

Assessment of USAID's support for fistula activities in Ethiopia

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Executive summary

This report is an external assessment of funding provided by the USAID/Ethiopia Office of Health, AIDS, Population, and Nutrition (HAPN) for fistula activities. The three partner organizations which receive funding are IntraHealth (through a sub-award from EngenderHealth), the Addis Ababa Fistula Hospital (AAFH), and the Integrated Family Health Program (IFHP). This assessment was managed through USAID's contractor, The Mitchell Group.

The objective of this assessment was to review the components of USAID/Ethiopia's fistula portfolio in relation to four strategic questions:

1. How effective is the current structure of the USAID/Ethiopia fistula program in engendering sustainability?
2. Does the current model use available resources effectively to facilitate as many fistula repairs as possible?
3. How effective are the prevention activities of AAFH, IntraHealth, and IFHP?
4. What recommendations can be made for future programming in obstetric fistula prevention, care, and treatment as

Key findings – program areas

Together, the three partners offer a thorough approach to fistula programming in Ethiopia. Through their individual and collective work, including in partnership with Government of Ethiopia (GoE), they have achieved significant gains in educating people about fistula, identifying women living with fistula, and providing high quality surgical repair of fistula so that women may return to a life of dignity.

1. Identifying and screening women with fistula

Each partner organization has activities to identify women with fistula and link them to facilities for repairs. Both IH and IFHP provide transport for women to reach the satellite Hamlin Fistula Centers (HFCs) established by AAFH to receive a fistula repair.

A clear mapping of 'who is doing what, and where' in regard to identifying and screening women would be useful to ensure best use of resources. Partners should be encouraged to seek the most appropriate strategy for their organization, utilizing their particular strengths in community outreach and referral.

The challenges ahead are to identify women in more remote areas and link them to care, and to harmonize the payments that are being made for identifying women with fistula.

2. Prevention

IH and IFHP are addressing prevention through education on maternal health, and training health workers. AAFH has health officers and focal persons who conduct outreach, do patient identification, and work with and train GoE health workers.

A note of caution in the prevention messages about fistula: early marriage and pregnancy are not the key drivers of fistula. While it is important to advocate against early marriage, it is access to skilled, appropriate and timely care that will save women's lives and reduce fistula.

3. Transport

Transportation from remote areas to hospitals providing fistula repair is a pivotal component of the program. Without appropriate transport, women's vulnerability increases. Transport needs to be a key component of funding by donors for fistula.

4. Training

All the partners are involved in training cadres of health workers and community members on fistula, and to some extent, emergency obstetric care. It would be useful for partners to do a 'mapping' of this training to ensure best use of resources and to avoid duplication if it exists.

5. Fistula surgery

AAFH has established five satellite HFCs to make fistula repair more available in remote areas. This is extremely important, and the team encourages AAFH to consider further expansion. Without diminishing the vital role of these services, concerns were raised that the responsibility of fistula repair resting with AAFH may excuse the Government from taking up fistula treatment. It would be useful to explore the possibilities for public-private partnerships in order to increase access to treatment in future.

6. Reintegration

Experience shows that once a woman is healed of her fistula and is completely dry she can typically reintegrate home. The exception may be women who lived with fistula for a long time before repair, and therefore experienced severe isolation. As such, the team does not recommend a new program focusing on reintegration, at least until there is more evidence from international experience that supports the precise usefulness of such an intervention. In the meantime, an inventory of the modalities and amounts of money that the partners give women post-repair would be helpful.

7. Cooperation and collaboration

Overall, conversations with partners, GoE, other NGOs, and USAID pointed to positive relationships and cooperation among the USAID funded agencies. This includes cooperation with GoE at the regional and woreda levels. Managers in the regional health bureaus did point to several issues that need to be addressed including that across donor funded projects (not only fistula) health workers are repeatedly taken from post for training, leaving a gap in workers on site. Concerns were also raised around per-diems, which essentially pays people for showing up at a workshop rather than performing on the job.

Key findings – partners

Details of the work of each partner are provided in the body of this report. For summary purposes, below are the major "Questions for Consideration" related to each partner.

1. IntraHealth and the PRUs

The PRUs provide a platform for both fistula as well as strengthening maternal health services. The Team believes it is a misnomer to consider the PRUs only for “pre-repair” since they serve a broader function at the community level regarding maternal and reproductive health education, and strengthening service delivery. Questions for consideration include:

- Are the PRUs less sustainable than other fistula-related interventions?
- What components of the PRUs could be responsibly integrated into GoE structures or programs of other NGOs, for example the HFCs?
- What are the benefits and drawbacks of integrating different components of the PRU into government services? In particular, there are concerns that health centers are not in a position to provide these services (they do not have in-patient capacity), and reportedly health workers are resistant to doing fistula related care?

2. IFHP

IFHP is structured as a government capacity building project in 286 woredas across the country. This broad reach affords ample opportunity to take fistula education and case identification to scale. Questions for consideration include:

- To what extent is fistula addressed in the current IFHP program and the upcoming MNH program? Does fistula get lost in the broad public health messaging of the IFHP program?
- There are a seemingly small number of fistula referrals from IFHP to the Mekele HFC. How can the numbers of patients be increased?

3. AAFH

AAFH holds the primary role for provision of fistula repair in Ethiopia. In addition, it has recently begun training health officers and focal people to conduct community outreach and identifying ‘hidden cases’. AAFH has also established a midwifery school.

- Are there ways to encourage greater GoE engagement with fistula – e.g., integration of fistula training into pre-service training of gynecologists? Foster a public-private partnership between AAFH and GoE in the provision of fistula?
- Where can partnerships with IH, IFHP and other organizations be built to strengthen synergies and decrease duplication in community outreach efforts?

Moving forward with funding for fistula

To date, USAID has funded a promising set of partners who are addressing fistula through different approaches, both integrated and ‘stand-alone’. Each approach is bearing fruit, and also raises some questions around effectiveness and institutionalization in future. The Team recommends that USAID continue to support a mixed portfolio of partners given the benefits of the current mix. This will increase the likelihood of achieving optimal program results (health systems strengthening; adherence to a focus on fistula while linking to broader maternal health); provide an opportunity to test promising program approaches for the future; and, facilitate treatment for the highest number of women as per USAID’s Congressional Directive on fistula.

Several issues merit further consideration and action, with full details contained in the report:

1. Focus on finding women in remote areas using existing and new strategies utilized by the USAID partners, government workers, and intermediary partners.
2. Measure the cost effectiveness of programs while recognizing that donor-funded projects typically teeter on the edge of elimination once donor funding ceases; government-led donor funded initiatives included.
3. Institutionalize comprehensive emergency obstetric care (EmOC) through the fistula partners and GoE in order to reduce the numbers of women living with fistula.
4. Retain the three existing IntraHealth PRUs and establish the two new ones, while testing scenarios for institutionalizing components of the PRUs into NGO and GoE structures.
5. Ensure fistula features into the IFHP MNH program and the IFHP section working on gender and harmful traditional practices.
6. Foster strategies with GoE for integrating fistula into system-wide programs on community and maternal health.
7. Build synergies between AAFH and the other partners for developing models for prevention, outreach and referral; assess most efficient strategies and distribution of workload to avoid duplication.
8. Delineate maternal *morbidity* as well as maternal mortality in all maternal health programs. The magnitude of maternal morbidity far exceeds that of mortality, and the strategies for reducing maternal mortality also address morbidity.

Detailed questions, including those related to possible scenarios for the PRUs, are provided in the “Moving Forward” section of this report.

Prolapsed uterus

At the request of USAID/Ethiopia, the Team informally explored the issue of prolapsed uterus. The Team was humbled, and concerned, to hear the stories about the suffering women experience from prolapsed uterus and the apparent extent of the condition in Ethiopia. The Team recommends strongly that USAID/Ethiopia and partners explore the potential for supporting training and service delivery for prolapsed uterus in government medical training programs and government hospital services; among NGOs in Ethiopia; and, to possibly create special surgical initiatives (‘camps’) with visiting expatriate surgeons on a regular basis. This may offer at least some hope to women living with prolapsed uterus while a more expansive program is someday developed.

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Lastly, thanks to Premila Bartlett, Sophia Brewer, Michael Dejene and Sara Roswurm who ensured the smooth logistics of the assessment, and made the job of the Team much easier.

I. Background

Introduction

This report is an external assessment of funding provided by the USAID/Ethiopia Office of Health, AIDS, Population, and Nutrition (HAPN) for fistula activities. The three partner organizations which receive funding are IntraHealth (through a sub-award from EngenderHealth), the Addis Ababa Fistula Hospital (AAFH), and the Integrated Family Health Program (IFHP). The assessment was managed through USAID's contractor, The Mitchell Group.

USAID funding for AAFH supports the satellite Hamlin Fistula Centers (HFCs) in Bahir Dar and Mekele to conduct fistula repairs, as well as the Bahir Dar, Mekele, and Yirgalem HFCs to conduct outreach and prevention activities. USAID funding also supports the Lutheran Mission (through AAFH) which is working with the Arba Minch Hospital to conduct fistula repairs. The AAFH and the HFCs are the principal sites for fistula repair in Ethiopia. These facilities provide a vital service to girls and women with fistula throughout the country, to girls and women beyond Ethiopia's borders, and to the many doctors from varied lands that come to AAFH for training.

