi
9:15am	2. Proposed study in the context of FC+ research agenda	Vandana Tripathi
9:30am	3. Synthesis of relevant literature/evidence	Celia Pett
10:00am	4. Presentation of illustrative study design	Michel Boulvain
10:30am	5. Debate 1: Defining the outcome of interest – incidence of fistula vs. bladder dysfunction/return to normal function. <i>What is the impact on study relevance and value?</i>	Lauri Romanzi
11:15am	6. Debate 2: Defining the intervention and comparison arms. <i>The problem of 'clean controls' in a context of variable practices after obstructed labor</i>	Vandana Tripathi
12:00pm	Lunch – provided at EngenderHealth	
1:00pm	7. Study parameters: Participants/eligibility, assignment/randomization level, sample sizes	Mark Barone
2:30pm	Break	
2:45pm	8. Study feasibility: Partners, possible sites, funding	Lauri Romanzi
3:30pm	9. Wrap-up: Next steps, participant roles	Vandana Tripathi

PARTICIPANTS

Steven Arrowsmith, Consultant
Mark Barone, EngenderHealth
Lauren Bellhouse, FC+
Michel Boluvain, Hôpitaux Universitaires de Genève*
Suzy Elneil, FIGO*
Vera Frajzyngier, Pfizer, Inc.
Erin Mielke, USAID
Mulu Muleta, Women and Health Alliance International*
Celia Pett, Consultant*
Lauri Romanzi, FC+
Joseph Ruminjo, FC+
Mary Ellen Stanton, USAID
Vandana Tripathi, FC+

*Participating remotely

APPENDIX L: FC+ ORAL AND POSTER PRESENTATIONS AT THE WAHO/ECOWAS GOOD PRACTICES FORUM: JULY 2015

Oral Presentations

1. An innovative project integrating intimate partner violence screening and counseling into a family planning clinic in Conakry, Guinea: Fabio Verani, EngenderHealth Gender Technical Advisor (presented by Alexandre Delamou)
2. Decentralization and Scale-Up of Fistula Services from 2002 onward in Niger: Dr. Fatimata Moussa, EngenderHealth Niger Program Manager
3. Sustainable innovation in monitoring for health projects – DHIS2 and the Fistula Care Plus project: Dr. Chidimma Anyanwu, FC+ Nigeria M&E Advisor
4. Integrating Family Planning with Obstetric Fistula Services: Achieving Reproductive Intentions: Bethany Cole, Global Projects Manager
5. Management of Women Deemed Incurable in Nigeria: Dr. Suleiman Zakariya, FC+ Nigeria Clinical Associate
6. Maximizing service coverage: the pooled effort strategy for obstetric fistula repair in Nigeria: Dr. Adamu Isah, FC+ Nigeria Deputy Director
7. Programmatic implementation of RCT on Short Duration Bladder Catheterization After Female Genital Fistula Repair: Preliminary Experiences from Niger/Nigeria/Sierra Leone- Dr. Joseph Ruminjo, Clinical Director
8. REF Partnership in Niger from 2003 Onward: FC+ Niger Representative

Posters

1. Draft Guidelines for Catheterization as Conservative Treatment in Nigeria: Dr. Adamu Isah, FC+ Nigeria Deputy Director
2. Rights and Choice Framework: Bethany Cole, Global Projects Manager
3. Village Safe Motherhood Committees in Guinea (poster): Bethany Cole, Global Projects Manager

APPENDIX M: INTEGRATING PELVIC ORGAN PROLAPSE (POP) AND ANCILLARY CARE INTO FISTULA CARE SERVICES

Workshop Objectives

By the end of the workshop, participants will be able to -

- Describe FC *Plus* (FC+) and program partner lessons learnt from current and previous implementation of prolapse services.
- Outline strengths, opportunities, and available resources within existing fistula care services for integrating POP services.
- Discuss challenges, potential threats, and conflicts within existing fistula care services for integrating POP.
- List relevant draft training materials, protocols, and draft curricula for review by a subset of their colleagues.
- Agree on the way forward for synergies between fistula care and POP services that could facilitate service integration in prevention, surgical and non-surgical treatment, reintegration and continually inform training and service delivery strategies.
- Plan for integrating established standards of terminology, evaluation, and management of POP and colorectal and lower urinary tract dysfunctions to include clinical and programmatic monitoring.

Anticipated Outcomes

Adaptation of established international academic standards for POP services

Collaboration with academic institutions and professional societies - OB/GYN, Urology, Midwifery, Nursing, Anesthesia

A plan to produce a POP service training manual, potentially as a companion to the FIGO Global Competency-based Fistula Training manual

A plan to produce and disseminate clinical publications on POP and related pelvic floor conditions.

Agenda

AD = Altine Diop, BC = Bethany Cole, BF = Betty Farrell, IA = Isaac Achwal, JR = Joseph Ruminjo, LR = Lauri Romanzi LK = Laura Keyser JM = Jessica McKinney. Mary Nell Wegner participation by phone = ‡

Tuesday	Wednesday	Thursday	Friday
<ul style="list-style-type: none"> • 9:00 Welcome & Registration (AD) • 9:30 Introductory exercise (BF) [15] ‡ 	<p>9:00 Check-in</p> <ul style="list-style-type: none"> • Review of Day 1 and clarification of questions (BC) [10] 	<p>9:00 Check-in</p> <ul style="list-style-type: none"> • Response to Parking Lot issues (LR) [10] 	<p>9:00 Check-in</p> <ul style="list-style-type: none"> • Review of Day 3 and clarification of questions [10]

Tuesday	Wednesday	Thursday	Friday
<ul style="list-style-type: none"> 9:45 Opening Remarks- USAID initiatives related to maternal morbidities (E Mielke) [30] ‡ 	<ul style="list-style-type: none"> 9:10 Example of pessary integration using the Five-Step Approach (BF) [45] 	<ul style="list-style-type: none"> 9:10 Small Group Exercise: Application of Service Integration Approach to POP-integration in existing FC services – Action Plans in 4 sites (LR/BF) [60] 	<ul style="list-style-type: none"> 9:05 Physical Therapy – Beyond Pelvic Floor Exercises (LK, JM) [25]
<ul style="list-style-type: none"> 10:15 Workshop Goal, Objectives, and Expectations (BF) [10] ‡ 10:25 Introduction to workshop: Compartment-based training objectives (LR) [20] ‡ 	<ul style="list-style-type: none"> 9:55 Service Integration tools: facility audit and interview tools – are your sites ready for integrated POP & incontinence E&M (JR/BF) [25] 	<ul style="list-style-type: none"> 10:15 BREAK [15] 	<ul style="list-style-type: none"> 9:30 Clarify tasks, assignments, and communications within each WG (LR/JR) [30] 10:00 Current and potential POP integration sites: (LR) [30] <ul style="list-style-type: none"> -Panzi (DRC)/Kinsasha (St. Joseph)? – Consultant - TBD -Kitovu (Uganda) – Consultant, Judith Goh -Abakaliki (Nigeria) – Consultant, Suzy Elniel -La Morde/CMFR (Niger) – Consultant, Rene Genadry 10:30 Group Work – Completion of Action Plans (BF) [40]
<ul style="list-style-type: none"> 10:45 BREAK [15] 	<ul style="list-style-type: none"> 10:20 BREAK [20] 	<ul style="list-style-type: none"> 10:30 Group exercise continues (BF) [45] 	
<ul style="list-style-type: none"> 11:00 Review of Findings from Survey Monkey (VT) [30] 	<ul style="list-style-type: none"> 10:40 Initial feedback on facility assessment tool (JR) [25] 11:05 Groups: Strengths, Opportunities, Available Resources within fistula care services for POP service integration 	<ul style="list-style-type: none"> 11:15 Presentation & Discussion of service protocols and post-training functions of POP/incontinence-integrated FC providers (JR/LR) [45] 	<ul style="list-style-type: none"> 11:10 BREAK [15]

Tuesday	Wednesday	Thursday	Friday
	(JR/BF) [45]		
	<ul style="list-style-type: none"> 11:40 Plenary discussion (BF) [45] 		
<ul style="list-style-type: none"> 11:30 Review of POP service experiences in FC sites [45] - panel DRC: Ken Raha Uganda: Maura Lynch Nigeria: Prof Ojengbede W. Africa: Rene Genadry Kenya: Weston Khisa -Comments from other contributors in the groups. 12:15 Scope of POP services (non-surgical – pessary, PT; surgical; co-morbidity – urinary/anal incontinence; cross-cutting fistula [closed and incontinent]; Quality of Life (LR) [45] 			11:25 Group Work – Completion of Action Plans (BF) [65]
1:00 LUNCH	12:15 LUNCH	12:00 LUNCH	12:30 LUNCH
<ul style="list-style-type: none"> 2:00 Pelvic Floor PT project in DRC. (JM or LK) [15] 	<ul style="list-style-type: none"> 1:00 Indicators for FC+ implementation (VT) [30] ‡ 2:00 Groups: Challenges, potential threats, conflict within fistula care services for POP 	<ul style="list-style-type: none"> 1:00 Preliminary feedback on protocols and training materials reviewed – additions, deletions, priorities (JR/LR) [60] <ul style="list-style-type: none"> Form Protocol & Clinical-Service Delivery WG Formation of Training WG Formation of 	<ul style="list-style-type: none"> 1:30 Presentation of plans for POP integration with FC services (BF/LR) [60] ‡

Tuesday	Wednesday	Thursday	Friday
	service integration (BF) [30]	Women's Experience WG <ul style="list-style-type: none"> 2:00 Wrap up (JR) END by 3:00pm 	
<ul style="list-style-type: none"> 2:15 Service Integration: Integration Defined, Background, and Five-Step Approach (BF) [60] ‡ 	<ul style="list-style-type: none"> 2:30 Plenary discussion (BF) [60] 	<ul style="list-style-type: none"> Pam Barnes hosted Reception 	<ul style="list-style-type: none"> 2:30 Final agreements based on integration plans and WG tasks (LR/JR) [30] ‡
<ul style="list-style-type: none"> 3:15 Wrap up (BF)[10] 	<ul style="list-style-type: none"> 3:30 Wrap up (BF) [10] 		<ul style="list-style-type: none"> 3:00 Closing remarks (LR and Mary Ellen Stanton/Erin Mielke) 3:30 Final Workshop Evaluation – electronic (BF)
C	L	O	S E

Last name	First Name	Organization
1. Mukisa	Rose	EH
2. Achwal	Isaac	EH
3. Mpunga	Michel	EH
4. Huda	Dr. Sk. Nazmul	EH
5. Isah	Adamu	EH
6. Sadauki	Habib	EH
7. Balarabe	Issoufou	EH
8. Elneil	Suzy	FIGO
9. Raha	Kenny	PANZI
10. Ojenbede	Dr. Oladosu	Nigerian Hospital
11. Adeoye	Prof Sunday	Nigerian Hospital
12. Khisa	Weston	Kenyatta Hospital
13. Idris	Saad	Nigerian Hospital
14. Anastasi	Erin	UNFPA
15. Allen	Darcy	UNFPA
16. Farrell	Betty	Consultant
17. Lynch	Maura	
18. Wegner	Mary Nell	MHTF
19. Stanton	Mary Ellen	USAID
20. Mielke	Erin	USAID
21. Genadry	Rene	University of Iowa
22. McKinney	Jessica	Physical therapist – PFPT specialist-NYC
23. Keyser	Laura	Physical therapist – PFPT specialist-NYC
24. Pett	Celia	Consultant
25. Arrowsmith	Steve	Consultant
26. Ayenachew	Fekade	Hamlin Fistula Ethiopia
27. Romanzi	Lauri	EH
28. Bellhouse	Lauren	EH
29. Tripathi	Vandana	EH
30. Ruminjo	Joseph	EH
31. Cole	Bethany	EH

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

Country/Site	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	FY 14/15					Pre-FC Total	FC Total	FC+ Total	Grand Total	
	Total	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18	
Africa Mercy																		
Benin	NS	0	110	21	20	0	0	NS	NS	NS	NS	NS	NS	NS	NS	151	NS	151
Ghana	63	0	0	0	0	0	0	NS	NS	NS	NS	NS	NS	63	0	NS	63	
Liberia	NS	59	0	0	0	0	0	NS	NS	NS	NS	NS	NS	NS	59	NS	59	
Togo	NS	0	0	97	0	0	0	NS	NS	NS	NS	NS	NS	NS	97	NS	97	
Total	63	59	110	118	20	0	0	NS	NS	NS	NS	NS	NS	63	307	NS	370	
Bangladesh																		
Ad-Din Dhaka	NS	NS	NS	34	50	53	42	15	4	8	6	4	22	NS	179	37	216	
Ad-Din Jessore	NS	NS	NS	2	1	25	48	0	16	1	0	4	21	NS	76	21	97	
Ad-Din Khulna	NS	NS	NS	NS	NS	NS	NS	NS	12	5	0	20	37	NS	0	37	37	
BSMMU	NS	NS	NS	NS	NS	NS	NS	NS	NS	2	7	9	18	NS	0	18	18	
Dr. Muttalib	NS	NS	NS	NS	NS	NS	NS	NS	NS	7	19	4	30	NS	0	30	30	
Kumudini Hospital	53	57	49	37	25	33	48	26	7	14	35	29	85	53	249	111	413	
LAMB Hospital	116	52	81	70	74	73	129	67	24	16	26	21	87	116	479	154	749	
Mamm's Institute	NS	NS	NS	NS	NS	NS	NS	NS	24	8	19	19	70	NS	0	70	70	
Memorial Christian Hospital (MCH)	63	13	1	NS	0	0	NS	NS	NS	NS	NS	NS	NS	63	14	NS	77	
Total	232	122	131	143	150	184	267	108	87	61	112	110	370	232	997	478	1707	