USAID fistula funding to IntraHealth (IH) focuses on Amhara Region, where three pre-repair units (PRUs) support women living with fistula and serve as the locus of outreach conducted by community core groups which educate the community about fistula and maternal health, identify fistula cases for referral to the PRU and hospital, and encourage women to deliver at health facilities. The Dangla PRU includes a facility for comprehensive emergency obstetric care through a partnership among AAFH, IH and the Amhara Regional Health Bureau.

Funding to IFHP is not specifically earmarked for fistula. Rather, it funds IFHP's comprehensive integrated health program in 286 woredas throughout the country. Community education efforts include addressing harmful traditional practices including early marriage (which can contribute to fistula), and case identification and referral for fistula repair.

The objective of this assessment was to review the various components of USAID/Ethiopia's fistula portfolio: community education, identification of women with fistula, pre-repair centers, transport and referral, and surgical repair. The assessment included a review of the capacity, benefits and challenges of the three partners' work, as well as the linkages across the partners and with Government of Ethiopia.

The program objectives of the partners funded by USAID/Ethiopia are:

IntraHealth (through EngenderHealth)

- To increase the access of women with obstetric fistula to treatment and care
- To build facility and provider capacity in providing quality RH services, particularly in obstetric fistula prevention, care, and MCH-related services

- Bring about broad behavioral change at all levels around maternal health that includes obstetric fistula prevention and care, pre and post fistula treatment services, an increase in the seeking of maternal health services

Integrated Family Health Project

- To identify and refer fistula cases at the community level

Addis Ababa Fistula Hospital

- To increase the access of obstetric fistula patients to treatment and care

Together, the three partners offer a thorough approach to fistula programming in Ethiopia. Through their individual and collective work, including in partnership with Government of Ethiopia (GoE), they have achieved significant gains in educating people about fistula, identifying women living with fistula, and providing high quality surgical repair of fistula so that women may return to a life of dignity.

The period of this assessment was 3 May – 11 June 2010. Team members included Ms. Maggie Bangser (Tanzania/USA) and Dr. Abonesh Haile-Mariam (Ethiopia). While efforts have been made by the Team to verify information, there may be omissions and errors, for which the Team members take responsibility.

Strategic questions for the assessment

The statement of work (SOW) for the assessment included four strategic questions (see Appendix 1 for complete SOW).

1. How effective is the current structure of the USAID/Ethiopia fistula program in engendering sustainability?
 - a. Sustainability and replicability of the pre-repair center model
 - b. Integration of program activities with GoE programs at the national, regional, and local levels
2. Does the current model use available resources effectively to facilitate as many fistula repairs as possible?
3. How effective are the prevention activities of AAFH, IntraHealth (IH), and IFHP?
4. What recommendations can be made for future programming in obstetric fistula prevention, care, and treatment as
 - a. Currently structured
 - b. As a component of a comprehensive maternal health program

Seven general program questions and additional specific questions were also included in the SOW as time permitted. Given time constraints, the Team focused principally on the four strategic questions and attempted to address key general programs as time allowed.

Methodology of the assessment

The methodology of the assessment consisted of:

- Review of approximately 20 program documents and reports from USAID/Ethiopia and its fistula partners
- Interviews with headquarters and field staff of the partner institutions, as well as other organizations involved in reproductive and maternal health
- Program discussions with USAID/Washington and USAID/Ethiopia staff
- Two-day site visits to each of Bahir Dar and Mekele to meet program staff of partner organizations, community members and beneficiaries of the programs
- Follow up discussions through meetings and electronic communication after the in-country phase of the assessment.

A draft report was sent to USAID/Ethiopia for review and from USAID/Ethiopia to the partners for their review. Comments were received from USAID/Ethiopia and IH and these have been addressed, to the extent possible, in the final version of this report.

Caveats and limitations

This assessment was conducted in a short period of time, with 12 days in-country of which four were available for site visits to partners' work. As such, only a cursory view of the program was possible and similarly, discussions with USAID/Ethiopia staff. This assessment reflects the impressions gleaned from those meetings and site visits, and the information available in the documentation. The assessment is not a thorough or comprehensive external evaluation of any of the partner's work.

Translators were available as needed for interviews. However, some level of nuance and interpretation may have been lost given the language barriers.

Context of the assessment

Ethiopian women face among the highest maternal mortality and morbidity rates in the world as a result of poor socioeconomic status, limited access to and utilization of health services, an array of challenges in seeking appropriate care at time of delivery, and severely limited emergency obstetric care. An estimated 20,000 women die annually in Ethiopia from childbirth related complications, while many more sustain life-long disabilities such as obstetric fistula. It is estimated that about 9,000 cases of fistula occur each year in Ethiopia.

The GoE has introduced strategies to reduce maternal and neonatal mortality and morbidity, and name these as top priorities. GoE seeks to strengthen the health system, through a continuum of care approach, to link households to the highest referral level for appropriate care. The new Health Extension Program (HEP) is one of the key pillars of the health sector, and reaches the community with preventive health information. The other main strategy is to strengthen the health system through the expansion of health infrastructure, training of skilled health providers, and strengthening the logistics and health information systems.

The 2008 National Baseline Assessment for Emergency Obstetric and Newborn Care (EmONC), based on 797 facilities (751 of which provided services for childbirth), contains extensive and useful information for policy making and planning on maternal health. One of the key objectives of the Assessment was to establish a baseline for indicators that determine, among other attributes:

- if the number of fully functioning EmONC facilities is sufficient for the entire
- population of the country,
- if the distribution of these facilities is equitable,
- if pregnant women access these facilities for delivery,

Only 10% of the facilities visited met the criteria of fully functioning as defined by the performance of seven life-saving interventions for basic EmONC; or nine interventions for comprehensive EmONC. A health facility qualifies as functionally providing basic EmONC if all seven life-saving interventions or signal functions are provided in the three months prior to the assessment. A facility qualifies as functionally providing comprehensive EmONC if caesarean delivery and blood transfusion services are provided in addition to the seven basic services (Monitoring Emergency Obstetric Care: A Handbook. WHO, UNICEF, UNFPA and AMDD, 2009).

As of 2008, only 51% of hospitals qualified as comprehensive and only 1% of health centers could be considered basic EmONC. Nationally, only 7% of births occurred in hospitals and health centers; less than 1% of deliveries in Ethiopia were cesareans; and only 7% of births were assisted by skilled attendants, and 26 % of facilities reported using partograph.

Access to services was also assessed, showing that fees for service and lack of transportation to a facility are key barriers to access, and over 60% of facilities charged fees for services including delivery.

Data from Amhara and Tigrey (the two regions visited during this fistula assessment) is worrying. In Tigrey, only 9% of deliveries take place in a facility, and only 4% of facilities meet the UN criteria of providing emergency obstetric and neonatal care (EmONC). Thirteen percent of women with direct complications of childbirth are treated. In Amhara, 5% of deliveries take place in a facility, and 2% of facilities provide EmONC. Only 4% of women with direct complications of childbirth are treated. The caesarean section rate in both regions is below 1%.

Fistula repairs, outside of the Addis Ababa Fistula Hospital and the HFCs, are scarce. Only 3% of facilities in Ethiopia (other than AAFH and the HFCs) reported performing fistula repair during the three months prior to the survey (8% in Amhara; 2% in Tigrey).

II. Effectiveness and comparative advantages of partners including the ‘pre-repair units’ (PRUs)

This section begins with an overview of seven program areas, across the partners: identifying and screening women with fistula; prevention; transport; training; fistula surgery; reintegration; cooperation and collaboration. Several suggestions for moving forward are presented.

Following the overview are highlights of the three partners in five areas:

1. Prevention/community awareness; identifying/treating women with fistula
2. Health systems
3. Assets of the program (with some sub-themes)
4. Questions for consideration
5. Program reach

A. Overview of program areas, across partners

1. Identifying and screening women with fistula

Each of the three partner organizations has activities to identify women with fistula and link them to facilities for repairs. In the case of IH and IFHP, community representatives and local health workers are primarily involved to educate people about fistula and identify 'hidden cases'. IH works on fistula in Amhara Region, principally through Community Core Teams (CCTs). IFHP's program works through Community Health Volunteers and IFHP's 'partner organizations' such as Women's Affairs, REST, etc. In the case of AAFH, women with fistula are identified through outreach organized by focal persons in the Tigrey HFC; in Yirgalem, the Prevention Officer carries out this work in close coordination with the GoE health extension workers (HEWs) and others. An upcoming poster campaign in several regions will complement these efforts.

The HFCs in Bahir Dar and Mekele report receiving patients through the IH and IFHP contact points. In Bahir Dar, the largest numbers of referrals come through IH; in Mekele the largest number through health workers. It is reported that in the area around the Dangla PRU, there is no longer a backlog of women with fistula which is a positive sign.

Both IH and IFHP provide transportation for women to reach HFCs. IH has vehicles dedicated to this purpose (although there is a need for more vehicles) and IFHP uses its organizational vehicle pool. Both partners also arrange other modes of transport, e.g., hiring minibuses.

At the moment, there seems to be a division of work geographically across the three partners, so using similar cadres of health workers and messages does not create duplication. However moving forward, it would help to have a clear mapping of 'who is doing what, and where' in order to ensure that resources – financial as well as human – are used most effectively.