	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	FY 14/15 Oct 14 - Sep 15				Pre-FC Total	FC Total	FC+ Total	Grand Total	
Country/Site	Total	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18
DRC																	
HEAL Africa Hospital	268	200	214	210	163	288	264	NS	29	0	15	0	44	268	1339	44	1,651
Imagerie Des Grands-Lacs	NS	0	0	0	38	78	89	NS	0	9	15	16	40	NS	205	40	245
Maternité Esengo de Kisenso	NS	NS	NS	NS	NS	NS	27	NS	NS	NS	NS	NS	NS	NS	27	NS	27
Maternite Sans Risque Kindu	NS	NS	NS	NS	35	151	82	NS	NS	21	19	28	68	NS	268	68	336
Mutombo	NS	NS	NS	NS	104	80	119	NS	NS	NS	NS	NS	NS	NS	303	NS	303
Panzi Hospital	371	134	268	262	180	500	567	NS	0	36	31	38	105	371	1911	105	2,387
St. Joseph	NS	NS	NS	NS	45	124	208	NS	33	25	30	40	128	NS	377	128	505
DRC Bilaterals																	
Project AXxes	NS	361	442	514	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	1317	NS	1,317
PS Kabongo	NS	NS	NS	NS	NS	50	0	NS	NS	NS	NS	NS	NS	NS	50	NA	50
PS Katako Kombe	NS	NS	NS	NS	NS	87	0	NS	NS	NS	NS	NS	NS	NS	87	NA	87
PS HGR Katana	NS	NS	NS	NS	NS	NS	50	NS	NS	NS	NS	NS	NS	NS	50	NA	50
PS Kaziba	NS	NS	NS	NS	NS	152	135	60	38	NA	60	60	158	NS	287	218	505
PS Lodja	NS	NS	NS	NS	NS	82	0	NA	NS	NS	NS	NS	NS	NS	82	NS	82
PS Luiza	NS	NS	NS	NS	NS	28	0	NA	NS	NS	NS	NS	NS	NS	28	NS	28
PS Malemba Kulu	NS	NS	NS	NS	NS	60	0	NA	NS	NS	NS	NS	NS	NS	60	NS	60
PS Tshikaji	NS	NS	NS	NS	NS	49	0	NA	NS	NS	NS	NS	NS	NS	49	NS	49
PS Uvira	NS	NS	NS	NS	NS	13	37	NA	NS	NS	NS	NS	NS	NS	50	NS	50
Total	639	695	924	986	565	1742	1,578	60	100	91	170	182	543	639	6490	603	7732
Ethiopia																	
Arba Minch Hospital	NS	NS	NS	27	0	0	0	NA	NA	NA	NA	NA	NA	NS	27	NA	27

	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	FY 14/15 Oct 14 - Sep 15					Pre-FC Total	FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18
Bahir Dar Fistula Center	564	596	297	383	307	392	0	NA	NA	NA	NA	NA	NA	564	1975	NA	2,539
Mekelle Center	NS	NA	166	177	195	198	0	NA	NA	NA	NA	NA	NA	NS	736	NA	736
Total	564	596	463	587	502	590	0	NA	NA	NA	NA	NA	NA	564	2,738	NA	3,302
Guinea																	
Ignace Deen	193	63	49	20	NS	NS	0	NS	NS	NA	NA	NA	NA	193	132	NS	325
Jean Paul II	NS	36	88	126	144	185	90	NS	NS	NA	NA	NA	NA	NS	669	NS	669
Kissidougou	298	130	148	132	193	189	173	NS	NS	15	NA	NA	15	298	965	15	1278
Labe	NS	NS	31	114	122	123	132	NS	NS	5	NA	NA	5	NS	522	5	527
Mercy Ships training repairs	NS	NS	NS	NS	NS	NS	25	NS	NS	NA	NA	NA	NA	NS	25	NS	25
Total	491	229	316	392	459	497	420	NS	NS	20	NA	NA	20	491	2,313	20	2,824
Mali																	
Gao Regional Hospital	NS	NS	46	40	91	53	0	NA	NA	NA	NA	NA	NA	NS	230	NA	230
Kayes Hospital	NS	NS	NS	NS	NS	NS	70	NS	NA	NA	NA	NA	NA	NS	70	NA	70
Mopti	NS	NS	NS	NS	NS	NS	20	NS	NA	NA	NA	NA	NA	NS	20	NA	20
Sikasso	NS	NS	NS	NS	NS	NS	140	NS	NA	NA	NA	NA	NA	NS	140	NA	140
Total	NS	NS	46	40	91	53	230	NS	NA	NA	NA	NA	NA	NS	460	NA	460
Niger																	
Dosso Regional Hospital	NS	17	15	22	41	21	13	NS	NS	NS	NS	NS	NS	NS	129	NS	129
Lamorde Hospital (Niamey)	27	70	84	129	173	110	92	NS	NS	NS	NS	NS	NS	27	658	NS	685
Maradi Regional Hospital	NS	123	59	63	67	45	65	0	11	22	5	17	55	NS	422	55	477
National Maternity Center, Niamey	NS	NS	NS	NS	NS	NS	80	NS	NS	NS	NS	NS	NS	NS	80	NS	80

	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	FY 14/15 Oct 14 - Sep 15				Pre-FC Total	FC Total	FC+ Total	Grand Total	
Country/Site	Total	Total	Total	Total	Total	Total	Total	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18
National Obstetric Fistula Center, Niamey (now CNRFO)	NS	NS	NS	NS	NS	NS	NS	105	10	19	73	42	144	NS	0	249	249
Tahoua	NS	NS	NS	6	52	33	44	22	0	22	5	1	28	NS	135	50	185
Tera District Hospital	NS	3	NS	NS	0	0	0	NS	NS	NS	NS	NS	NS	NS	3	NS	3
Zinder	NS	NS	NS	NS	NS	NS	79	NS	NS	NS	NS	NS	NS	NS	79	NS	79
Total	27	213	158	220	333	209	373	127	21	63	83	60	227	27	1,506	354	1,887
Nigeria																	
National Obstetric Fistula Centre Abakaliki	NS	NS	189	330	268	277	316	71	76	75	64	68	283	NS	1,380	354	1,734
Babbar Ruga Hospital (Katsina)	356	536	331	359	330	416	359	160	89	62	99	59	309	356	2,331	469	3,156
Faridat Yakubu General Hospital (Zamfara)	180	150	187	115	114	116	126	21	0	26	12	11	49	180	808	70	1,058
General Hospital Ogoja (Cross River State)	NS	0	0	0	NS	114	50	14	NS	17	0	NA	17	NS	164	31	195
UTH Ibadan	NS	NS	NS	NS	NS	NS	37	18	NS	6	0	NA	6	NS	37	24	61
Gesse VVF Center (Kebbi)	102	122	151	207	216	215	152	55	41	21	35	43	140	102	1,063	195	1,360
Laure Fistula Center at Murtala Mohammed Specialist Hospital (Kano)	339	473	337	265	379	288	313	122	118	84	108	76	386	339	2,055	508	2,902
Maryam Abacha Women's and Children's Hospital (Sokoto)	104	156	152	200	137	138	132	93	41	32	62	48	183	104	915	276	1,295

	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	FY 14/15 Oct 14 - Sep 15					Pre-FC Total	FC Total	FC+ Total	Grand Total
Country/Site	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18							
Ningi General Hospital (Bauchi)	NS	0	0	0	63	78	74	0	35	28	8	60	131	NS	215	131	346
Other	NS	0	0	136	0	43	0	NS	NS	NS	NS	NS	NS	NS	179	NS	179
Adeoyo GH	NS	NS	NS	12	6	18	NS	NS	18	18							
Jahun VVF Center	NS	NS	NS	NS	79	79	NS	NS	79	79							
Sobi General Hospital (Kw ara State)	NS	0	0	0	0	35	21	0	10	14	16	4	44	NS	56	44	100
Total	1,081	1,437	1,347	1,612	1,507	1,720	1,580	554	410	365	416	454	1645	1,081	9,203	2199	12483
Rwanda																	
CHUK	100	36	51	126	109	4	9	NS	NS	NS	NS	NS	NS	100	335	NS	435
Kanombe Hospital	NS	NS	14	48	38	55	35	NS	NS	NS	NS	NS	NS	NS	190	NS	190
Kibogora	NS	NS	NS	NS	NS	21	0	NS	NS	NS	NS	NS	NS	NS	21	NS	21
Ruhengeri	192	47	102	85	131	34	4	NS	NS	NS	NS	NS	NS	192	403	NS	595
Total	292	83	167	259	278	114	48	NS	NS	NS	NS	NS	NS	292	949	NS	1,241
Sierra Leone																	
Aberdeen	272	363	253	166	211	244	115	NS	NS	NS	NS	NS	NS	272	1,352	NS	1,624
Total	272	363	253	166	211	244	115	NS	NS	NS	NS	NS	NS	272	1,352	NS	1,624
Tanzania																	
Vodafone/CCBRT	NS	705	169	215	205	239	828	NS	NS	1533	1,533						
Total	NS	705	169	215	205	239	828	NS	NS	1533	1,533						
Uganda																	
Hoima	NS	NS	NS	NS	NS	184	102	63	0	0	49	0	49	NS	286	112	398

	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	FY 14/15 Oct 14 - Sep 15					Pre-FC Total	FC Total	FC+ Total	Grand Total
Country/Site	Total	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18							
Kagando / Bw era	253	118	85	206	363	143	237	NS	NS	NS	NS	NS	NS	253	1152	NS	1405
Kitovu / Masaka	604	192	183	243	248	190	183	NS	73	62	0	65	200	604	1239	200	2043
Total	857	310	268	449	611	517	522	63	73	62	49	65	249	857	2,677	312	3,846
Overall Total	4,518	4,107	4,183	4,972	4,727	5,870	5,133	1,617	860	877	1,035	1,110	3,882	4,518	28,992	5,499	39,009
EngenderHealth Supported	3,954	3,150	3,278	3,871	4,225	4,759	4,911	852	653	662	770	811	2896	3327	21126	3748	28,201
FC+ Supported								852	653	642	770	811	2876			3728	
USAID Bilaterals	564	957	905	1101	502	1111	222	765	207	215	265	299	986	1,203	5,132	1187	7,522
Total USAID-Supported	4,518	4,107	4,183	4,972	4,727	5,870	5,133	1617	860	857	1035	1110	3862	4,530	26,258	4915	35,723

NA= Data not available NS= Site not supported

APPENDIX O: DRAFT BRIEF – INVENTORY AND CONTENT MAPPING

A Review of Survey Tools to Identify Fistula Cases

Vandana Tripathi, *Fistula Care Plus*

Background & Methods

In 2014, the *Fistula Care Plus* (FC+) Project convened a consultation on approaches for the measurement and estimation of the prevalence and incidence of genital fistula.⁴¹ Participants agreed on the need to compile and compare the tools that have been used to identify fistula cases in recent studies, particularly through household surveys.

FC+ conducted an inventory of tools described in published studies (technical briefs or peer-reviewed journals) and used to identify suspected fistula cases through interviews and/or surveys. Online searches of PubMed, Google, and Google Scholar were conducted using the terms genital fistula and obstetric fistula in combination with prevalence, case finding, referral, and survey. The publications identified through these searches were reviewed to determine whether a formal survey or interview tool was used to identify fistula cases and whether suspected cases were verified through clinical examination. Where the survey/interview instrument was not provided with the publication, authors were contacted to request the full tool. The characteristics of all tools and studies identified through this process were summarized using a structured spreadsheet.

For studies that conducted verification using clinical examination and reported absolute numbers of suspected and verified cases, the percent of suspected cases that were confirmed to be fistula was used as a proxy for positive predictive value (PPV). Several studies calculated sensitivity, specificity, PPV, and/or negative predictive value (NPV) in reporting the validity of fistula screening tools. However, because of wide variation in methodology, reported data, and inclusion of controls (i.e., non-fistula cases), it was not possible to directly compare these statistical attributes across tools.

Results

The search strategy resulted in the identification of 13 tools to identify fistula cases through surveys and interviews. Copies were secured of 11 of these tools, which were all questionnaires or scripts to be administered by survey research assistants or interviewers. Table 1 summarizes key characteristics of these tools.

Regional distribution: While most programs to identify and treat obstetric fistula are currently located in sub-Saharan Africa, studies using surveys or interviews to identify fistula were equally

⁴¹ *Fistula Care Plus* and Maternal Health Task Force. 2014. *Fistula Care Plus: Report of Technical Consultation on Fistula Measurement and Estimation, July 10-11, 2014*. New York: EngenderHealth/*Fistula Care Plus*.

divided between South Asia and sub-Saharan Africa. Of the five studies reporting on the validation of screening tools, three were in South Asia and two were in sub-Saharan Africa.