No 'one size fits all' approach works for community education, identifying women, screening for fistula, and transporting women to repairs. Nor should one approach be enforced. Partners should be encouraged to seek out the most appropriate strategy to identify women and link them to hospitals for repair, utilizing each partner's particular strengths in community outreach and referral.

The IH approach, working through fistula mentors and CCTs, brings a tight focus on fistula and maternal health to the community outreach case identification. The back-up of the three pre-repair units (PRUs) ensures that identifying women with fistula is not lost in either broader maternal health messaging, or general public health messaging. At the same time, the sheer reach of the IFHP program into 286 woredas means that information about fistula is carried widely, but the risk is that in an overall public/family health initiative, a specific concern about fistula may get lost. Finally, the approach being used by AAFH to employ a focal person for this work raises sustainability questions akin to those facing IH's approach.

The question of sustainability is discussed in full below, but the assessment Team cautions against a narrow interpretation of "sustainability" given the reliance on donor funding among all three of USAID's fistula partners – and development efforts writ large. Thus, any 'incentive' that is paid to identify a women with fistula will cost money – whether it a payment in the form of salary to a mentor or focal person, a "volunteer" of a partner organization such as Women's Affairs, or a government HEW. Relative costs can be determined and choices made based on this, but an incentive is an incentive and funding is required for such a scheme.

The challenge ahead is to identify women in more remote areas and those who are particularly hidden and unable to access information, much less care. This will require the partners to move into hard-to-reach locations using existing strategies and new ones such as radio, religious networks and the strong civil service cadres of teachers and health workers including HEWs.

Another challenge is to harmonize – or at least document openly – the payments that are being made for identifying women with fistula. The Team heard several reports that the partners are giving payments to (one, some or all of) women themselves, the 'finders', and associated health workers for referral of women for repair. (Who exactly is receiving how much across the three partners should be confirmed by the partners.) This has created some level of tension across the partners and in some cases reportedly for the women themselves who become a source of competition. This matter needs to be resolved – ideally with a harmonized approach, but at the least with open knowledge by all partners about the level of payments and to whom payments are given. It is important to ensure that the safety, dignity and comfort of the women are not jeopardized.

2. Prevention

IH and IFHP are addressing prevention through education on maternal and reproductive health with community members as mentioned above, and through training health workers, principally HEWs. There was not enough time during the assessment to gather detailed information on the prevention education messages, but this would be worth exploring in future.

IH Mentors provide supportive supervision to 531 health centers and health posts in 17 woredas, including promoting the use of the partograph for monitoring labor. Mentors use a checklist to:

- Assess conditions in the health centers for high quality services
- Identify problems or obstacles in service delivery or in data reporting
- Make recommendations for improvements in service delivery or data reporting
- Assess whether recommended measures for action are implemented

- Communicate with health center staff, health center management and woreda officials about issues and recommendations.

IFHP's program is specifically designed to support government health service delivery overall. The reach of the IFHP program into 286 woredas (including 78 in Amhara) represents a particularly good opportunity to expand fistula awareness and improve maternal health service delivery. An evaluation of the IFHP program was conducted by USAID in 2010, and provides detailed information on the strengths of the program and areas for work in future (USAID/Ethiopia Integrated Family Health Program: Report of the Phase I Review).

To date, the IFHP program includes attention to gender and harmful traditional practices – and within that, fistula. However a specific focus on fistula has been minimal. The new IFHP program on Maternal and Newborn Health (MNH) represents an important opportunity to address prevention and treatment of fistula more directly.

AAFH has already begun training health officers within a new model for placing trained health officers and midwives in facilities providing emergency obstetric care. The health officers also work with AAFH focal persons (based at the HFCs) who conduct community outreach, do patient identification, and work with and train GoE health workers. This is first being tested in Mekele.

The provision of - or effective referral to - comprehensive EmOC is pivotal to future programming given it is a key to decreasing the incidence of fistula. Other sections of the report will discuss this more fully. IH has provided equipment to the Dangla Health Centre for emergency obstetric care (EmOC) and has trained two health officers and three midwives there. In addition, IH has budgeted for the cost of an anesthetist, generator and consumable items to make the health centre operational for EmOC for a one year period with approval from USAID/Ethiopia. Unfortunately, the EmOC services are still not functioning due to the lack of an experienced obstetrician/gynecologist who could provide services and mentor the staff posted there. USAID should quickly help to resolve this through its partnerships with GoE, IH and AAFH.

A note of caution in the prevention messages about fistula: while early marriage and pregnancy *may* contribute to a girl or very young woman getting fistula, early marriage and pregnancy are not the key drivers of fistula. Rather, it is lack of access to appropriate emergency obstetric services when a complication arises. During visits particularly in Mekele, community members spoke a lot about reducing early marriage. This was very encouraging and positive given that under any circumstance, girls should marry at an age that allows them full rights including to education. However it is important that the messages about early marriage not diminish the importance of messages around birth planning and effective access to health care at time of delivery. It is access to skilled, appropriate and timely care that will save women's lives and reduce fistula.

3. Transport

Transportation from remote areas to hospitals providing fistula repair is a pivotal component of the program. Without appropriate transport, women's vulnerability increases. Transport is a program component that is often overlooked by donors as a major area for funding and investment, perhaps due to the ease of transport that donors typically enjoy. For women with fistula, however, transport can make the difference between accessing fistula care – and not.

Partners are currently using a range of transport schemes to bring women with fistula to the HFCs. These and other strategies need to be supported, including the possibility of using government vehicles and government and/or community financing schemes.

4. Training

As mentioned in relation to prevention and outreach, all partners are involved in training different cadres of health workers and community members on fistula, and to some extent, emergency obstetric care. It would be useful for partners to do a 'mapping' of training to ensure maximum use of resources and to avoid duplication if it exists. The mapping could identify, among other items:

- who is being trained
- which skills, information sets, etc. are covered in each training program
- type of training, e.g., informational, theoretical, competency based
- particular outcomes at community/facility level
- locations reached by training

Several people noted that training of appropriate persons at health facilities to diagnose fistula correctly is needed in order to decrease the number of 'false positive cases' that are referred to the HFCs. This is not a concern among the PRUs given the thorough screening of women and care for them before referral.

Unfortunately the timeframe of this assessment did not allow for a review and set of recommendations regarding types of training that would be most useful to, and appropriate for, various cadres.

5. Fistula surgery

A major initiative of the AAFH in recent years has been to establish the HFCs in order to make fistula repair more available to women – particularly those in remote areas that cannot reach Addis Ababa. This extension of the AAFH services is extremely important, and the Team encourages AAFH to consider even further expansion to the extent it is feasible and appropriate for the institution.

“Using public transport robs a woman with fistula of her dignity.

She sometimes needs to take off her clothes and sit half naked in the bus in order to absorb the urine.

Sometimes she has to carry a container so her urine won't spill all over the bus.”

-Women's Association representative

Without diminishing the unique and vital role of these services, concerns were raised to the Team that the exclusive responsibility of fistula repair resting with AAFH may – however inadvertently – excuse the Government from taking up fistula care. Given the understandable capacity constraints in GoE hospitals to doing fistula repairs, it would be useful to at least explore the possibilities for public-private partnerships for fistula care in order to increase access to treatment. For example, in future, AAFH may consider piloting a scheme to mentor doctors in government hospitals and provide equipment and supplies necessary for fistula surgery, etc., rather than building a separate satellite facility.

The Team supports AAFH in its focus on fistula repair including its continued commitment to training Ethiopian doctors. The Team also appreciates that after training, doctors are often not placed in facilities supporting fistula care, or themselves are choosing not to do fistula surgery. As a result, AAFH needs to make decisions about how it targets its resources to interested doctors. The Team also considers it useful for AAFH to debate further its role in prevention, outreach and training of health workers (even if specifically on fistula) given the need for additional repair capacity in the country and the availability of partners such as IH, IFHP and others to do these other programming dimensions. This will be discussed further in the report.

6. Reintegration

The Team was not asked to look specifically at reintegration of women after repair, but it did feature in discussions.

After fistula repair, IH provides post repair rehabilitation in the PRUs for some period of time, transports women to their families, and undertakes follow up every three and six months post-repair. IFHP provide support to women for reintegration including transport home and payments (either cash and/or in-kind) to assist in re-starting life, for example the purchase of livestock for use and sale of subsequent offspring. AAFH does not provide cash or in-kind support, and focuses on getting the women ‘dry’ and back home as soon as possible.

Other agencies (e.g., Women’s Affairs) with other donor funding (e.g., Packard Foundation) are reportedly also providing cash or in-kind support to women after repair. An inventory of the various modalities and amounts would help clarify matters amongst the partners. Experience from several settings shows, however, that once a woman is healed of her fistula and is completely dry (including no stress incontinence), she can typically reintegrate home and is no worse off than other marginalized women. The exception may be women who lived with fistula for a long period of time before repair, and hence experienced severe isolation and stigma, making re-entry home more difficult. As such, the Team does not recommend at this time a new program focusing on reintegration, at least until there is more evidence from international experience that supports the particular usefulness of such an intervention.

7. Cooperation and collaboration

Overall, conversations with partners, GoE, other NGOs, and USAID all pointed to positive relationships and cooperation among the USAID funded agencies. This includes cooperation with GoE at the regional and woreda levels.