Data collectors: There was notable variation in the data collection approach applied in the included studies. Several studies used existing cadres of local health workers (e.g., Lady Health Workers in Pakistan, Health Extension Workers in Ethiopia) while others hired data collectors specifically for the study. Training of data collectors ranged from 1 to 4 days, where reported. Several studies did not report who administered the survey or interview tools.

Content areas: Tools varied widely in length and content, from a single question about leakage of urine and/or feces to dozens of questions about fistula symptoms, pregnancy and morbidity history, quality of life (QoL)/interference with activities of daily living (ADL), care-seeking, and treatment. Some tools were stand-alone assessments of fistula, whereas others asked about fistula within comprehensive maternal morbidity assessments. One tool was an assessment of all surgical need. All tools addressed obstetric fistula, but questions regarding other types of genital fistula were not uniformly included. Of the 11 tools whose full content could be reviewed, five included a question to assess whether fistula was iatrogenic, and three to assess for traumatic fistula. Similarly, other urogynecological needs were not consistently included. Four tools included questions to identify other types of incontinence (i.e., stress or urge) and three included questions to identify pelvic organ prolapse (POP).

Fistula symptoms: Core symptom questions are provided in Table 2. Almost all tools asked a question about **continuous** or **constant** leakage of urine or feces from the vagina or birth canal. Some tools separated questions about urinary and fecal incontinence, while most combined these into one question. A few tools referred to leakage that “you cannot control” or specified the leakage as occurring “day and night.” Several tools asked additional questions, particularly about the timing of leakage. One tool asked about clothes becoming wet with urine while the woman is asleep, presumably to ascertain the presence of a small, high fistula that would only result in leakage after a period of time spent lying down.

Validation: The results of validation through clinical examination of suspected cases were reported for only five tools. The percent of suspected cases that were clinically confirmed to be fistula ranged from 4% to 100%. For three of the five tools, this percentage was between 37% and 47%.

Job aids: Four job aids or program tools to identify fistula cases were also identified through outreach to peer organizations. Three of these were created by the FC+ project or its predecessor, the Fistula Care Project, and one is used by Maternity Africa. A separate mapping exercise is required to generate a more comprehensive inventory of program tools.

Discussion

The content inventory shows that a wide variety of tools has been used to screen for fistula cases through surveys and interviews. Some tools have evaluated fistula only, while others have

examined maternal morbidity or surgical need more broadly. Some tools focus exclusively on obstetric fistula while others attempt to identify traumatic or iatrogenic fistula.

Despite this variation, the actual question(s) probing for symptoms of fistula have been fairly similar across tools. Therefore, it is likely that the variation across studies in percent of suspected cases confirmed as fistula results from other aspects of study design. One possibility is that there is a data collector effect. For instance, Jokhio et al. reported that all 24 cases suspected to be fistula based on symptom reports were confirmed through clinical examination.⁴² This study, in Pakistan, relied on Lady Health Workers, who are well known to women in the community and may be better able to discuss “private” issues such as incontinence symptoms. However, Ballard et al. also relied on existing health worker cadres – Health Extension Workers – yet found that only 37% of suspected cases were in fact fistula.⁴³

Another factor that may account for the variation in PPV is language. Based on study descriptions, it appears that in all cases but a study in Afghanistan, tools were designed in English and translated into local languages. Therefore, the ability to provide locally appropriate translation may be especially relevant to the predictive value of screening tools; however, the need to translate may also introduce inconsistency, making it difficult to extrapolate about validity from one study or setting to another. For instance, Tunçalp et al. found that community education messages about fistula had very different local language equivalents in two states in Nigeria.⁴⁴ Such inconsistency or unpredictability may also limit the validity of estimates of prevalence made using the “correction factor” or PPV calculated from any individual study.

While acknowledging this concern, it is notable that three of the five studies reporting the results of clinical validation found that 37-47% of suspected cases were confirmed to be fistula. This is a relatively narrow range and may provide a “best guess” for the PPV of interview-based identification of fistula cases. However, there are dramatic differences in sampling in each study, and evaluation of the raw data from each study would be required to make a more confident inference about PPV. Additionally, the number of suspected and confirmed fistula cases in any one study is generally small; therefore, estimates of PPV are likely to lack statistical precision.

It is also important to note that only one study, in Nepal, described using controls in validation, i.e., conducting clinical examinations of women who not screen positive for fistula based on an interview/survey tool, to verify that they did not have fistula.⁴⁵ The absence of controls in other studies is understandable. Given the nature of fistula symptoms, there is generally more concern about false positives than false negatives in interview-based screening. Additionally the invasive and uncomfortable nature of clinical examination for fistula makes it ethically difficult for

⁴² Jokhio AH, Rizvi RM, Rizvi J, MacArthur C. Prevalence of obstetric fistula: a population-based study in rural Pakistan. *BJOG*. 2014 Jul;121(8):1039-46. doi:10.1111/1471-0528.12739.

⁴³ Ballard K. Personal correspondence.

⁴⁴ Tunçalp Ö, Isah A, Landry E, Stanton CK. Community-based screening for obstetric fistula in Nigeria: a novel approach. *BMC Pregnancy and Childbirth*. 2014;14:44. doi:10.1186/1471-2393-14-44.

⁴⁵ Chen CCG, Barry D, Khatry SK, Klasen E, Singh M, LeClerq SC, Katz J, Tielsch JM, Mullany LC. Validation of a Community-Based Obstetric Fistula Screening Questionnaire in Rural Nepal. Presented at 2014 Joint Annual Meeting of the American Urogynecological Society and International Urogynecological Association.

researchers to ask women with no urogynecological symptoms to undergo the procedure. However, the absence of controls in most studies introduces the risk of verification bias, possibly resulting in distorted parameters of validity.

Conclusion

There is a wide variation in the tools currently used to screen for fistula, and in their apparent ability to correctly identify women who have fistula. Given the large cost of household surveys, it is recommended that efforts to estimate fistula prevalence through surveys be nested within more comprehensive assessment of maternal morbidity and/or urogynecological need. It is also recommended that such efforts include clinical verification of suspected fistula cases in at least a subset of the survey sample, in order to expand the evidence regarding validity of screening tools. Ultimately, it is necessary for researchers to move toward the use of a standard, validated set of questions for there to be greater confidence in survey-based estimates of the fistula burden and greater comparability of findings across settings.

Acknowledgements: Emma Reidy provided assistance in the search for resources and summary of article characteristics.

Table 1: Survey/interview tools used in studies to estimate prevalence of obstetric fistula

Author/org	Publication year	Country	Description of questions	% cases confirmed at exam	Data collectors (training)	Intra-genic fistula	Traumatic fistula	Other incontinence	Prolapse
Ballard K et al.	In press	Ethiopia	- 16 questions, including age (1), pregnancy history (2), prolapse (1), and fistula (12) - Fistula questions include awareness (1), symptoms (1), causal events (5), care-seeking (5) - Adapts from DHS module	37%	Health Extension Workers (1-day training)	+	+		+
Chen G et al.	2014	Nepal	- 19 questions, including pregnancy history (4), fistula symptoms (9), prolapse (1), other incontinence (2), diagnoses received (2), surgery history (1) - 6 additional questions for observer/interviewer on signs of incontinence	4%	Female interviewers hired for study			+	+
DHS Program	2010	>20 countries	- 11 questions on awareness of fistula, incontinence symptoms, causal events, care-seeking, treatment results	N/A	Varies by survey	+	+		
Institute of Medicine/Tribhuvan University	2006	Nepal	- 1 question about fistula in comprehensive survey of maternal morbidity: "Do you ever suffer from the any of the following symptoms? 1. Continuous passing urine from Vagina; 2. Continuous/intermittent passing of stool from vagina; 3. Foul smell from vagina"	N/A	Staff nurses, Auxiliary Nurse-Midwives, Health Assistants (2-day training)				+
Jokhio et al.	2014	Pakistan	- 38 questions, including demographic (13), pregnancy/medical history (4), incontinence symptoms/history (16), effect on ADL/QoL (2), care seeking (2)	100%	Lady Health Workers	+		+	
Kalilani-Phiri LV et al. ²	2010	Malawi	N/A	N/A	Not reported	N/A	N/A	N/A	N/A

LSHTM/ AMANHI Study	In press	Bangladesh DR Congo Ghana India Kenya Pakistan Tanzania Zambia	- 2 fistula questions within comprehensive questionnaire about maternal morbidity; questions asked at baseline (2) and prenatal/postnatal (4) time points - Questions: "Since my last visit, have you experienced continuous dripping urine that you cannot control?" and "Since my last visit, have you experienced faeces passing through the vagina, birth canal?" - Questionnaire includes other questions about stress or urge incontinence - Also calls for ascertainment of fistula diagnosis in birth attendant interview	N/A	Hired for study			+	
Muleta M et al.	2007	Ethiopia	- 43 questions for women with fistula (WwF), including pregnancy/medical history, incontinence symptoms, QoL, care-seeking - WwF to be identified with household screening questions: "Ask if there is someone in the household who is or had been leaking urine and or feces continuously day and night; in bed and or while walking without any activity increasing intra-abdominal pressure (such as straining, coughing, carrying heavy load) irrespective of previous treatment history and results (whether she had treatment in the past or not, whether she is cured at the moment or not); and ask if she is willing to be interviewed. Explain that, the project covers transportation cost (for her and one other person accompanying her) to and from the institution where she can receive quality care/treatment free of charge." - Numerous questions about prolapse within questionnaire	N/A	Hired for study			+	
DLHS-3	2011	India	- 5 questions about incontinence symptoms and causal event - Questions represent half of DHS module	N/A	Not reported	+	+		

Patel HD et al./Surgeons Overseas Assessment of Surgical Need	2014	Sierra Leone	- 1 question with comprehensive assessment of morbidity: "Have you ever had a wound, burn, mass, deformity, leaking of urine or feces, bleeding from your bottom, bleeding from your penis, or an operation on your groin, genitalia or buttocks?" Yes to be followed by choices, including "leaking of urine or feces (like fistula)"	N/A	Local medical and nursing students				
Social and Health Development Program ²	2011	Afghanistan	N/A	41%	Hired for study (4-day training)	N/A	N/A	N/A	N/A
Stanton C et al.	2007	N/A	- 9 questions on pregnancy history, incontinence symptoms, care-seeking - Questions asked using sisterhood method (i.e., about living & deceased sisters, vs. directly about respondent)	N/A	N/A				
Tuncalp O et al.	2014	Nigeria	- 41 questions, including fistula symptoms, causal history, care-seeking (18) - 3 questions from DHS module were used to assess validity - questionnaire applied only to women with perceived fistula symptoms responding to community messaging	47%	Research assistants hired for study (3-day training)	+			

¹Only reported for studies that included: 1) verification of suspected fistula cases with clinical examination **and** 2) reporting of numeric results (i.e., number of suspected cases and number of confirmed cases)

²These two tools could not be located through online searches and inquires to the authors

Table 2: Wording of question(s) about fistula symptoms

Author/org	Fistula symptoms question(s)
Ballard K et al.	<ul style="list-style-type: none"> • Have you ever experienced a fistula, with constant leakage of urine or stool from your vagina during the day and night?
Chen G et al.	<ul style="list-style-type: none"> • Do you currently or have you ever experienced continuously dripping urine? • Currently, does your clothing get wet with your urine during sleep? • When you are not urinating, do you currently experience continuously dripping urine through the birth canal that you cannot stop? • Do you currently experience continuously dripping urine through the birth canal that you cannot stop all day and all night? • Do you currently or have you ever experienced feces passing through the birth canal? • When you are not defecating, do you currently experience feces passing through the birth canal that you cannot stop? • Do you have problems with leakage of stool (accidents or soiling because of the inability to control the passage of stool until you reached a toilet)? • When you are not defecating, do you usually experience leakage of stool from the anus that you cannot stop?
DHS Program	<ul style="list-style-type: none"> • Have you ever experienced a constant leakage of urine or stool from your vagina during the day and night?