In Amhara, a Reproductive Health Partners Forum has been established and IH helped to convene a harmonization workshop to clarify issues related to programming on fistula. The Team heard there is a similar forum in Tigrey. At the federal level, one donor involved in reproductive health recommended that fistula be addressed within the existing Safe Motherhood Technical Working Group, and not through a group looking only at fistula. This is an appropriate recommendation in the view of the Team. In each case, however – in regional and federal forums – it is important to make sure fistula is in fact addressed and not lost in a broader view of maternal health.

Managers in the regional health bureaus did point to several issues that need to be addressed: joint planning of activities and budgets, comprehensive reporting to regional authorities, and integration of fistula/maternal health programming into regional priorities. They also said that generally in donor funded projects – not only fistula related - health workers are repeatedly taken from post for training, often with little or no warning to health bureaus, thus leaving a gap in workers on site.

For the three partner organizations working on fistula, several obvious recommendations emerge from this information and previous issues raised in the report: to conduct a ‘mapping’ of which organization is doing what, where, with which cadres and community groups, and paying what incentives; to maximize engagement with regional and woreda authorities for planning, budgeting, and reporting; and to share this information across the three partners as well.

On the part of USAID/Ethiopia, overall feedback was positive regarding the relationship between partners and USAID, and GoE and USAID. Concerns raised were largely around per-diem for workshops, which is a problem in development overall and not only USAID or fistula related work. Nonetheless, the Team heard that USAID is too focused on workshops which is a poor use of funds and diverts people from their jobs. Furthermore, it essentially pays people for the wrong thing - for showing up at a workshop rather than performing on the job.

Lastly, it would be useful for USAID/Ethiopia to coordinate with AAFH to have their data presented in a format consistent with data supplied by other of the Fistula Care (EngenderHealth) sites so they can be easily compared.

B. Highlights of partners’ efforts

This section outlines (with some variation) highlights of each partner in terms of: prevention/community awareness and identifying women for repair; health systems strengthening; assets of the program; questions for consideration; and, program reach.

IntraHealth and the PRUs

The future role of the PRUs is a particular question for USAID; specifically, the sustainability of the model and the possibility of incorporating elements of the PRU into existing service delivery structures. Below and in the section on Moving Forward, several ideas and questions for consideration are presented.

Overall, PRUs provide a platform for both fistula as well as strengthening maternal health services at the health centers (HCs) where PRUs are based and their related health posts (HPs). The Team believes it is a misnomer to consider the PRUs only for “pre-repair” since they serve a broader function at the community level regarding maternal/reproductive health education, and strengthening service delivery at the health facilities they reach.

The Team explored the possibility that some elements of the PRUs might be integrated into existing services of health facilities and other GoE or NGO efforts. The benefits and risks to this as presented below and in following sections of this report.

1. Prevention/community awareness; identifying/treating women with fistula

- Focus region for fistula is Amhara.
- Community education and mobilization on fistula and maternal health done through 114 Community Core Teams of 10-12 members each.
- Health education given also to clients at HC reached.
- Effective identification and screening of women with fistula and communication to HFC for referral.
- Transport provided for repair at Bahir Dar HFC using primarily IH vehicles.
- Follow up support after repair.

2. Health systems strengthening

- Clinical support and supervision at HC by Fistula Mentor.
- Services provided through PRU: nutrition, counseling for family planning (FP); counseling for HIV and HIV positive women referred for treatment; treatment of infections; transport to HFC for repair; some reintegration.
- Supportive supervision at HC and HPs. Marked increase in correct use of partograph at HCs in 08/09 year.
- Support to woreda for health planning, regional harmonization of actors.
- Payments made to CCT (allowance), Mentors and nurse aides (salaries).

3. Noted assets of the PRUs

- Valued by community, woreda and regional health bureaus
- Provides psychological support (counseling), clinical support (infection treatment, deworming, etc.) and personal support (nutrition, place to stay, laundry help) to women pre-repair.
- cursory look at referrals to HFCs suggests the PRUs could be a cost-effective approach for identifying ‘hidden cases’ – significant number reached compared to health worker referrals and from other partners (a cost-effectiveness analysis of the approach was not possible in this assessment).
- Effectively identifies and organizes transport for women for HFCs.
- Coordinates health worker training, supportive supervision, capacity building for MH
- Maintains a focus on fistula.

4. Questions for consideration

- Are the PRUs providing a benefit in terms of surgical outcome of women with fistula and reduced bed time at HFC? These need to be examined.
- What is the appropriate way to contextualize the PRUs? Fistula only – or maternal health?
- Are the incremental costs of the PRU room and staff persons reasonable given the benefits of the PRU in terms of patient identification and clinical/psychological support?
- Are the PRUs less sustainable than other fistula-related interventions?
- What components of the PRUs could be responsibly integrated into GoE structures or programs of other NGOs, for example the HFCs?
- What are the benefits and drawbacks of integrating different components of the PRU given, in particular, that health centers are not in a position to provide these services since they do not have in-patient capacity and reports of resistance on the part of health workers?

5. Program reach

- 17 woredas; 531 health centers and health posts.
- April 2006 – March 2010: 1,110 women have sought care at the PRUs with 656 women referred to Bahir Dar Hamlin Fistula Center; approximately 2,661 health workers and 1,543 community volunteers received training; 6,254 events were held with 1,172,848 people reached.
- Bahir Dar HFC reports approximately half of patients coming through IH referrals.
- \$1.33m USAID funding over three years.

“We are planting a
crop.
It is growing.
Before it is ripe,
it is being cut.”

-An elder's comment on the possibility
of closing the PRU

IFHP

1. Prevention/community awareness; identifying/treating women with fistula

- Fistula education and referral a piece of overall IFHP comprehensive community health outreach on reproductive health, FP, nutrition, MNH. Fistula is under the section dealing with Gender and harmful traditional practices (HTPs).
- Working principally through intermediary partner organizations (IPOs) such as Development Associations of the regions, faith based organizations, Women's Affairs, etc. Also work with HOs, HEWs, community health volunteers (CHVs), community members, justice bodies, mobile FP van, etc.
- Community Conversations (CCs) ask people about 'best practices' and 'model families' on RH, HTP including fistula, HIV, etc.
- Arrange transport to Mekele HFC with IFHP vehicle or hired vehicle.
- Bypass the three fistula pre-repair centers as do not see value added.
- CHVs get a training allowance now (not a regular stipend), since quarterly payments to CHVs has ended.

2. Health systems strengthening

- IFHP is structured as a government capacity building project.
- Master trainers in specific health areas.
- Wide range of basic health issues covered including RH/FP, child health, HIV/AIDS, tuberculosis, and malaria.
- HEWs supported to do their assigned tasks, and seem to be effective.
- Supports GoE in planning, monitoring, supervision.

3. New maternal newborn health (MNH) program of IFHP

- MNH designed to strengthen health system through a Primary Health Care approach on maternal and newborn care, with a key objective to increase the number of deliveries at health centers.
- Health officers will be posted at zonal health offices to provide technical assistance to woreda health offices. No additional financial incentives to the government staff.
- ‘Learning phase’ in five districts in Tigrey, and one district in each of Amhara, SNNPR and Oromiya. Selected facilities in each district named. First phase estimated to last for two years; expansion afterwards.
- Main activities - system strengthening, training health providers in BEmONC, training community level health extension workers and mentoring, community mobilization for maternal transport. (Additional funding for JHPIEGO's technical support for training in BEmONC.)

4. Potential assets of the IFHP/MNH program

- IFHP utilizes comprehensive health approach, with a planned focus through MNH on maternal health.
- Broad reach into GoE structures; funding includes coordinators placed at regional, zonal and woreda levels.
- Focus on systems strengthening.
- Plan includes upgrading facilities for comprehensive EmOC.
- Program provides opportunity to identify women with fistula, provide transportation, train health officers to screen and confirm cases.

5. Questions for consideration

- To what extent is fistula addressed in the current IFHP program and the upcoming MNH program? (No mention of fistula in the recent IFHP evaluation; staff report that planning for MNH program has not yet given attention to fistula.)
- What steps will IFHP/ MNH take to harmonize work on fistula?
- Funding to IFHP is large - \$50million. How is sustainability being addressed?
- Seemingly small number of fistula referrals from IFHP to the Mekele HFC. How can the numbers of fistula patients referred to the HFCs be increased?

6. Program reach

- Current IFHP reaches 286 woredas predominantly in Amhara, Oromia, SNNPR, Tigrey. 29 out of 47 woredas in Tigrey are covered.
- Source of referrals to Mekele HFC – 10% from IFHP.

- Source of referrals to Bahir Dar HFC – 12% from IFHP.

AAFH

1. Prevention/community awareness; identifying/treating women with fistula

- AAFH places value on psychological support provided at PRUs, and waiting space for when HFCs get full.
- Beginning prevention program; want to work with partners on this. Particularly in-line with IH model of working.
- Have requested specifically that patients be identified in East Amhara for referral to the Mekele HFC. Want to do local mappings to avoid overlap.
- Structure of outreach program:
 - AAFH has health officers based at their HFCs. They are paid by AAFH. The HO manages the strategy of community intervention from the HFC.
 - The HOs at the Mekele HFC hire focal people based at HCs and community level for identification of fistula patients in rural areas (12 now in Mekele). HO also makes visits to rural locations to train health workers, TBAs, HEWs, community reps, etc.
 - Incentive of 200 birr is paid to focal person for identifying woman. That money can be shared with others involved in identification and screening.
 - Money is not given to women for reintegration.
 - Mekele model will be trialed in other locations where the demographics are similar. Other regions may follow a different model, based on what AAFH sees to be most effective given the demographics of the location.
 - Poster campaign in rural areas on fistula, cell number for referring women.
 - No transport arranged yet, waiting for 4 vehicles from USAID funds.

2. Health systems strengthening

- Leading fistula repair training center and hospital in the world.
- Four HFCs have been established, with one more planned.
- Enables USAID to meet Congressional Directive of numbers of women repaired.

3. Training

- Expect to train the HOs at Dangla HC in c-section. If it works there, may extend.
- Train gynecology residents for two months.
- Midwifery training – three year BA program, first graduates will graduate in September. Competency-based training. Plan to have 25 clinics total – 5 per region.
- Midwifery students, upon graduation, will be placed for several years at a maternity ward within a health centre within a government facility in the woreda from which the student comes. AAFH will ensure that the HC is equipped, supplied and has access to emergency transport for referral for EmOC. A midwife supervisor will be placed in the HFC which is located at the GoE referral hospital in order to provide mentoring and supportive supervision. They will make visits to the clinics where the AAFH trained midwives are located. The basic salaries for the rural midwives will be paid by the GoE. AAFH will provide some top-ups and a career plan to keep them engaged.

4. Program reach

- Initial agreement with USAID was to support operational and outreach costs of Bahir Dar HFC; amended to include Mekele (outreach and operations) and Yirgalem (outreach only).
- \$3.14m for 2006-21 (USAID money).
- USAID funding reaches 77 woredas in Amhara, SNNPR, and Tigrey.
- Bahir Dar HFC operating at 95% capacity; Mekele HFC at 50%. At Bahir Dar HFC, the largest numbers of referrals come through IH; the existing PRUs may help explain why the center has reached 95% capacity. It is hoped that the Mekele HFC will also benefit from referrals through the two new proposed PRUs feeding to that site.

5. Questions for consideration

- Does the role of AAFH in Ethiopia diminish GoE ownership of fistula? Are there ways to encourage greater GoE engagement with fistula – e.g., integration of fistula training into pre-service training of gynecologists? Foster a public-private partnership between AAFH and GoE in the provision of fistula repairs in government hospitals?
- What are suitable ‘boundaries’ for AAFH community outreach efforts and where can partnerships with IH, IFHP and other organizations be built to strengthen synergies and decrease duplication?

IV. Moving forward with funding for fistula

A. Finding the balance

A major question in programming for fistula across a range of settings is how much to integrate and how much to maintain a singular focus. The answer is typically to find the appropriate balance. Integration of fistula into maternal health or public health initiatives allows for broader reach, but fistula can get lost. A singular focus on fistula typically provides women with higher quality and more efficient service delivery, but there’s usually a question of long term institutionalization. In both cases – integrated programming or stand-alone – sustainability is at play since any donor funded effort (even broad ones supporting government programs) require external funding.

To date, USAID has funded a promising set of partners who are addressing fistula through different approaches, both integrated and ‘stand-alone’. Each approach is bearing fruit, and also raises some questions around effectiveness and institutionalization in future. Overall, given the benefits of the current mix, but recognizing the considerations outlined below, the Team recommends that USAID continue to support a mixed portfolio of partners. This will increase the likelihood of achieving optimal program results (health systems strengthening; adherence to a focus on fistula while linking to broader maternal health); provide an opportunity to test promising program approaches for the future; and, facilitate treatment for the highest number of women as per USAID’s Congressional Directive.

And lastly, there is the question of multiple players and multiple donors. While USAID is the major donor in Ethiopia funding fistula related work, it is not the only donor and others may join the work in future. The Team does not have specific information on grant-making plans of other donors, and recommends that USAID communicates with partners to find this out. Similarly, the partners funded by USAID are not the only ones working on fistula and this, too, may grow. Keeping an eye on the entire field of actors and donors will be important for USAID to determine what kinds of fistula interventions its funding would support most effectively in future.

B. Timing

This overall recommendation takes timing into consideration. The GoE's Health Extension Program reportedly provides information on fistula through HEWs. This is a promising platform for additional outreach and case identification, as is GoE's recently announced commitment to significantly up-scaling maternal health services. On fistula programming more specifically, the HFCs are now largely up and running, and the IH and IFHP programs are making progress. This is an opportune time to build on these early successes and not cut them short.

At the same time, it is important to identify the programming elements that illustrate 'best practices', as well as those that may be phased out in future. One example is the MNH effort within the IFHP which presents an opportunity to assess the benefits and drawbacks of larger more institutionalized programming on maternal health (including fistula prevention).

C. General considerations across partners

1. Reaching women in remote areas

Overtime, it will be increasingly important to focus efforts on remote areas of the country where women have the least access to health care including maternal health. Already the Team heard that there is a decrease in the numbers of women living with fistula for extremely long periods before repair, likely due to the success of outreach and patient identification. This is a very positive sign. In future, and following on the experience in several other countries, the current fistula program may well find that fewer women are coming for repair from the areas in relative proximity to AAFH and the HFCs. This is likely to represent success in reaching those women who are relatively easier to locate. Focusing outreach on remote areas – either through HEWs, other front-line people, or the PRUs – will provide an avenue for pushing the boundaries of information and contact to women needing access to treatment. Building on the GoE social mobilization effort to promote maternal health using the Federation of Women's Associations may also be a useful platform for expanding reach to new and remote areas of the country.

2. Examining costs

USAID, understandably, seeks cost efficiency in its funding. Given time constraints of this assessment and the priorities given to the Team, a cost-benefit or cost-effectiveness study was not possible. USAID may want to consider examining this in relation to the different approaches of its partners in future. The Team cautions that sustainability needs to be carefully considered, since in reality any donor-funded program is un-sustainable while receiving funds and typically teeters on the edge of elimination once donor funding ceases; government-led donor funded

initiatives included. The question is really more about vision, leadership, appropriate integration into government structures and measuring outcomes than about whether or not donor funding continues.

If USAID moves forward with a cost-effectiveness study of its fistula related work, it could compare elements of various models for example grant dollars against: numbers of women with fistula reached/referred; numbers of people reached with community education; health system improvements in maternal health (e.g., health workers trained, health workers supervised); etc. Within this, a study could also shed light on the human costs of the different approaches in terms of for example: whether the potentially higher costs of providing women with psychological support before/during/after fistula repair justifies the program costs of providing such supports.

D. Institutionalizing EmOC through the fistula partners

While the experience of trying to institute comprehensive EmOC at the Dangla Health Centre has not yet been productive, the Team encourages USAID to continue supporting various strategies to strengthen CEmOC capacity – both through NGO initiatives and GoE systems.

USAID could support all three of its current fistula partners to test strategies for improving CEmOC: AAFH’s proposed health officer training/EmOC program; the IFHP/MNH proposal which includes CEmOC; and reformulating the PRU approach into a ‘phased’ strategy of improving CEmOC services akin to the AAFH CEmOC program. This may present opportunities for supporting current grantees to bridge between existing prevention/ID/referral models to institutionalizing EmOC – a key pillar of maternal health programming and preventing fistula.

Further discussions with the partners may also identify a streamlined way to approach this. For example having partners test a phased approach from fistula -> EmOC in different regions. Or, to test a methodology that GoE can take to scale such as the MNH program seeks to do over time.

E. The partners – considerations for future programming and support

1. IntraHealth, and the PRUs

At this time, the Team does not advise integrating PRUs completely into health centers given the lack of capacity at HCs to take on these functions, and the reported unwillingness of many health workers to deal with fistula patients. The Team sees a positive value in the role of the PRUs, although appreciates that in the medium term several components may best be integrated into GoE programs (community awareness, patient identification) and even those of other NGOs including IFHP/MNH (outreach, patient identification) and the HFCs (e.g., pre operative care). Given the timing issues noted above, however, the Team does not recommend disbanding the PRUs now. The Team also recommends that the two additional PRUs under discussion be opened, but with modifications either immediately or in the near-term.

AAFH recommended that PRU’s serve an important “step” in fistula care but should not exist indefinitely. AAFH suggests that after raising awareness of fistula and identifying women for referral, the money for the PRUs could be re-focused on improving access to emergency obstetric care in that region. As part of this, the PRU pre-operative supports (e.g., the room for

women) could be annexed to the wards in the primary or district hospitals (or upgraded health centers) in remote localities. This would need to wait for the GoE maternal health upgrading program to be underway and successful.