Institute of Medicine/Tribhuvan University	<ul style="list-style-type: none"> Do you ever suffer from the any of the following symptoms?(1. Continuous passing urine from vagina; 2. Continuous/intermittent passing of stool from vagina; 3. Foul smell from vagina)
Jokhio et al.	<ul style="list-style-type: none"> Do you leak urine at all? (Yes/No) How often do you leak urine? (1. About once a week or less often; 2. Two or three times a week; 3) about once a day; 4) Two or three times a day; 5. Several times a day; 6. All the time) How much urine do you usually leak? (1. A small amount (That is in drops); 2. A moderate amount; 3. A large amount) When does urine leak? (1. Leaks before you can get to toilet; 2. Leaks when you cough laugh or sneeze; 3. Leaks when you run, jump, play or exercising, straining or heavy work; 4. Leaks when you are asleep; 5. Leaks when you have finished urinating and are dressed; 6. Leaks continuously all the time)
Kalilani-Phiri LV et al.	N/A
LSHTM/ AMANHI Study	<ul style="list-style-type: none"> Since my last visit, have you experienced continuous dripping urine that you cannot control? Since my last visit, have you experienced faeces passing through the vagina, birth canal?
Muleta M et al.	<ul style="list-style-type: none"> Is there someone in the household who is or had been leaking urine and or feces continuously day and night; in bed and or while walking without any activity increasing intra-abdominal pressure (such as straining, coughing, carrying heavy load) irrespective of previous treatment history and results (whether she had treatment in the past or not, whether she is cured at the moment or not). What type of incontinence do you have now? (1. I can control feces but not urine; 2. I can control feces but not urine and flatus; 3. I can control urine but not feces; 4. I can control feces and urine but not flatus; 5. I can't control both feces and urine) How often do you leak urine? (1. I am leaking, all the time; 2. I am leaking while coughing and sneezing; 3. I am leaking the moment I got out of bed; 4. I am not leaking urine) How often do you leak feces (1. I am leaking, all the time; 2. I am leaking while coughing and sneezing; 3. I am leaking the moment I got out of bed; 4. I am not leaking feces; 5. I am leaking feces when I have diarrhea) How often do you leak both urine and feces (1. I am leaking, all the time; 2. I am leaking while coughing and sneezing; 3. I am leaking the moment I got out of bed; 4. I am not leaking both /leaking only one of them)
NDLHS-3	<ul style="list-style-type: none"> Have you ever experienced a constant leakage of urine or stool from your vagina during the day and night, i.e. continually wet?
Patel HD et al./Surgeons Overseas Assessment of Surgical Need	<ul style="list-style-type: none"> Have you ever had a wound, burn, mass, deformity, leaking of urine or feces, bleeding from your bottom, bleeding from your penis, or an operation on your groin, genitalia or buttocks?" Yes to be followed by choices, including "leaking of urine or feces (like fistula)"
Social and Health Development Program	N/A
Stanton C et al.	<ul style="list-style-type: none"> Sometimes women experience very difficult and long labor before childbirth. This long labor can injure some women and leave them unable to control their urine and/or feces. These women leak urine/feces constantly. Does your sister have this condition now? That is, does she leak urine/feces constantly without being able to control it?
Tuncalp O et al.	<ul style="list-style-type: none"> Have you ever experienced a constant leakage of urine or stool from your vagina during the day and night?

APPENDIX P: FC+ WEBSITE AND MEDIA STRATEGIES

During FY14/15, Fistula Care *Plus* implemented an updated online strategy aiming to best present these resources in the most user friendly, inviting manner to a range of visitors while working to increase overall website traffic. To determine the strategy of the FC+ website, we first sought to address two key questions: 1.) *Who is our target audience* and 2.) *What are we hoping to provide them?* Unlike many program or NGO websites, we are not currently asking our visitors for an “action” such as an email list or pitch for donations. Instead, the Fistula Care *Plus* website acts as a clearinghouse for Fistula Care/FC+ resources and related information. Our target audience was identified as those who are interested in, or working on, issues related to maternal morbidities, fistula, maternal and newborn health, or in the countries we have a presence. Many visitors are anticipated to have backgrounds in the topic area who are looking for technical resources, while others may be members of the general public brought to the website through social media or organic web searches. The current site has all the elements of an ideal informational resource, as we have available resources for all levels of knowledge about the prevention and treatment of obstetric fistula.

A series of updates were implemented to enhance the project’s online presence. These include:

- **Recent news and publications:** Located on the FC+ website homepage, the recent news and publications box is updated twice weekly with links to FC+ related events, recent publications, and news articles featuring our work.
- **Twitter:** A new addition, the FC+ twitter account has helped to draw visitors to the FC+ website and recent publications. Relatively easy to establish and maintain, Twitter has allowed us an additional platform for communication with a wider group of people outside those who regularly visit the website. Tweets have been related to FC+ activities, updates in other partner or USAID-funded programs, new research and publications, and recent news and updates within the global MNCH community. When our messages are re-tweeted by other organizations (such as UNFPA, MHTF, EngenderHealth), it also provides a means for their followers who may not yet be familiar with FC+ to access our account and, subsequently, our website for more information. The Twitter account was launched on April 21, 2015 to announce the release of the RCT results in the Lancet. Following this, it has been a strong platform to communicate events for 23 May, participate in partner-sponsored Twitter chats, and to provide updates from conferences such as FIGO, WAHO, and GMNHC.
- **Blog:** The blog provides an identifiable voice from the FC+ team. During year two, there have been 23 blog posts, averaging at 2 per month. A blog post request form is sent quarterly along with viewer metrics to FC+ global and field staff in order to determine interest in blog topics and authorship. Authors have now been enabled on the blog, and each post is accompanied by the author’s name that is linked to a bio and past posts.
- **Resources and Publications:** This section is currently being updated with resources, publications, and presentations from 2014-2015. Where possible, publications will be accompanied by cover pages to be more identifiable and a less text-heavy resource library.
- **Metrics:** Monthly and quarterly metrics for both the website and twitter account are compiled and shared with the global team. This allows staff to identify activities/events that have been particularly successful with the online community, as well as areas for growth.

APPENDIX Q: GENDER EQUALITY STRATEGY AND PLAN OF ACTION FOR FC+

Addressing obstetric fistula is, by its very nature, a strategy to address gender inequality. Obstetric fistula derives from a lack of attention and resources to the basic and emergency needs of girls and women from their earliest days – poor nutrition, inequities in educational opportunities, early marriage, poor maternal health services, including access to emergency obstetric care, poor post-delivery care. In conflict areas, in addition to these challenges, women also experience sexual and gender-based violence (SGBV) that can result in traumatic genital fistula. These are the root causes of the gender inequity that leads to fistula. The international field of obstetric fistula has organized its work around addressing a continuum of care: prevention, treatment and reintegration and the *Fistula Care Plus* (FC+) project is engaged in all these activities.

Under the previous project, the majority of effort was spent establishing or strengthening existing treatment services, and increasing awareness at the policy, community and individual levels of the causes of fistula and addressing myths and misunderstandings. Gender was integrated into specific activities. For example, *Counseling the Obstetric Fistula Client: A Training Curriculum* and its accompanying *Counseling the Traumatic Fistula Client: A supplement to the Obstetric Fistula Counseling Curriculum* were both developed through a gender lens.

Under the FC+ project, two countries (Niger and Nigeria) have included plans to address early marriage in their workplans. In Nigeria, at the request of the USAID Mission, and with assistance from a consultant on gender, the project developed an algorithm for addressing the psychosocial and health needs of the girls abducted from Chibok and have also developed a tracking tool to document the support provided to women who experience SGBV.

The FC+ strategy for the immediate future consists of the following five elements:

- To educate EngenderHealth staff and partners on gender equality and how to integrate it into programming for obstetric fistula. This will begin with workplanning workshops in 2015 at which a gender specialist will conduct training and explore how gender can be integrated effectively into proposed workplans. EngenderHealth has new staff at the field level in Nigeria, Uganda, Niger and the D.R. Congo for whom this would be beneficial. (A gender 101 training has already taken place in Bangladesh.)
- FC+ partner TERREWODE, is a Ugandan NGO working to support community engagement on gender issues and the reintegration of women with fistula. They have received a subaward to enhance community understanding and practices to prevent fistula, improve access to treatment, reduce stigma and support reintegration of women and girls with fistula, including those whose fistula is deemed incurable and those whose

fistula is the result of sexual violence. Ultimately, our goal is that this Ugandan NGO will provide south-to-south support for these issues.

- Continued support to the Nigeria and D.R. Congo programs for work addressing the needs of women who have experienced SGBV.
- Support for the Niger and Nigeria programs in collaboration on addressing the issues of early marriage.
- A focus on moving from straightforward community engagement activities to gender transformative activities as described in Figure 1 below.

Figure 1: Framework for Design, Monitoring, and Evaluation of Community Engagement Approaches

	COMMUNITY ENGAGEMENT PROCESS & ACTIVITIES	OUTPUTS	OUTCOMES	IMPACT
	Are we engaging communities in addressing SRH issues of concern?	Are we enhancing community capacities and building community assets?	Are we influencing intentions and behaviors related to SRH among the population in general?	Are there measurable improvements in SRH outcomes?
COMMUNITY ENGAGEMENT	<ul style="list-style-type: none"> • Communities (including representatives of most affected and/or marginalized groups) are involved in the process of: <ul style="list-style-type: none"> ○ Defining priorities ○ Identifying solutions ○ Developing and implementing action plans ○ Monitoring and evaluating results • The problem exploration and action planning process is sustained over time. 	<ul style="list-style-type: none"> • Capacities are developed—i.e., there are measurable changes in knowledge and skills among community partners: <ul style="list-style-type: none"> ○ Knowledge about the issue ○ Analytic and problem-solving skills ○ Leadership skills ○ Decision-making and planning skills ○ Communication and conflict negotiation skills ○ Resource identification and mobilization skills • Social capital is developed—i.e., community networks and support systems are created or strengthened to improve health outcomes. 	<ul style="list-style-type: none"> • Changes in knowledge of, awareness about, and attitudes toward SRH intentions and behaviors. • Changes in care-seeking (preventive and curative services). • Changes in access to or use of existing or new community resources. 	<p>Changes in the incidence of SRH problems—among the general population, as well as among marginalized, vulnerable, and affected groups.</p>
GENDER-TRANSFORMATIVE COMMUNITY ENGAGEMENT	<ul style="list-style-type: none"> • Gender analysis informs the identification of key community partners and stakeholders. • The community engagement approach and process takes gender into account in order to support and ensure participation of affected and/or marginalized groups. • A problem exploration process guides community participants in exploring imbalances in power and the influence of gender norms. • Community-defined vision/priorities reflect commitment to change identified gender norms and power imbalances that contribute to poor health. • In developing, implementing, and evaluating community action plans, community partners take on roles that diverge from traditional gender norms. 	<ul style="list-style-type: none"> • Social capital created among community partners (i.e. increased awareness, knowledge, skills, and capacities) falls outside traditional gender domains and norms. • Marginalized or disadvantaged groups increase their participation and take on increased decision-making and leadership roles. • Community support systems and services are developed or modified to better meet, serve, or benefit disadvantaged groups and enhance their access and participation. 	<ul style="list-style-type: none"> • Changes in gender roles and norms and perceptions of rights related to women's and men's health and health behaviors. • Reduced vulnerabilities (e.g., lack of decision-making power over health, lack of participation/ expression, discrimination, etc.) among marginalized and affected groups—both women and men. • Increased access to new or existing community resources among marginalized and vulnerable groups. 	

APPENDIX R: POPULATION COUNCIL: BARRIERS TO OBSTETRIC FISTULA TREATMENT IN DEVELOPING COUNTRIES: A SYSTEMATIC REVIEW

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Abstract:

Background: Obstetric fistula is a hole that develops between the vagina and bladder and/or rectum due to prolonged obstructed labor, and results in urinary and/or fecal incontinence.

Despite its near eradication in the developed world due to the availability of timely cesarean section when labor is prolonged, obstetric fistula persists in many developing countries across Africa and Asia. Although fistula is often treatable, an estimated 2 to 4 million women currently live with untreated fistulas worldwide. Women suffering from fistula in developing countries face several barriers which prevent them from receiving timely treatment, and many live with the condition for years.

Aim: The aim of this systematic review is to identify the barriers that women living with fistula in developing countries face, which prevent them from deciding to seek care, prevent them identifying and reaching medical centers, and/or prevent them from receiving adequate and appropriate care.

Methods: Bibliographic databases, grey literature, journals, and network and organization websites were searched in English and French from June-July 2014 using key search terms and specific inclusion and exclusion criteria. Experts provided recommendations for additional articles to be included in the review. Articles were reviewed for discussion of barriers to fistula treatment. Once articles discussing fistula and barriers to treatment were identified, they were sorted into 5 categories based on the extent to which barriers to treatment were discussed. Articles concerning interventions targeting barriers to fistula care were analyzed further.

Results: Out of the 3,972 articles screened, 110 were included in the review. Nine barriers to treatment were identified from these articles, including: psychosocial; cultural; awareness; social; financial; transportation; facility shortages; quality of care; and political barriers. The 110 articles were sorted into 5 categories based on their discussion of treatment barriers, and included: barriers as primary study focus (2); article identifies factors that researchers perceived as barriers (39); article briefly mentions barriers (29); barriers mentioned in a needs assessment, review, or annual report (28); interventions to treatment barriers (12). Interventions primarily focused on facility shortages, transportation, and awareness, and outcome data covered only short time periods; the success of interventions in providing long-term alleviation of barriers is unclear.

Conclusions: Results from the review indicate that while barriers to fistula treatment may be easily identified, their alleviation is difficult and requires sustainable interventions that target several barriers. Additionally, there is a lack of scientific studies with regards to fistula, including a lack of prevalence studies, and a lack of studies focusing on barriers to fistula treatment. The results presented in this review identify current research gaps that must be addressed, and information that can be utilized to plan and implement future interventions to improve access to fistula treatment in the developing world.

Executive Summary

Background

Obstetric fistula is a maternal morbidity that persists in some low-income countries despite its near eradication elsewhere decades ago. Fistulas occur due to prolonged pressure during obstructed labor that damages the tissue between the vagina and bladder and/or rectum. The dead tissue leaves women incontinent, trickling urine and/or feces through the vagina. Prolonged obstructed labor is a condition rooted in populations with high levels of poverty and weak health systems, as it predominantly affects marginalized women who lack access to high quality obstetric care. In such settings, unrepaired fistula can lead to lifelong ostracism, stigma, and shame.

UNFPA (2011) estimates that there are between 2-4 million women currently living with fistula worldwide; with at least 50,000 to 100,000 women who develop fistula every year. Determining the number of women with fistula worldwide is difficult, however, as many of these women are marginalized from society with little economic, social, or political power. A recent systematic review found a pooled prevalence of 0.29 cases of fistula per 1,000 women of reproductive age and a pooled incidence of 0.09 new cases of fistula per 1,000 recently pregnant women each year, which suggests no more than one million women with fistula globally (Adler et al. 2013). The true number of women living with fistula may actually be higher, as untreated patients who never reach a medical facility may go uncounted by researchers.

Fistula is both preventable and treatable in most cases, and in recent years various initiatives have been established to both prevent and repair fistula. However, women experience delays in seeking repair due to a number of factors. They may initially be unaware that their problem is medical, or that repair is possible. If they are aware of treatment options, women may lack the resources needed in order to seek care. Even if financial and transportation barriers to care are overcome, women may face delays in receiving the appropriate care once at the facility, due to a lack of skilled fistula surgeons in developing countries, and long hospital wait times (Mukisa & Cole, 2013; Chong, 2004; Bangser, 2011; Fiander et al., 2011; Matsamura, 2004).

This research aims to identify and understand the barriers affecting women's access to fistula repair, in order to inform the design of possible interventions that may be effective in addressing these barriers. This work may also identify research gaps surrounding fistula in developing countries that require targeted formative research before interventions can be designed. To identify the strategies and intervention possibilities that can best improve the uptake of fistula repair services, a systematic review of the literature was undertaken.

Methods

A three-stage search protocol was developed using key terms to identify papers. At the first stage, titles and abstracts identified from bibliographic database and grey literature searches were screened using explicit inclusion and exclusion criteria. At the second stage, full articles included from the first phase were reviewed in parallel by two raters with any discrepancies then discussed and agreement reached on how to standardize extracted data. The third stage included a qualitative review of references in key articles, expert inquiry and data extraction from relevant sources. Papers that met the inclusion criteria included interviews, case studies, assessments, or reports, and were required to discuss at least one of the three phases of delays in seeking care, or an intervention that aimed to reduce the prevalence or incidence of fistula.

Search Results

A total of 3,921 articles were identified in the electronic database search. Thirty were added from a review of the grey literature and 21 from the expanded search. A total of 110 studies were included in the systematic review.

Review Results

The 110 articles were further categorized into nine types of barriers—psychosocial, cultural, awareness, social, financial, transportation, facility shortages, and quality of care—that fit into Thaddeus and Maine's (1994) Three Delay model. The articles can be further broken down into five types: articles that have barriers to treatment as their primary focus; articles that identify factors that we perceive as barriers; articles that briefly mention barriers; reviews, needs assessments, or annual reports; and articles that focus on interventions that aim to alleviate barriers to treatment. Interventions were analyzed in further detail to ascertain which barriers they appear to target and whether they did so effectively in the study time period.

Discussion

From those articles included in the review, it is consistently seen that obstetric fistula is directly linked to poverty, income inequality, gender disparities, discrimination, and poor education. The review found that previous interventions might have been able to achieve increased access to fistula treatment by removing the barriers that prevent one or more of the three delays in seeking maternal healthcare. For example, community-based models to identify women who are disempowered and stigmatized can address the first barrier of limited awareness and knowledge. Transport and healthcare financing models that successfully refer women with fistula from the community to a surgical center are critical to overcome the second barrier that prevents women from being able to reach a medical facility. Provider empathy and respectful care, strong surgical skills, and high priority registration at facility ensure that the third delay, receiving appropriate care at the facility, is reduced for women who seek fistula repair services. However, there remains a lack of meaningful evaluations and sound study designs regarding previous intervention studies, and it is therefore not possible to determine the true effect of interventions on treating women with fistula and removing the barriers to care.

Conclusions

Results from the review indicate that while barriers to fistula treatment may be easily identified, their alleviation is difficult and requires sustainable interventions that may target several barriers. Additionally, there is a lack of scientific studies with regards to fistula, including a lack of prevalence studies, and a lack of studies focusing on barriers to fistula treatment. The results presented in this review identify current research gaps that must be addressed, and information that can be utilized to plan and implement future interventions to improve access to fistula treatment in the developing world.

APPENDIX S: SURVEY OF FC+ SUPPORTED SITES: POP DEMAND, SERVICES, AND INTEREST

**Survey of FC+ Supported Sites:
POP Demand, services, & interest**

Vandana Tripathi | FC+ Workshop on Integration



The slide features three logos at the bottom: USAID (From the American People), Fistula Care Plus (a purple circular logo), and EngenderHealth (a yellow flower logo with the tagline 'for a better life').

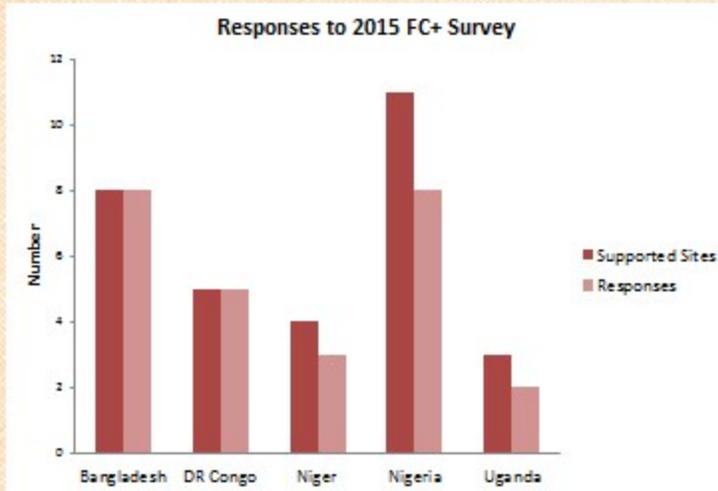
FC+ internal surveys

- FC+ uses Survey Monkey to periodically survey supported sites
- 2015 survey topics:
 - Fistula backlog – volume & processes
 - POP services – demand, capacity, & current practices



2015 FC+ survey responses

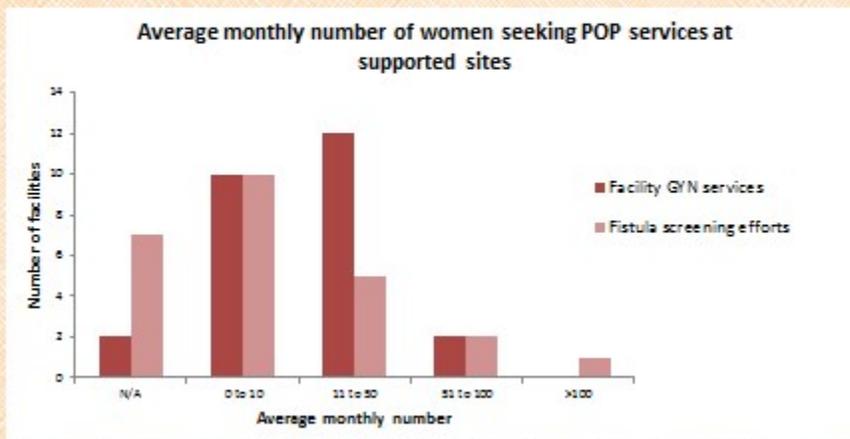
- 26 out of 31 facilities (84%) responded



Fistula Care Plus

Current POP service demand

- 24 facilities (92%) report a need for POP services



Fistula Care Plus

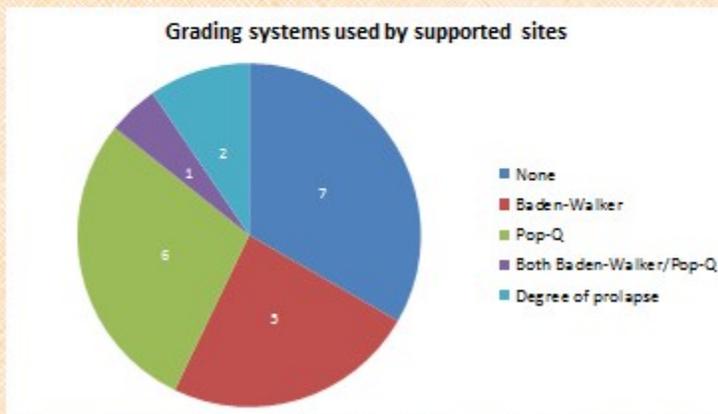
Current POP service capacity

- 22 facilities (85%) provide POP treatment services
 - Of 4 who do not, 3 report need
- 15 facilities (58%) report that need for POP services is not met or only partially met.
- 19 facilities (73%) report that they do not refer out for POP services
 - Those that refer send patients to facilities up to 320kms away
- Suggests significant unmet need for POP services



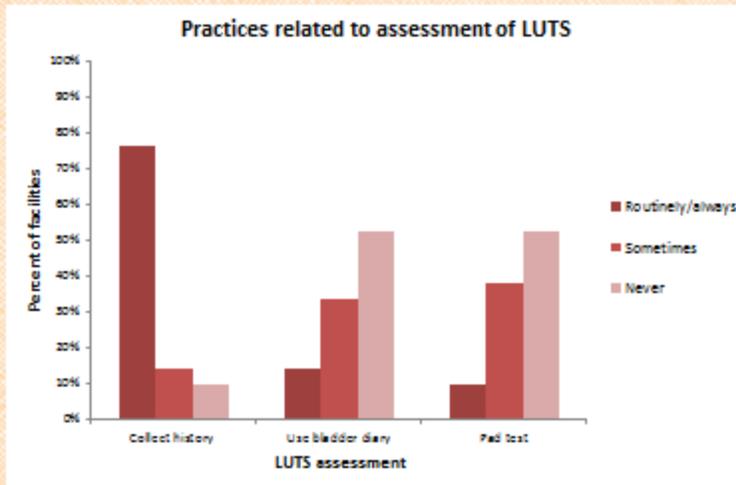
POP assessment & grading

- 15 facilities (71% of those with POP services) perform compartment-based assessment
- Varying practices in grading POP cases



Assessment of lower urinary tract symptoms (LUTS) in POP patients

- Facilities tend to rely on history-taking; less use of bladder diary or pad test.



Bladder function testing capacity & practices

- 9 facilities (43%) have both skills and materials for simple cystometrics.
 - 5 regularly use for testing of LUTS, 4 for urinary incontinence, 1 for voiding dysfunction
- No facilities have both skills and materials for multichannel urodynamics.
 - Only 1 has skills
- Most facilities (75%) use full bladder/reduction of POP/cough test to assess for stress urinary incontinence (SUI) among POP patients.
 - 4 use simple cystometrics.

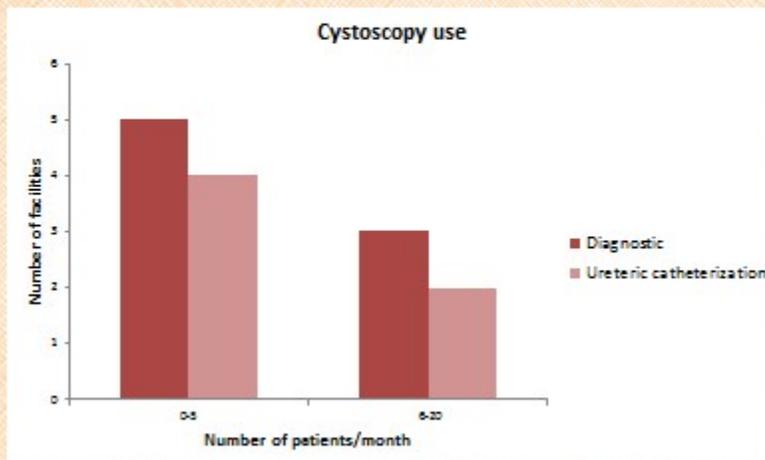
POP physical therapy & pessary management

- 11 (50%) facilities provide physical therapy (PT) instructions to patients.
 - Only 6 (27%) report that all/most POP patients receiving PT instruction return for evaluation
- Only 7 (<33%) facilities provide pessary management of POP.
 - Most report providing 1-5 patients with pessaries per month.
 - Only 3 report very reliable pessary procurement.
 - All use simple ring pessaries.