Considerations for future support to IH and the PRUs:

1. Fund simple ‘operations research’ to inform upcoming roll-out of PRUs to two new sites and to inform the appropriate ‘lifespan’ of PRUs (would need to identify appropriate agency to do the research).
 - a. Do women who go through PRUs have better surgical outcomes?
 - b. Do women who go through PRUs have reduced bed-time at HFCs before surgery?
 - c. Are there particular aspects of the Mentors’ training and supervision that uniquely contribute to the maternal health services at participating HCs and HPs? How would these achievements inform and strengthen GoE maternal health services, including introduction of EmOC?
 - d. What is the feasibility and cost effectiveness of integrating PRU components into upgraded health centers and at appropriate hospital levels?
2. Test scenarios for institutionalizing components of the PRUs into NGO and GoE structures and possible associated risks.
 - a. What specific clinical and support functions (nutrition, treatment of infections, counseling) could be integrated into HFCs *assuming* bed space?
 - i. Risk - Hidden cases, once identified, never reach the hospital for repair due to social/logistical constraints to reach HFCs
 - b. How could the community education component of the PRU be incorporated into IH’s PMTCT; IFHP’s comprehensive program and new MNH program?
 - i. Risk - the IH PMTCT program currently serves high HIV prevalent areas which are predominantly urban, so not where hidden cases of fistula reside.
 - ii. Risk – fistula may get lost in the multi-faceted nature of IFHP’s work.
 - c. What are the benefits and drawbacks of integrating PRU components into GoE health centres, woreda activities, etc.?
 - i. Risk - GoE lacks capacity to carry out these activities, and may well not sustain a commitment to fistula.
 - ii. Risk – Health centres lack space for inpatient care and have high staff turn over, making it difficult to maintain continuity of services and providers’ skills.
3. Expand PRUs to the two new sites in East Amhara within a strategy to test revised models for institutionalization (see also EngenderHealth/IH note on revised strategies). Possible revisions to test:
 - a. Role of the Mentor (in each case, need to address who will pay salary, supervise, hire/fire, etc.)
 - i. Keep PRU intact; shift mentor to woreda health bureau to be integrated into on-going woreda health activities.

- ii. Keep mentor at PRU; integrate mentor's activities more fully into woreda administration.
- iii. Eliminate position of mentor; train a GoE health worker to be a 'master trainer' for the site
- b. Community education
 - i. Train a focal person at kebele, woreda and/or zonal level to supervise the CCTs rather than the Mentor. Supervision will be an issue as is keeping focal persons motivated.

2. IFHP and the new MNCH program

The Team received information on the new MNH program of IFHP late into the assessment period, so a full review of the program was not possible. Given the information obtained, the Team feels that the MNH component provides an excellent opportunity to test a strategy for building broad systems for maternal health. It will take some time, however, to realize these objectives, particularly ensuring comprehensive EmOC which is a key to reducing fistula. Moreover, the new MNH program will cover only one district in each of the major regions, so results will not be seen in the near-term.

Considerations for future support to the IFHP/MNH:

1. The MNH program and the section working on gender and harmful traditional practices should ensure that fistula features into its programs and is specifically addressed in the MNH efforts. To date, there has been little mention of fistula in IFHP's documents and discussions with staff, beyond the Team's site visit in Mekele which was pre-announced to address fistula.
2. IFHP/MNH foster strategies with GoE for integrating fistula into system-wide programs on community and maternal health
 - a. Identify 'hidden' fistula cases through the woreda management Team where the HEW is a member
 - b. Support kebeles and woredas to develop mechanisms to refer women with fistula to HFCs for treatment
 - c. Coordinate transport for women with fistula
 - i. Explore use of GoE vehicles and ambulances
 - ii. Explore if different health financing schemes could including emergency transport for maternal health complications, fistula referrals
 - d. Train and supervise HOs based at HCs to screen and confirm cases of fistula

3. AAFH

The principal role of AAFH and its HFCs is to provide all, or at least the vast proportion, of fistula repairs in the country. This is a vital service that requires continued support. Most importantly, continued support for the clinical work will enable girls and women to return to a life of dignity; it also enables USAID to fulfill the mandate of the Congressional Directive to reach women with fistula repairs.

As described earlier in this report, AAFH is also beginning a program of community outreach and patient identification, together with training of health officers and midwives. The AAFH

approach is somewhat different than those of IH and IFHP, and therefore adds additional experience and information to the collective understanding of how best to improve service delivery to prevent fistula and make referral for treatment more efficient.

At the same time, there may be ways in which to share the responsibility of testing these different approaches so AAFH can continue to focus its efforts on treatment. In line with the recommendations above on the PRUs and the new MNH program, synergies should be sought with AAFH's plans for outreach/referral. One strategy may be to have AAFH focus its new program on testing models of effective outreach/referral, and partnering with IH and IFHP to implement 'best practices'. In essence, then, AAFH would not move concertedly into implementing outreach itself.

This decision is, of course, for AAFH to make in light of the experiences it has with the existing models of outreach and referral, and its view of the gaps that need to be filled. The Team recommends on balance, however, that AAFH emphasize expansion of its HFCs to reach women in new areas. Outreach and referral could remain the purview of IH, IFHP and other partners, with AAFH contributing to the conceptual and technical design of these strategies but not their actual implementation.

4. USAID

In addition to its role as a donor, USAID/Ethiopia can play a particular role as a partner in fistula work in-country. Several recommendations follow:

1. Overall, continue funding current partners in order to maintain the momentum on fistula to date, and the gains made in prevention and care.
2. Delineate maternal *morbidity* as well as maternal mortality in all maternal health programs. The magnitude of maternal morbidity far exceeds that of mortality, and the strategies for reducing maternal mortality also address morbidity. Programs and research should encompass both dimensions of maternal ill-health and state so explicitly.
3. Together with its partners:
 - a. Support advocacy and capacity building for the integration of fistula prevention and care into the national health systems policy and service delivery strategy.
 - b. Ascertain, principally with AAFH, the potential for including fistula repair technique into a competency based pre-service gynecology training curriculum. The realistic-ness of this idea should be objectively assessed. Related questions should also be asked regarding – after training – the capacity in Ethiopia for adequate supervision and mentoring of trained doctors, the infrastructure needs that trained doctors have for performing fistula repair, and whether doctors once trained are able to operate in a conducive environment. AAFH would be the appropriate partner to take this forward.
4. Clarify the blockages to getting the Dangla EmOC facility fully functioning, and resolve the impasses.

5. Assess the situation at Dangla in terms of what it means for USAID's future investment in strengthening provision of comprehensive EmOC services.

V. Prolapsed uterus: the next frontier

The Team, at the request of USAID/Ethiopia staff, also explored the issue of prolapsed uterus during interviews. The Team was humbled, and concerned, to hear the stories that partners told about the suffering women experience from prolapsed uterus and the apparent extent of the condition in Ethiopia.

No formal assessment was done of prolapsed uterus, so all information is purely anecdotal. What the Team heard, however, is very worrying. It was reported, for example that 15 women arrive at each day at Bahir Dar Regional Hospital for treatment, but only three to four surgeries are done each month. Furthermore, the Team was told that there are extremely long and uncertain waiting times for repair of prolapsed uterus in hospitals and that the cost is prohibitive (e.g., 1,000 birr for surgery).

Several recommendations were given for taking initial steps to assist women living with this condition. The recommendations include to support training and service delivery for prolapsed uterus in government medical training programs and government hospital services; among NGOs in Ethiopia; and, to create special surgical initiatives ('camps') with visiting expatriate surgeons on a regular basis. The Team spoke with AAFH staff about the possibility of the hospital in Addis or the HFCs doing surgery for prolapsed uterus. The Team was told that while the interest is there to assist women with the condition, the current mission of the AAFH is on fistula repairs, and a new focus on prolapsed uterus is not possible.

The Team encourages USAID/Ethiopia and its partners to explore further how to assist women with prolapsed uterus, possibly through joint funding with other donors and technical assistance from expatriate medical organizations. The reality of life for women with prolapsed uterus sounds extremely similar to the lives of women with fistula: physical pain and emotional turmoil. Women with prolapsed uterus also deserve care and to return to a life of dignity.

Appendix 1

Statement of Work for the Assessment

- 1. Project Title: Fistula Program**
- 2. Project Number: GHS-A-00-07-00021-00 (EngenderHealth); 663-G-00-06-00418 (AAFH); 663-A-00-08-00414-00 (IFHP)**
- 3. Project Dates: October 1, 2008-September 30, 2009; (EngenderHealth); June 20, 2006-August 31, 2009 (AAFH); June 25, 2008- June 30, 2013 (Pathfinder)**
- 4. Project Funding: \$850,000 (EngenderHealth) over one year; \$1,004,833 over three years (AAFH); \$50,000,000 for Phases I and II (Pathfinder)**
- 5. Implementing Organizations: IntraHealth, Addis Ababa Fistula Hospital, Pathfinder International**
- 6. Agreement Officer's Technical Representative (AOTR/COTR): Premila Bartlett (EngenderHealth, AAFH), Eshete Yilma (IFHP)**

I. Identification of the Task

The USAID/Ethiopia (USAID/E) Health, AIDS, Population, and Nutrition (HAPN) Office requests technical assistance from The Mitchell Group (TMG) to design and implement an independent external review of fistula activities implemented by IntraHealth (through a sub-award from EngenderHealth), Addis Ababa Fistula Hospital (AAFH), and the Integrated Family Health Program (IFHP). The objective of this review is to assess the various components of the fistula portfolio: community identification, pre-repair (or early repair) centers, and surgical repair, looking at the capacity and benefits of all the components as well as the linkages between them.

USAID works with the Addis Ababa Fistula Hospital, EngenderHealth/IntraHealth, and IFHP to increase the number of treated fistula cases through a comprehensive community outreach program that provides pre repair, repair, and post repair services that include nutritional support, transport, and community reintegration activities. Specific objectives of these projects are:

Addis Ababa Fistula Hospital

- To increase the access of obstetric fistula patients to treatment and care

EngenderHealth/IntraHealth

- To increase the access of women with obstetric fistula to treatment and care
- To build facility and provider capacity in providing quality RH services, particularly in obstetric fistula prevention, care, and MCH-related services
- Bring about broad behavioral change at all levels around maternal health that includes obstetric fistula prevention and care, pre and post fistula treatment services, an increase in the seeking of maternal health services

Integrated Family Health Project

- To identify and refer fistula cases at the community level

The USAID/E HAPN Office requests that the review be completed by May 31, 2010, in order that the findings, conclusions and recommendations can be used in future programming of fistula funds for Ethiopia.

II. Background

Ethiopia has one of the world's highest rates of maternal deaths and disabilities (Save the Children/US 2006). The maternal mortality ratio for the period 1998-2004 is estimated at 673 for every 100,000 live births (DHS 2005). This means 19,000 Ethiopian women die of causes related to childbirth each year (DHS 2005, PRB 2006).

Obstetric fistula is one of the major complications of childbirth. It is a hole formed in the vaginal wall linked with the bladder (vesico-vaginal fistula), the rectum (recto-vaginal fistula) or both. The immediate consequences of this damage are urinary incontinence and/or fecal incontinence, the constant leaking of urine and feces. The long-term social consequences are grave: usually divorce and a lifetime of rejection.

Obstetric fistula in Ethiopia is mostly attributable to maternal malnutrition, early marriage, a lack of skilled care and Emergency Obstetric Services at delivery. Chronic malnutrition can result in stunted pelvic development, elevating the risk of fistula regardless of the age of childbirth. Early marriage is common in Ethiopia. Young girls are given to husbands at an early age and pregnancy follows before full maturity of the pelvis. Without medical help, labor is prolonged and after four to seven days of pressure from the unborn baby's head on the mother. In Ethiopia, some 9,000 women develop a fistula during childbirth annually and most of them do not receive care (WHO 2006).

III. Purpose of the Assignment

The review Team is asked to complete a portfolio review to address the following questions:

Key Strategic Questions

- 1. How effective is the current structure of the USAID/Ethiopia fistula program in engendering sustainability?**

Sustainability and replicability of the pre-repair center model

- a. What is the cost-effectiveness of pre-repair centers?
- b. Is there evidence that women who go through pre-repair centers have better outcomes than those who go directly to HFCs for obstetric fistula repair?
- c. Is it feasible for HFCs to provide pre- and post-obstetric fistula repair services?

Integration of program activities with GEO programs at the national, regional, and local levels

- a. How effective are the AAFH, IntraHealth, and IFHP programs in working with the *woreda* and regional health bureaus with respect to obstetric fistula prevention, care, and treatment services?
- 2. Does the current model use available resources effectively to facilitate as many fistula repairs as possible?**
 - a. Which of the current models being implemented by AAFH, IntraHealth, and IFHP is most effective in terms of identifying “hidden” fistula cases and also in terms of sustainability?
 - b. Should the Mission consider working with the “best” approach or use a combination of approaches?
- 3. How effective are the prevention activities of AAFH, IntraHealth, and IFHP?**
 - a. Given available resources, what are the most strategic prevention activities that can be implemented?
- 4. What recommendations can be made for future programming in obstetric fistula prevention, care, and treatment as 1) currently structured, and 2) as a component of a comprehensive maternal health program?**

General Programmatic Questions

1. What progress have the programs made toward achievement of their respective objectives?
2. On what basis do the programs set their annual targets? Did the programs achieve their targets and are targets appropriately set?
3. How well did the programs collaborate and complement one another?
4. How did the program address sustainability through ownership?
5. What were the programs’ constraints and how, if applicable, did they overcome those constraints?
6. What are the lessons learned?
7. What recommendations can be made for future programming in obstetric fistula prevention, care, and treatment?

Specific Questions for Partners - The following should be addressed as time allows.

1. AAFH: Are fistula prevention, identification, or treatment activities integrated into *woreda*, zonal, or regional planning? Does Addis Ababa Fistula Hospital work with any of these levels on a strategy for prevention (including referral/transportation), identification (including referral/transportation), pre-repair and follow up care? If not, would it be beneficial to do so?

What is the capacity of the AAFH (including all HFCs) for fistula repair? Are they operating at full capacity? What capacity do the sites have for pre- and post-repair care?

2. IntraHealth: What has been accomplished with respect to IntraHealth’s activities to upgrade facilities, capacity building for staff, and client utilization of the facilities for

births? What practices have been put in place with respect to infection prevention, monitoring labor (use of partograph) and a timely response to address prolonged labor and outcomes at these centers? Is there capacity to perform c-section or a referral to a nearby facility? Have there been any improvements in outcomes related to use of facilities for birth, management of prolonged labor, and birth outcomes? Are women counseled on family planning before being discharged from the facility following delivery?

3. IFHP: How many women have been identified, transported and repaired? How do their efforts relate to the caseload/targets/capacity at the hospitals doing repairs? Is there a strategy (in regions with a HFC) that is coordinated for identification and treatment? Given the Health Extension Worker (HEW) and Voluntary Community Health Worker (VCHW) outreach in communities and follow up of all pregnant/postpartum women, can they help identify women with symptoms of fistula early in the postpartum period and have them referred for early treatment (i.e., catheter protocol treatment or early surgical repair)?

IV. Review Methods

The review will be carried out by a Team of two independent, external consultants over a three-week period using multiple methods, including: key informant interviews, field observation, and a review of IntraHealth and Addis Ababa Fistula Hospital reports, tools, and materials. The review Team will develop a valid sampling scheme to identify a small but representative subset of facilities by region. Interviews will include the following:

- USAID Mission staff, including relevant members from the Health Team, Office of Financial Management, and Program Office
- USAID/Washington staff involved in fistula programming
- AAFH, EngenderHealth, and IntraHealth staff
- Integrated Family Health Project (Pathfinder International/Ethiopia) staff
- Government of Ethiopia representatives—Ministry of Health, Regional Health Bureaus
- Beneficiaries (women who have benefitted from pre repair, post repair, and fistula repair services)
- Members of the Community Gore Groups

V. Information Sources

Consultants will be provided the following background documents in preparation of the assignment:

Justification for Exception to Competition
Program Descriptions
Expanded Service Delivery (ESD) reports, workplans
Fistula care reports, workplans

Quarterly Reports
AAFH reports, Annual Work Plans, and Follow-on Justification

VI. Tasks to Be Accomplished:

Below is a list of the specific tasks to be accomplished by the consultant Team, with an estimated level of effort for each task (See separate Level of Effort (LOE) Excel spreadsheet for more detail).

Review background documents/develop review methodology/complete field visit and interview schedule in consultation with AOTR and Evaluation Coordinator/participate in briefing with USAID/Washington technical staff	3 days
International travel day (international consultant only)	2 days
In-briefing with USAID/Ethiopia and EngenderHealth/IntraHealth, AAFH, and IFHP staff	2 days
Team planning meeting	1 day
Conduct field visits and interviews	4 days
Core Team synthesis/analysis of findings in Addis	2 days
Follow up stakeholder meetings	2 days
Conduct debriefings for USAID and Partners (separately)	1 day
Draft and submit report to USAID/E	3 days
Finalize Report – Team Leader incorporates Mission comments and submits report electronically to Evaluation Coordinator (TL: 5/TM: 3)	5/3 days

Total LOE – 25 days of LOE for Team Leader and up to 22 days for the Team Member.

VII. Team Composition and Participation

The core Team is anticipated to be composed of two persons:

1. The **Team Leader** will be an international consultant with extensive FP/RH and MCH technical and program implementation experience and will play a central role in guiding the review process. The consultant will take part in an in-brief with USAID/Washington fistula Team prior to commencement of in-country work, in brief with USAID/E and the implementing partners; debrief USAID/E the implementing partners, and Government of Ethiopia on review findings, and produce a draft report to be left with USAID/E, followed by a final report for USAID/E. The Team Leader will finalize the Team work plan for the assignment; establish assignment roles, responsibilities, and tasks for each Team member; facilitate the Team Planning Meeting (TPM) to set the agenda and other elements of the TPM; take the lead on preparing, coordinating input, submitting, revising and finalizing the assignment report; manage Team coordination meetings in the field; coordinate the workflow and tasks and ensure that Team members are working to schedule.

2. The **Program Evaluation Specialist** will be an international or local consultant who has a background in public health and who is familiar with standard evaluation methodologies. The consultant will be responsible for writing some sections of the report. The consultant will assist the Team leader in the development of any qualitative instruments to be used during site visits as well as the analysis of any data collected.

Other Team Participants: One or more USAID staff and GoE representatives may join the review Team during the Team planning meetings, site visits, debriefings, and report preparation. EngenderHealth/IntraHealth, AAFH, and IFHP staff members may accompany the Team on site visits as appropriate, but will not be present during interviews with the local partners, stakeholders, or beneficiaries.

Review Logistics: Review Logistics will be provided by the local sub-contractor hired by TMG. TMG will be responsible to manage and direct the efforts of the local sub-contractor. The Evaluation Logistics Assistant will be responsible for logistics, coordination and administrative support, and ensuring all aspects of the review are carried out seamlessly. S/he will assist the Team Leader and the implementing agencies in facilitating meetings, coordinating logistics and organizing site visits. The Evaluation Logistics Assistant will collect and disseminate background documentation to the review Team.