Cystoscopy

- 8 (36%) facilities have access to cystoscopy



Surgical POP management: Vaginal surgery

	Procedure	Facility conducts procedure? (n=19)	
		Yes	No
Apex	Uterosacral cuff or vault suspension	7	12
	Uterosacral hysteropexy	8	11
	Sacrospinous vault or uterine suspension	10	9
	Enterocele repair	14	5
	Other	3	16
Anterior	Anterior colporrhaphy cystocele repair	18	1
	Vaginal paravaginal cystocele repair	13	6
	Other	1	18
Posterior	Levatorplasty rectocele repair	9	11
	Site-specific rectocele repair	14	6
	Perineorrhaphy	19	1
	Perineoplasty	12	8
	Other	1	19



Surgical POP management: Abdominal surgery

	Procedure	Facility conducts procedure? (n=20)	
		Yes	No
Apex	Uterosacral vault suspension	9	11
	Uterosacral hysteropexy	6	14
	Sacro-colpopexy	8	12
	Sacro-hysteropexy	5	15
	Other	2	18
Anterior	Paravaginal repair cystocele	7	13
	Other	1	19



Surgical POP management: Surgery for concomitant urinary incontinence

	Procedure	Facility conducts procedure? (n=20)*	
		Yes	No
Vaginal	Urethropexy (Kelly Plication)	11	9
	Other (please describe below)	3	17
Abdominal	Urethropexy (Burch Procedure)	4	16
	Other	0	20
Combined	Rectus fascia autologous sling	3	17
	Fascia lata autologous sling	1	18
	Other	2	18

For fascia lata autologous sling n= 19

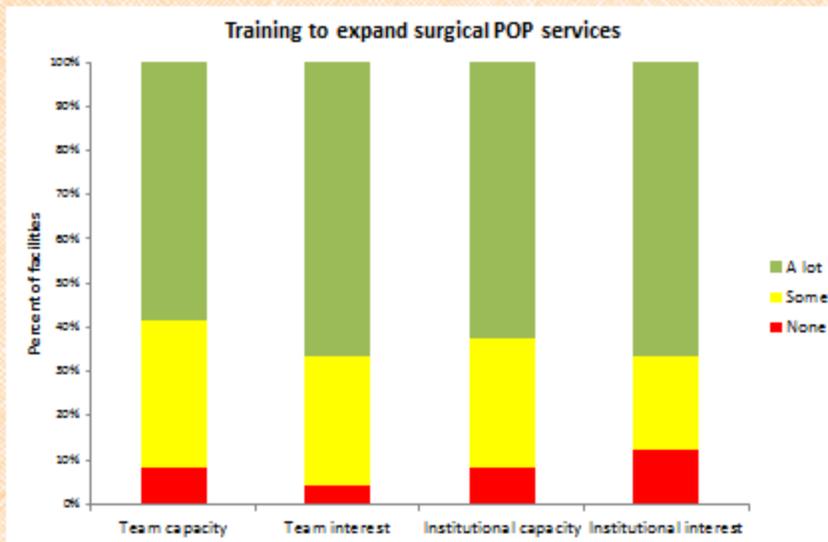


Surgical POP management: Surgery for concomitant rectal incontinence

	Procedure	Facility conducts procedure? (n=20)	
		Yes	No
Vaginal	Anal sphincteroplasty	14	6
	Other	1	19

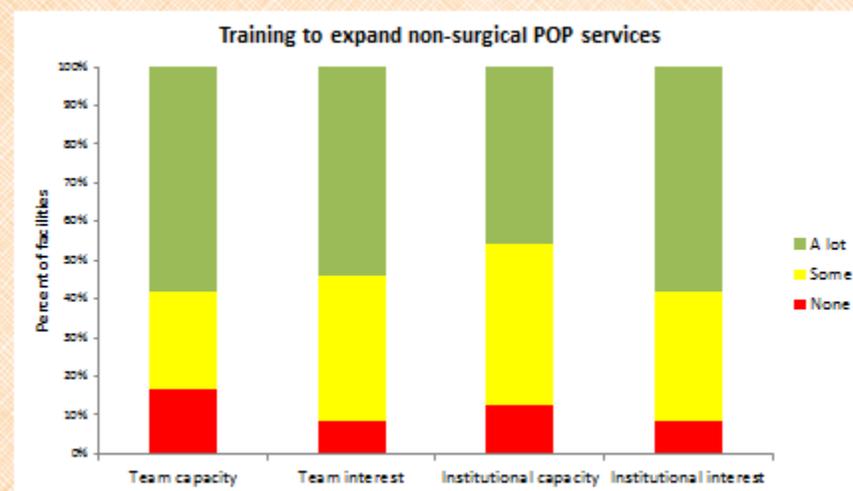


Expanding surgical POP services: capacity & interest



Fistula Care Plus

Expanding non-surgical POP services: capacity & interest



Fistula Care Plus

- 15 facilities report access to referral for PT
 - 12 report access to female therapists interested in PT for POP

Fistula/POP integration: Synergies & conflicts

- Respondents asked to identify integration synergies/conflicts related to:
 - Human resources
 - Access/availability of camps/routine fistula services
 - Development of surgical skills
 - Infrastructure
 - Equipment
 - Expendable supplies/equipment
 - Data management systems
 - QA/QI
 - Prevention
 - Community engagement
 - Referral mechanisms



Fistula/POP integration: Synergies & conflicts

- Respondents found many synergies and potential conflicts.
 - Nearly 2X as many synergies as conflicts (134 vs. 73)
- Topic with most synergies: development of surgical skills, followed closely by QA/QI & infrastructure.
 - Fewest synergies: Referral mechanisms
- Topic with most potential conflicts: Infrastructure, followed closely by expendable supplies
 - Fewest conflicts: Community engagement



Fistula/POP integration conflicts

- Current data & QA/QI systems inadequate/overwhelmed
 - “manual data system,” “still using books,” “paper lists,” “no computers”
- Difficulty of getting adequate staff/inter-cadre tensions
 - Including due to remote location, lack of funding
 - “Taking over responsibility from the gynecologists”
- Limited infrastructure/space/capacity
 - Esp. OTs/post-op space
 - Threat of decline in fistula repairs
- Lack of equipment/supplies including POP-specific
 - Poor supply chain, frequent stockouts

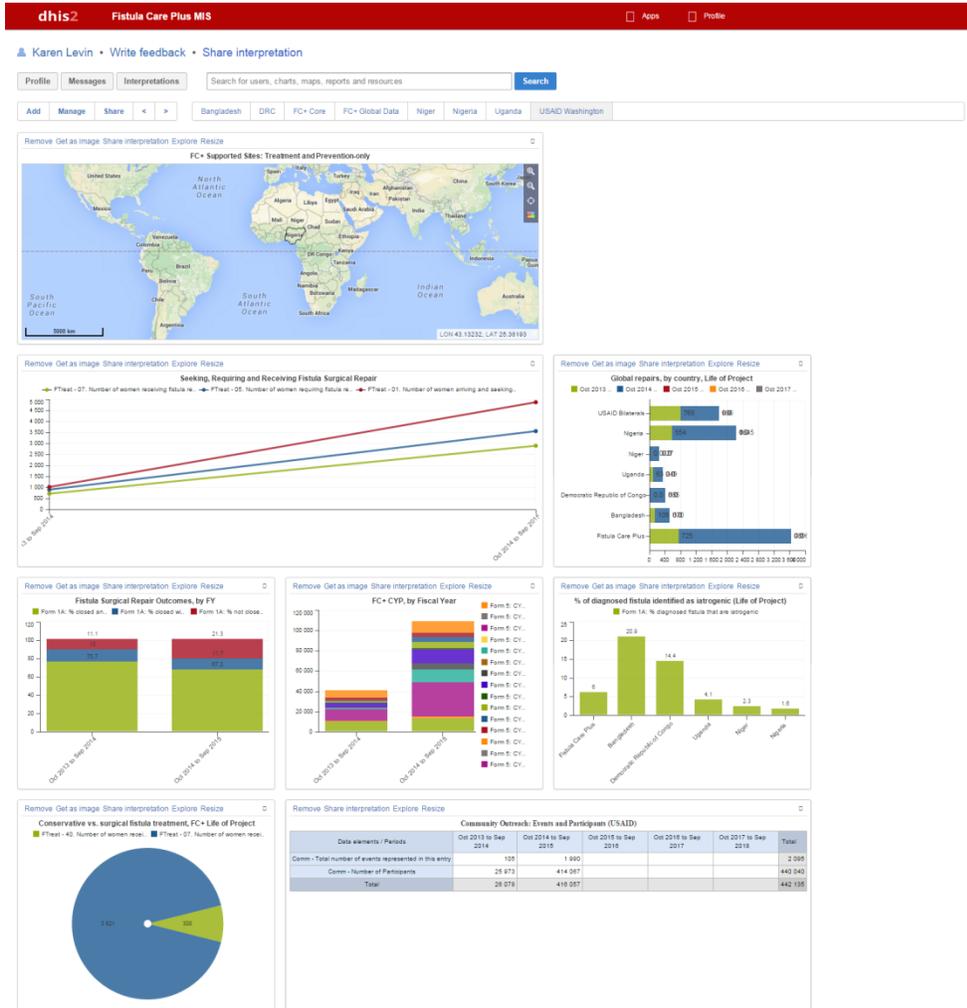


Fistula/POP integration conflicts

- Community factors
 - Poverty, traditional beliefs
 - Lack of transport, insecurity
- Less government/donor funding/revenue from POP
 - Concern that POP tx costs more than fistula tx
 - “low revenue for the hospital”
- Separate capacity building required
 - Lack of mentors for POP (vs. fistula)



APPENDIX T: ACTUAL FC+ USAID/WASHINGTON DASHBOARD SCREENSHOT



APPENDIX U: FC+ SUPPORTED TREATMENT SITES MEETING TO DISCUSS DATA IN FY14/15

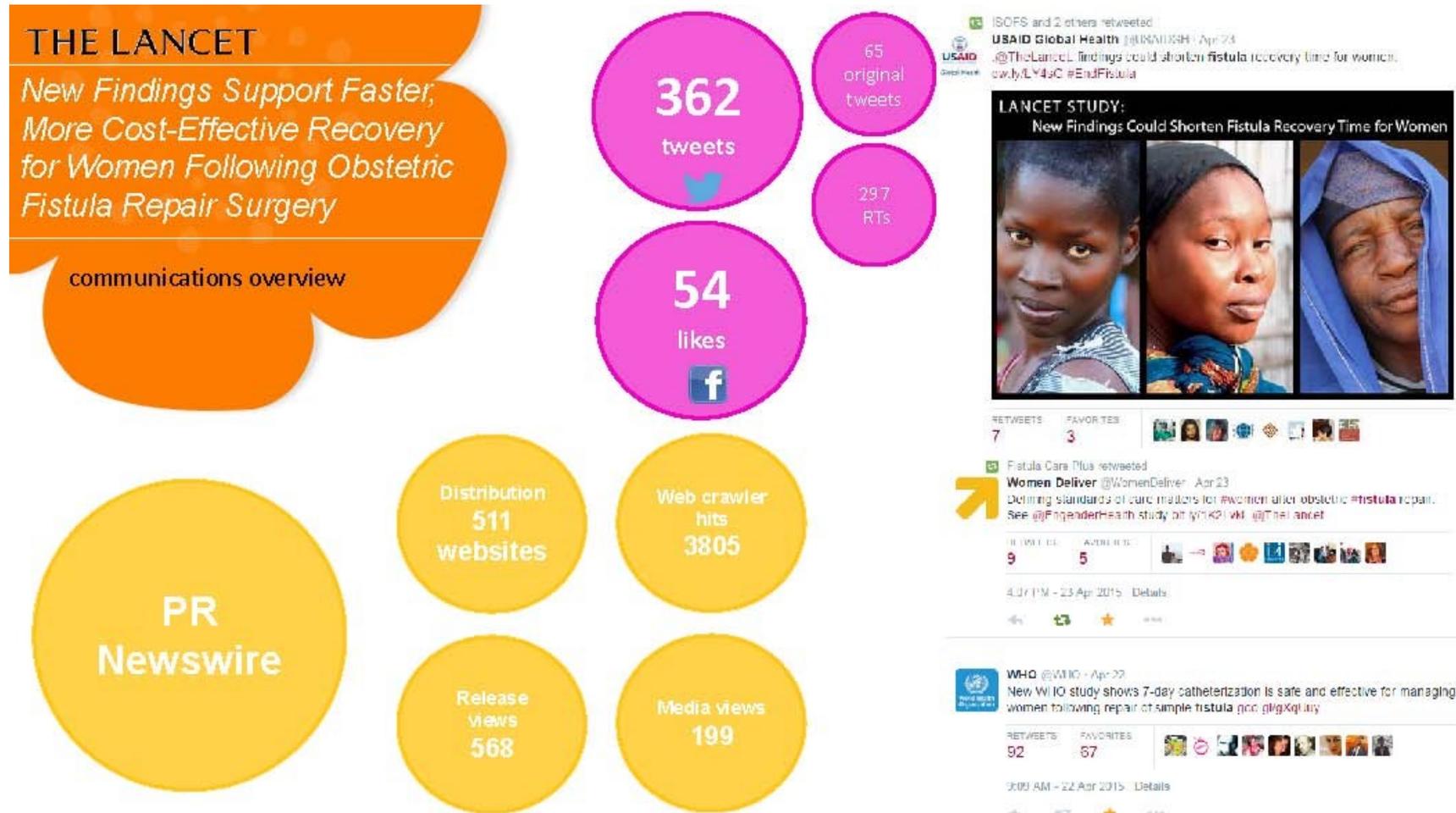
Country/Site	Q1	Q2	Q3	Q4	Total Number of Meetings in FY14/15
Fistula Care Plus Total: 29 treatment sites					55% met at least twice 66% met at least once
Bangladesh: 8 treatment sites					13% met at least twice 25% met at least once
Ad-Din Dhaka	0	0	0	0	0
Ad-Din Jessore	0	0	n/a	0	0
Ad-Din Khulna	0	0	n/a	0	0
Kumudini Hospital	0	0	0	1	1
LAMB Hospital	0	0	1	1	2
Bangabandhu Sheikh Mujib Medical University	n/a	0	0	0	0
Dr. Muttalib Community Hospital	n/a	0	0	0	0
Mamm's Institute of Fistula & Women's Health	0	0	0	0	0
DRC: 5 treatment sites					40% met at least twice 60% met at least once
St. Joseph's Hospital/Satellite Maternity Kinshasa	1	2	0	1	4
Panzi Hospital	0	0	1	0	1
HEAL Africa	0	0	0	0	0
IGL	n/a	1	1	1	3
MSRK	n/a	n/a	0	0	0
WA/Niger: 3 treatment sites					100% met at least twice 100% met at least once
Centre de Santé Mère / Enfant (CSME) Maradi	0	0	1	1	2
Centre National de Référence des Fistules Obstétricales (CNRFO), Niamey	0	0	1	1	2
Centre de Santé Mère /Enfant (CSME) Tahoua	0	0	1	1	2
Nigeria: 11 treatment sites⁴⁶					91% met at least twice 100% met at least once
General Hospital, Ningi	1	1	1	1	4
General Hospital, Ogoja	1	1	0	0	2
National Fistula Center, Abakaliki	1	1	1	1	4

⁴⁶ Jigawa a Hospital is not included in FY 14/15 for data review meetings as they were not supported until the fourth quarter, and as such, did not have data to review during the fiscal year.

Country/Site	Q1	Q2	Q3	Q4	Total Number of Meetings in FY14/15
Laure WF Center	1	1	1	1	4
National Fistula Center, Babbar Ruga, Katsina	1	1	1	1	4
Gesse WF Center, Birnin Kebbi	1	1	1	1	4
Sobi Specialist Hospital, Ilorin	1	1	1	1	4
Maryam Abatcha Women and Children's Hospital, Sokoto	1	1	1	1	4
Faridat General Hospital, Gusau	1	1	1	1	4
University College Hospital, Ibadan	1	1	0	0	2
Jahun WF Center, Jigawa State	n/a	n/a	n/a	n/a	n/a
Adeoyo General Hospital, Ibadan	0	0	1	0	1
Uganda: 2 treatment sites					0% met at least twice 0% met at least once
Kitovu Mission Hospital	0	0	n/a	0	0
Hoima Regional Referral Hospital	n/a	n/a	0	n/a	0

n/a indicates the site was not supported/did not provide repairs during this quarter

APPENDIX V: ENGENDERHEALTH-DEVELOPED MEDIA INFOGRAPHIC FOR CATHETERIZATION STUDY



APPENDIX W: FC/ FC+ PEER REVIEWED PUBLICATIONS⁴⁷

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.

⁴⁷ This summarizes all peer-reviewed publications throughout the life of both the FC and FC+ projects, as of April 2015.

- 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*. 2015 Jul 4;386(9988):56-62.

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.

- 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.

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*. 2015 Sep;30(7):885-94.

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.

- Delamou, A., Delvaux, T., Utz, B., Camara, B. S., Beavogui, A. H., Cole, B., Levin, K., Diallo, M., Millimono, S., Barry, T. H., El Ayadi, A. M., Zhang, W.-H. and De Brouwere, V. Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea. *Tropical Medicine & International Health*. 2015 Nov;20(11):1454-1461.

Objectives: To analyse the trend of loss to follow-up over time and identify factors associated with women being lost to follow-up after discharge in three fistula repair hospitals in Guinea. **Methods:** This retrospective cohort study used data extracted from medical records of fistula repairs conducted from 1 January 2007 to 30 September 2013. A woman was considered lost to follow-up if she did not return within 4 months post-discharge. Factors associated with loss to follow-up were identified using a subsample of the data covering the period 2010–2013. **Results:** Over the study period, the proportion of loss to follow-up was 21.5% (448/2080) and varied across repair hospitals and over time with an increase from 2% in 2009 to 52% in 2013. After adjusting for other variables in a multivariate logistic regression model, women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be lost to follow-up than women operated at Jean Paul II hospital (OR: 50.6; 95% CI: 24.9–102.8) and (OR: 11.5; 95% CI: 6.1–22.0), respectively. Women with their fistula closed at hospital discharge (OR: 3.2; 95% CI: 2.1–4.8) and women admitted for repair in years 2011–2013 showed higher loss to follow-up as compared to 2010. Finally, loss to follow-up increased by 2% for each additional kilometre of distance a client lived from the repair hospital (OR: 1.002; 95% CI: 1.001–1.003). **Conclusion:** Reimbursement of transport was the likely reason for change over time of LTFU. Reducing geographical barriers to care for women with fistula could sustain fistula care positive outcomes.

- Delamou, A., Diallo, M., Beavogui, A. H., Delvaux, T., Millimono, S., Kourouma, M., Beattie, K., Barone, M., Barry, T. H., Khogali, M., Edginton, M., Hinderaker, S. G., Ruminjo, J., Zhang, W.-H. and De Brouwere, V. Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea. *Tropical Medicine & International Health*. 2015 20: 813–819.

OBJECTIVES: Female genital fistula remains a public health concern in developing countries. From January 2007 to September 2013, the Fistula Care project, managed by EngenderHealth in partnership with the Ministry of Health and supported by USAID, integrated fistula repair services in the maternity wards of general hospitals in Guinea. The objective of this article was to present and discuss the clinical outcomes of 7 years of work involving 2116 women repaired in three hospitals across the country. **METHODS:** This was a retrospective cohort study using data abstracted from medical records for fistula repairs conducted from 2007 to 2013. The study data were reviewed during the period April to August 2014. **RESULTS:** The majority of the 2116 women who underwent surgical repair had vesicovaginal fistula ($n = 2045, 97%$) and 3% had rectovaginal fistula or a combination of both. Overall 1748 (83%) had a closed fistula and were continent of urine immediately after surgery. At discharge, 1795 women (85%) had a closed fistula and 1680 (79%) were dry, meaning they no longer leaked urine and/or faeces. One hundred and fifteen (5%) remained with residual incontinence despite fistula closure. Follow-up at 3 months was completed by 1663 (79%) women of whom 1405 (84.5%) had their fistula closed and 80% were continent. Twenty-one per cent were lost to follow-up. **CONCLUSION:** Routine programmatic repair for obstetric fistula in low resources settings can yield good outcomes. However, more efforts are needed to address loss to follow-up, sustain the results and prevent the occurrence and/or recurrence of fistula.

- Frajzyngier V, Ruminjo J, Asiiimwe 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 the 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, 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. *Journal of Health Informatics in Developing Countries*. 2015 9(1): 14-22.

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.

- 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 Dec;25(12):1699-706.

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, Asiiimwe 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, Faisel 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]
- Tripathi V, Stanton C, Strobino D, Bartlett L. Development and Validation of an Index to Measure the Quality of Facility-Based Labor and Delivery Care Processes in Sub-Saharan Africa. *PLoS ONE*. 2015. 10(6): e0129491.

BACKGROUND: High quality care is crucial in ensuring that women and newborns receive interventions that may prevent and treat birth-related complications. As facility deliveries increase in developing countries, there are concerns about service quality. Observation is the gold standard for clinical quality assessment, but existing observation-based measures of obstetric quality of care are lengthy and difficult to administer. There is a lack of consensus on quality indicators for routine intrapartum and immediate postpartum care, including essential newborn care. This study identified key dimensions of the quality of the process of intrapartum and immediate postpartum care (QoPIIPC) in facility deliveries and developed a quality assessment measure representing these dimensions. **METHODS & FINDINGS:** Global maternal and neonatal care experts identified key dimensions of

QoPIIPC through a modified Delphi process. Experts also rated indicators of these dimensions from a comprehensive delivery observation checklist used in quality surveys in sub-Saharan African countries. Potential QoPIIPC indices were developed from combinations of highly-rated indicators. Face, content, and criterion validation of these indices was conducted using data from observations of 1,145 deliveries in Kenya, Madagascar, and Tanzania (including Zanzibar). A best-performing index was selected, composed of 20 indicators of intrapartum/immediate postpartum care, including essential newborn care. This index represented most dimensions of QoPIIPC and effectively discriminated between poorly and well-performed deliveries.

CONCLUSIONS: As facility deliveries increase and the global community pays greater attention to the role of care quality in achieving further maternal and newborn mortality reduction, the QoPIIPC index may be a valuable measure. This index complements and addresses gaps in currently used quality assessment tools. Further evaluation of index usability and reliability is needed. The availability of a streamlined, comprehensive, and validated index may enable ongoing and efficient observation-based assessment of care quality during labor and delivery in sub-Saharan Africa, facilitating targeted quality improvement.

- Tunçalp O, Tripathi V, Landry E, Stanton CK, Ahmed S. Measuring the incidence and prevalence of obstetric fistula: approaches, needs, and recommendations. *Bulletin of the World Health Organization*. 2015 Jan; 93(1):60-62. [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

- 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. *Being revised and e-published as a technical brief*.

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 Impact/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 Impact/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 Impact/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 Impact/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.

APPENDIX X: FC/FC+ PUBLICATION READERSHIP METRICS*

TITLE	VIEWS	JOURNAL	PUB YEAR
Obstetric fistula and the challenge to maternal health care systems	n/a	IPPF Medical Bulletin	2007
Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies	n/a	Reproductive Health Matters	2008
Current practices in treatment of female genital fistula: a cross sectional study	7138	BMC Pregnancy and Childbirth	2010
Determinants of postoperative outcomes of female genital fistula repair surgery.	n/a	Obstetrics and Gynecology	2012
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	n/a	BJOG	2012
Factors influencing urinary fistula repair outcomes in developing countries: a systematic review	n/a	American Journal of Obstetrics and Gynecology	2012
Non-inferiority of short-term urethral catheterization following fistula repair surgery: study protocol for a randomized controlled trial	3699	BMC Women's Health	2012
Development and comparison of prognostic scoring systems for surgical closure of genitourinary fistula.	n/a	American Journal of Obstetrics and Gynecology	2013
Outcomes in obstetric fistula care: a literature review	n/a	Current Opinion in Obstetrics and Gynecology	2013
Profiles and experiences of women undergoing genital fistula repair: findings from five countries	846	Global Public Health	2013
Striving for excellence: nurturing midwives' skills in Freetown, Sierra Leone.	n/a	Midwifery	2013
Assessing the quality of record keeping for cesarean deliveries: results from a multicenter retrospective record review in five low-income countries.	2342	BMC Pregnancy and Childbirth	2014
Clinical Procedures and Practices Used in the Perioperative Treatment of Female Genital Fistula during a Prospective Cohort Study.	1923	BMC Pregnancy and Childbirth	2014
Community-based screening for obstetric fistula in Nigeria: a novel approach	2275	BMC Pregnancy and Childbirth	2014
Iatrogenic genitourinary fistulas: An 18-year retrospective review of 801 iatrogenic injuries	n/a	International Journal of Urogynecology	2014
Rethinking how to promote careseeking: Factors associated with institutional delivery in Guinea	n/a**	Health Care for Women International	2014
Measuring the incidence and prevalence of obstetric fistula: approaches, needs, and recommendations	n/a	Bulletin of the World Health Organization	2014
Mortality risk associated with surgical treatment of female genital fistula.	228	International Journal of Gynecology and Obstetrics	2014
The value of building health promotion capacities within communities: Evidence from a maternal health	n/a	Health Policy and Planning	2014

intervention in Guinea.			
Breakdown of simple female genital fistula repair after 7 day versus 14 day postoperative bladder catheterisation: a randomised, controlled, open-label, non-inferiority trial	n/a	The Lancet	2015
Development and validation of an index to measure facility-based labor and delivery care processes in sub-Saharan Africa. ***	3588	PLOS ONE	2015
Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea	n/a	Tropical Medicine and International Health	2015
Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea.	n/a	Tropical Medicine and International Health	2015
What to measure and why. Experience developing monitoring indicators for an emerging maternal health issue: the case of obstetric fistula"	n/a	Journal of Health Informatics in Developing Countries	2015
Obstetric fistula and the challenge to maternal health care systems	n/a	IPPF Medical Bulletin	2007
TOTAL	22,039		

* Metrics only available for 8 of the 21 published articles.

** Published through the Maternal and Child Health Integration Program/Maternal and Child Survival Program.

***Though metrics are not available for, this was one of the top three most downloaded articles in Health Care for Women International in 2014.)

Updated 11/5/2015.

APPENDIX Y: FC+ CORE INDICATORS: ANNUAL ACHIEVEMENTS

Note: Benchmarks for FY 13/14, FY 15/16, and FY 17/18 are drawn from the approved FC+ PMP. Benchmarks for FY 15/16 have been estimated based on FY 13/14 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 Values⁴⁸			
<i>Year</i>	<i>Target</i>	<i>Actual</i>	<i>Notes</i>
FY2013/14	5	5	
FY2014/15	5	6	FC+ has supported activities in Togo through the USAID/WARP mission
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 reported via indicator 2.

⁴⁸ Benchmarks are aggregated for all indicators unless otherwise stated.
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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	USAID also supported treatment sites in Tanzania and DRC (one) through bilateral projects.
FY2014/15	32	31	
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 subaward agreements negatively affected prevention-only site support
FY2014/15	39	749	FC+ has temporarily taken on support of a large number

			of prevention-only sites in Nigeria following the close of the TSHIP project.
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 policy⁴⁹ 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	5	
FY2014/15	5	5	
FY2015/16	6		
FY2016/17			
FY2017/18	7		

⁴⁹ Adapted from World Health Organization definitions. Available at: http://www.who.int/mental_health/policy/services/1_MHPolicyPlan_Infosheet.pdf. Accessed January 22, 2014.
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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	0	Policy efforts related to WDI/TF/POP to begin in FY14/15
FY2014/15	1	2	Nigeria and Uganda have both held national level meetings drafting policy related to treatment and reintegration of WDI
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	2	Budget allocations made in Nigeria and Uganda

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	3	See FY13/14
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 ⁵⁰	3	In addition to the 3 PPPs (Bangladesh, Nigeria, and Uganda), an individual has

⁵⁰ This will be achieved in Y2 due to the shortened Y1.
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			also donated commodities in Uganda
FY2014/15	2	3	Partnerships for private contribution to fistula activities are active in DRC, Nigeria, and Uganda. Proposals for such partnership are pending in Bangladesh and Niger.
FY2015/16	3		
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	0	Delays in funds release and subaward approvals negatively affected ability to implement community volunteer/educator trainings in FY13/14
FY2014/15	494	776	
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 subaward approvals negatively affected ability to implement community outreach and education in FY13/14.
FY2014/15	586	1,990	
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. ⁵¹			
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 subaward approvals negatively affected ability to implement community outreach and education in FY13/14
FY2014/15	232,100	414,067	
FY2015/16	480,000		

⁵¹ 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.