Selection Criteria for Review Team

Senior Team Leader (Maximum 100%) distributed as follows:

1. **Education: (25%)** – An advanced degree (MD, PhD, MPH, MA) from a reputable accredited institution in any medical or social sciences field pertinent to working with maternal and reproductive health.
2. **Work Experience: (35%)** – Minimum 10 years of progressively responsible experience with recognized organization(s) in the design, implementation and evaluation of reproductive and maternal health programs with demonstrated technical expertise and skills in family planning/reproductive health, including obstetric fistula.
3. **Skills and Abilities: (40%):** Demonstration of strong analytical, managerial and writing skills; exceptional leadership in coordinating a Team; exceptional communication and interpersonal skills; ability to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts; fluency in English and proven ability to communicate clearly, concisely and effectively both orally and in writing; ability to produce a succinct quality document that gives direction and facilitates improvement for the obstetric fistula program.

Mid-level Program Evaluation Specialist (Maximum 100%) distributed as follows:

1. **Education: (25%)** MA, MS, MPH, MBA or BA from a reputable accredited institution in any of the social sciences pertinent to working with maternal and reproductive health.
2. **Work Experience: (35%)** – Minimum six years of progressively responsible experience with recognized organization(s) in the design, implementation and evaluation of public health

programs with demonstrated technical expertise and skills in maternal and reproductive health programming in Sub-Saharan African countries.

- 3. Skills and Abilities: (40%):** Demonstration of strong analytical, managerial and writing skills. Strong skills in data analysis and information compilation techniques. Prior work with management information systems and the use of progress indicators in monitoring project outcomes is desirable. Ability to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. Fluency in English proven ability to communicate clearly, concisely, and effectively both orally and in writing.

Mid-Level Evaluation Logistics Assistant (Maximum 100%) distributed as follows:

- 1. Education: (25%)** MA, MS, MPH, MBA or BA. Four years of work experience may be substituted for the degree.
- 2. Work Experience: (35%)** – Minimum six years of progressively responsible experience within GoE and/or NGO work settings handling complex logistics, such as coordinating business travel and meetings.
- 3. Skills and Abilities: (40%):** Must have a demonstrated ability to be resourceful and to successfully execute complex logistical coordination; ability to multi-task, work well in stressful environments and perform tasks independently with minimal supervision; ability to work collaboratively with a range of professional counterparts at all levels, including those from host country governmental and non-governmental organization, U.S. Government agencies and other donors; capacity for effective time management and flexibility. Must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGOs counterparts. Must be fluent in English and Amharic and have proven ability to communicate clearly, concisely and effectively both orally and in writing.

VIII. Schedule and Logistics

The in-country phase of the review will be conducted over a period of up to 25 days with a desired start date on or about May 3, 2010. The Evaluation Logistics Assistant, in collaboration with the USAID/E Evaluation Coordinator, EngenderHealth/IntraHealth, AAFH, and IFHP, will arrange all of the partner meetings, site visits and debriefings in advance. All associated travel and per diem costs for non-USAID staff will be covered by TMG under the technical directive of USAID/E.

IX. Period of Performance

In country work is to be carried out over a period of approximately two weeks, beginning on or about (o/a) May 3, 2010, and concluding o/a May 13, 2010.

XI. Deliverables

Finalized no later than in-country Team Planning Meeting: Team Leader will develop an assessment methodology and field visit and interview schedule in consultation with the

USAID/E AOTR, USAID/E Evaluation Coordinator, and EngenderHealth/IntraHealth and Addis Ababa Fistula Hospital.

Within three days after Team Leader arrival in country: Team planning meeting and in-briefing with USAID/E. USAID/E Health Team technical staff to review and comment on review methods.

Prior to departure: Team makes a presentation to USAID/E and a separate presentation to IntraHealth, Addis Ababa Fistula Hospital, IFHP, and its partners.

After departure: Team leader submits final unedited content to USAID/E within one week of receiving comments from USAID/E. The report (not including attachments) will be no longer than 30 pages with an Executive Summary, Introduction, Methodology, Findings, Lessons Learned, Conclusions, and Recommendations in English in the exact format specified by the USAID/E Evaluation Coordinator.

Upon final approval of the content by USAID/E, TMG will have the report edited and formatted. This process takes approximately 3-4 weeks. The final report will be submitted electronically to USAID/E Evaluation Coordinator.

TMG makes the results of its evaluations public on the Development Experience Clearinghouse and on its project web site unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, TMG will request USAID/E confirmation that it will be acceptable to make this document publicly available. If there are certain restrictions regarding specific parts of the report that should be removed from a public version due to procurement-sensitive information, TMG is able to produce a second version suitable for public availability.

Appendix 2
Persons interviewed

USAID	
Sophia Brewer	USAID/Ethiopia
Adisfrie Bekele	USAID/Ethiopia
Pamella Bartlett	USAID/Ethiopia
Jeanne Rideout	USAID/Ethiopia
Trisch MacDonald	USAID/Washington
IntraHealth	
Aynalem Yigzaw	Senior Program Coordinator
Annely Dessie	Amhara Regional Coordinator
Molla Getie	Project Officer-Bahir Dar
Ali Shiferaw	Fistula Mentor-Dangla
Menna	Fistula Mentor-Worota
IFHP	
W/ro Bogalch Alemu	IFHP
Ato Girmay	IFHP (Tigrey Coordinator)
Ato Tilahun Gidey	IFHP Country Director
Dr Tesfaye Bulto	Deputy Technical Director
Dr Wassie	MNH Adviser
Ato Girma kaside	M/E Officer
EngenderHealth	
Dr Yetnayet Demissie	Deputy Country Director
Karen Beattie	Fistula Care, New York
Evelyn Landry	Fistula Care, New York
Carrie Ngongo	Fistula Care, New York
AAFH	
Mark Bennet	CEO
Professor Gordon Williams	Medical Director
Dr. Andrew Browning	Bahir Dar Hamlin Fistula Centre
Dr. Bitew Abebe	Bahir Dar Hamlin Fistula Centre
Mulu Atsbeha	Coordinator, Mekele Hamlin Fistula Center
Health Officers (3)	Bahir Dar and Mekele Hamlin Fistula Centers
Government partners	
Endalkachew Desalegne	Head, Worota Woreda Health Bureau
S/r Haimanot Firde	Deputy head, Fogera Health Bureau

H/O Tseganesh	Deputy Head, Worota Town Health Center
Maritu	Head, Amhara Women's Association
Ato Mulusew	Amhara Regional Health Bureau, Head Disease Control and Health Promotion
Yohannes Tewolde	Head of Disease Prevention and Health Promotion, Tigrey Regional Health Bureau
Ametemariam Gebre Michael	Head of Women Affairs, Tigrey Women Affairs
Genet Bekuma	Hagere Selam Kebele, HEW
Abebe Tadese	Hagere Selam Kebele , Woreda Health Expert
UNFPA	
Dr. Muna Abdella	National Program Officer for Maternal Health
Others	
Dr. Zewditu Kebede	Program Director, CORHA
Dr. Michael Dejene	MDPHCS/TMG
Dr. Annabel Erulkar	Country Representative, Population Council
Community members and women with fistula	Dangla, Worota, Mekele Rural, Bahir Dar and Mekele Hamlin Fistula Centres

Appendix 3

Documents reviewed

1. Statement of Work (SOW) for Portfolio Review of USAID/Ethiopia Fistula Program: Project Identification Data
2. USAID/Ethiopia Health, AIDS, Population and Nutrition Office, Program Description for Fistula Identification, Referral and Treatment in Ethiopia, December 2005
3. The Acquire Project Final Report, Obstetrics Fistula in Amhara Regional State, Ethiopia January 2006-2007
4. IntraHealth International's Ethiopia Fistula Care Project, Project Review, November 2008
5. Fistula Care Associate Cooperative Agreement, Annual Report October 2008 to September 2009
6. The Quarterly/Semi-Annual or Annual Report, Oct –Dec 2009, IntraHealth International.
7. AAFH: Fistula Prevention and Repair, Program Description with budget for 2020-2012
8. AAFH: Annual Work Plan of the Hamlin Fistula Bahir Dar and Mekelle Centers and Prevention Activities-USAID funded projects for FY 2010, July 2010
9. FY09 1st Quarter Report of AAFH, ending December 31,2008
10. FY09 1st Quarter Report of AAFH, ending December 31,2009
11. EngenderHealth 2009, Fistula Care Brief on Fistula Pre-Repair Center Model in the Amhara Region of Ethiopia
12. Assessment of Sites for New Pre-Repair Units in the Amhara Region, March 15-20,2010
13. USAID/Ethiopia Integrated Family Health Program: Report of the Phase I Review, February 21-March 5,2010
14. IntraHealth training tools for health providers: on the care of the fistula patient, for partograph use, for community based awareness raising about the causes of fistula and prevention, and a checklist for supportive supervision
15. FMOH, UNICEF,UNFPA, WHO and AMDD: Report of the National Baseline Assessment of the Emergency Obstetrics and Neonatal Care, Ethiopia 2008
16. IntraHealth/ Amhara Region, Report of the Partner's workshop on fistula prevention, identification, care, referral, treatment and reintegration, March 2009/2010
17. IFHP and Maternal and Neonatal Health Interventions, Third draft – Oct 28, 2009
18. IntraHealth/EngenderHealth: PRUs' strengths and weakness and alternatives
19. Program documents of the Population Council's activities with vulnerable girls
20. USAID Summary data on fistula funded activities