FY2016/17			
FY2017/18	1,200,000		

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	0	Delays in approvals/conduct of Pop Council study have negatively impacted ability to move forward with designing and piloting initiatives
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	0	Delays in approval and conduct of Pop Council study have negatively impacted ability to design/test new technologies
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. ⁵²			
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	912	
FY2014/15	4,000	3,790	
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.			

⁵² 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.

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	1,300 ⁵³	852	Delays in funds release and subaward approvals negatively affected ability to support fistula repairs during FY13/14.
FY2014/15	3,830	2,876	Repairs benchmark increased due to requests from Bangladesh and Nigeria missions
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%	76%	Closed and continent data is incomplete for FY13/14 due to new data collection tools. Data presented is what is available for this time period.
FY2014/15	75%	67%	79% of fistulas successfully closed (67% closed and continent, 12% closed and incontinent) 21% not closed
FY2015/16	75%		
FY2016/17			
FY2017/18	75%		

⁵³ 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.

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 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%	.4%	
FY2014/15	<20%	2.3%	
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.
<p>Categories of health system personnel trained may include:</p> <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 <p>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</p>

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	403	Delays in funds release and subaward approvals negatively affected ability to implement training in FY13/14 Number revised from FY13/14 report to reflect additional data submitted from countries post-reporting
FY2014/15	929	1,065	
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	0	Sites identified, implementation will begin in FY15/16
FY2015/16	8 ⁵⁴		
FY2016/17			
FY2017/18	8		

⁵⁴ This is based on the assumption that FC+ will be supporting POP services in 2 countries.

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
FY2013/14	0	NA	No sites supported yet
FY2014/15	30	NA	No sites supported yet
FY2015/16	976 ^b		
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. ⁵⁵ 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	40,039	
FY2014/15	90,500	107,985	
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.			

⁵⁵ Office of Sustainable Development, Bureau for Africa, USAID. Health and Family Planning Indicators: A Tool for Results Frameworks Volume I. Accessed: January 20, 2014.
Annual Report • October 2014 – September 2015

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
FY2013/14	53,698	38,373	
FY2014/15	117,800	149,610	
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			
Definition: A two part indicator will be used to assess partograph completeness and management of labor according to protocol.			
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:			
<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. 			
Part 2: % of partographs with action line reached in which the correction actions were taken.			
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.			
Data source and collection: Collected annually from medical monitoring reports by FC+ staff and in-country partners			
Benchmark Values			
Year	Target	Actual	Notes
FY2013/14	0	NA	
FY2014/15	50% of sites receiving a mean		Data will be submitted with FY15/16 annual report

	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	1	Population Council formative research in Nigeria completed; Uganda pending.
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 ⁵⁶ , 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	
FY2014/15	45%	55%	
FY2015/16	50%		
FY2016/17			
FY2017/18	75%		

⁵⁶ 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.

APPENDIX Z: CLINICAL DATA FOR DECISION MAKING – TECHNICAL BRIEF



Improving Clinical Data for Decision Making at EngenderHealth

Background

Evidence-based decision making for clinical practices, policies, and programs is the standard in the field of sexual and reproductive health (SRH), as in most fields of medicine and public health. Quality evidence is essential to allow providers, program managers, and policymakers to make objective, informed decisions that result in the best possible clinical care for clients. Quality evidence also allows stakeholders to implement programs and activities with the highest potential impact, even with limited resources. In addition, to demonstrate program impact to stakeholders, including donors and policymakers, quality evidence is critical.

EngenderHealth is increasingly investing resources to capture, synthesize, and disseminate high-quality data, to support evidence-based decision making. However, like many organizations, at times we collect too much data, do not collect the right data, and/or do not make optimal use of the data collected. In addition, there are redundancies among the data collected through clinical support and through monitoring, evaluation, and research (ME&R) activities. In many ways, these two teams have been working in silos.

By improving the ways in which we generate and use clinical data, we will be better positioned to improve our programs and the support we provide to in-country partners. By making the needed investments, we hope to develop effective processes for data management and use. In particular, those processes will enable us to have data of the highest quality, which are needed to effectively develop and strengthen our programs and the organization. Furthermore, with better data, we will be able to contribute to the development, improvement, and implementation of SRH programs and practices globally.

Why the C in CDDM?

At EngenderHealth, **all** of our programs need high-quality data and strong processes for decision making. Our programmatic focus is broad-ranging—from improving clinical service delivery, to increasing demand for SRH services, to improving policies and the enabling environment for SRH. We also work with a range of stakeholders, including individuals, communities, providers, government, health care providers, and nongovernmental and community-based organizations. However, this initiative focuses on **clinical** data for decision making, because the majority of our data come from the clinical setting.

“Clinical data” refers to data associated with any activity that occurs within a facility or similar. Clinical data include data on client satisfaction, client-provider interactions, provider training and follow-up,

service processes (including facility set-up and infection prevention practices), and interviews with facility staff.

Making CDDM Work: The Example of Fistula Care Plus

Strengthening the availability and use of data is a key objective of the Fistula Care *Plus* (FC+) project, as it was under the Fistula Care project. The FC+ data for decision making (DDM) vision is that: global and country-level DDM discussions will identify priorities for technical assistance and special studies; each country will conduct its own local DDM; and data will be shared externally with supported facilities for use in local advocacy and decision making. Along with training health facility staff in the use of DDM, FC+ staff conducts “internal DDM” activities to assess and guide project implementation.

Each quarter, FC+ data are collected at the facility level and reported up to country staff. Country offices collate, clean, and report the data to headquarters. The FC+ core team, including management, clinical, and ME&R staff, conducts a global DDM meeting each quarter. At this meeting, data visualizations are presented for key FC+ indicators from the Project Monitoring Plan to examine project trends and identify incipient problems or emerging successes. Indicators are presented against targets and benchmarks and are shown globally as well as by country. Examples of indicators reviewed at global DDM meetings include: number of women seeking, requiring, and receiving fistula and prolapse repairs; surgery outcomes; percentage of fistulas identified as iatrogenic; planned vs. conducted trainings and community events; planned vs. conducted family planning counseling sessions; and couple-years of contraceptive protection delivered.

Global DDM discussions include discussions both on how to improve the quality of the data collected and on what the data mean for the FC+ program. Following DDM discussions, a set of action points is circulated among the core team and other actors, as relevant. All global DDM slides are also shared with each FC+ country office. A post-DDM meeting is also held one month later to follow up on specific issues in greater depth. Each quarterly global DDM meeting begins with a review of action points from the previous meeting, to assess whether actions have been taken and issues resolved. FC+ is tracking the frequency and percentage of “repeat issues”—problems that are identified at multiple meetings over the course of the project, without being adequately resolved.

An example of an issue identified through the global DDM process is low “closed and dry” rates following fistula repair in two FC+ countries. Identification of this issue has led to local investigation of the underlying reasons, including analysis of case mix (complex vs. simple fistulas, number of previous repairs), repair type (routine vs. camp/concentrated efforts), and facility characteristics. The findings will be discussed at a DDM follow-up meeting so that appropriate programmatic responses can be identified.

FC+ introduced these global DDMs in FY2015 and is documenting the experience of using these forums to promote program analysis and improvement. At the end of a full year of implementation, FC+ will review the effectiveness of the global DDM process in identifying and resolving program challenges, particularly those related to clinical services and quality of care. Based on these learnings, expectations regarding DDM functioning and responsibilities will be systematized into job descriptions.

A Starting Point: A Global Staff Meeting on CDDM

In early 2015 (March 23-27), we convened a five-day global staff meeting in Istanbul, with the aim of improving the way in which the organization captures and uses clinical data. The meeting brought together Senior Clinical and ME&R staff from EngenderHealth field programs as well as key headquarters-based staff. The chief objective was to determine organization wide strategies, tools and

approaches for streamlining data collection, management and analysis and for improving clinical data usage. In addition, we aimed to facilitate greater and more effective cross-organizational learning and sharing. In the lead up to the meeting, the Clinical Support team (CST) updated the CMC Toolkit and the Clinical Training Toolkit used for ECQ activities. On a parallel track and in collaboration with the CST, the HQ Monitoring, Evaluation & Research (ME&R) team completed an extensive review of tools used for program monitoring and evaluation across our programs and projects. Following that review, the teams developed draft template tools and guidance documentation, for use in the ME&R of our programs activities.

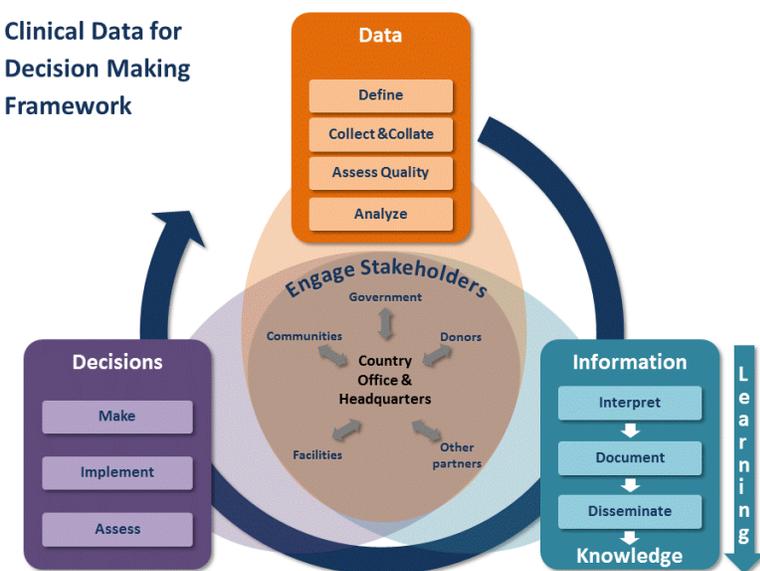
Our Organizational Vision: What Can CDDM Do for EngenderHealth as an Organization?

Strong systems for CDDM will ensure that we collect the data we need, have data when we need them, and use data to inform our decisions. Our vision is that *every decision we make at EngenderHealth is based on easy-to-use data capable of improving our effectiveness and demonstrating our impact.* In particular, data should be readily available and capable of being understood and synthesized by all staff.

The key results EngenderHealth hopes to achieve by focusing on CDDM are to:

1. Develop robust, streamlined, and adaptable processes for data collection and management
2. Link data use and programmatic action at the project and organizational levels
3. Make evidence-based decisions
4. Facilitate and strengthen sharing of programmatic experience cross-organizationally and more broadly in the SRH community
5. Demonstrate the effectiveness and impact of our work

Figure 1. Clinical Data for Decision-Making Framework



To realize these results, EngenderHealth will focus on a number of action steps over the next several years, beginning with the rollout of a CDDM Framework (Figure 1) and a guidance document. Together the framework and the guidance document will support staff in developing and implementing strong systems for data collection and use, including establishing clear roles and responsibilities for all staff involved in CDDM. The framework was drafted by participants of the Istanbul meeting (March 23-27, 2015) and was finalized based on group discussions. The guidance document will be drafted by the

CDDM Core Team during Fall 2015 and will be rolled out to the organization at the Program Managers' Meeting in February 2016. Both the framework and the guidance document will be pilot-tested with one project in early 2016 before being rolled out organization-wide.

We will develop a toolkit for clinical data collection, which will bring together into one toolkit the Clinical Monitoring and Coaching and the Clinical Training toolkits and our routine program monitoring and evaluation tools; it will also include guidance on adapting, piloting and implementing the tools. The

toolkit will be designed to standardize, harmonize, and streamline data collection across the organization. The availability of this toolkit will also reduce the amount of staff time required at project start-up and throughout the life of the project, by allowing staff to adapt a standard template tool instead of creating new ones.

We will develop templates for provider interviews and observations of service provision, client interviews, and facility assessments (for readiness and for quality of processes), as well as for other tools used routinely for clinical data collection. Where there are currently no standard monitoring tools, new tools and forms will be created. Before being rolled out organization-wide, the toolkit will be reviewed and approved by clinical, ME&R, and technical staff and will be pilot-tested in two projects.

In addition, EngenderHealth has committed to several other steps for improving CDDM processes across the organization. Importantly, our long-term objective is to move to electronic or mobile data collection and a cloud-based, integrated data management system.

To read our full action plan, the Istanbul report or other outputs from the meeting, visit the [CDDM Intranet page](#). To find out more about the CDDM initiative, feel free to reach out to the CDDM Core Team with questions, comments, or concerns: Caitlin Shannon, Carmela Cordero, Ghazaleh Samandari, Levent Cagatay, Mark Barone, Nichelle Walton, and Sara Malakoff.