



Joint AusAID and USAID Review of Support to Hamlin Fistula Ethiopia (Ethiopia)

Final report

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Fiona Duby

John Hailey

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Acronyms and abbreviations

AAFH	Addis Ababa Fistula Hospital
ANC	Ante Natal Care
AusAID	Australian Agency for International Development
AVI	Australian Volunteers International
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CEO	Chief Executive Officer
CPR	Contraceptive prevalence rate
EDD	Estimated delivery date
EDHS	Ethiopian Demographic and Health Survey
EMA	Ethiopia Midwives' Association
FGAE	Family Guidance Association of Ethiopia
FGC/M	Female Genital Cutting/Mutilation
FGOE	Federal Government of Ethiopia
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FUI	Female Urinary Incontinence
FP	Family Planning
GBV	Gender-based violence
GOE	Government of Ethiopia
HC	Health Centre
HDA	Health Development Army
HCM	Hamlin College of Midwives
HESP	Health Extension Service Package
HEW	Health Extension Worker
HFA	Hamlin Fistula Australia
HFE	Hamlin Fistula Ethiopia
HFE(A)	Hamlin Fistula Ethiopia (Australia)
HFIF	Hamlin Fistula International Foundation
HHJ	Healing Hands of Joy
HMIS	Health Management Information System
HP	Hamlin Partner NGOs
HRD	Human Resource Development

HSDP	Health Sector Development Program
HTP	Harmful Traditional Practice
IFHP	Integrated Family Health Project (Pathfinder, John Snow Incorporated)
IntraHealth	International NGO affiliated with North Carolina School of Medicine
IUCD	Intrauterine contraceptive device
Jhpiego	International NGO affiliated with the Johns Hopkins University
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MOU	Memorandum of Understanding
NGO	Non Government Organisation
OPD	Outpatient Department
OF	Obstetric Fistula
OR	Operations Research
PNC	Post-natal care
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCH	Reproductive, maternal, neonatal and child health
QA	Quality assurance
SMART	Specific, Measurable, Achievable, Relevant, Timebound
SNNPR	Southern Nations and Nationalities Peoples Region
TBA	Traditional Birth Attendant
TOR	Terms of Reference
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VfM	Value for money
WAHA	Women and Health Alliance
WHO	World Health Organisation

Glossary¹

Obstetric fistula (OF) or vaginal fistula is a medical condition in which a fistula (hole) develops between either the rectum and vagina or between the bladder and vagina after severe or failed childbirth (obstructed labour), when adequate medical care is not available.

A **rectovaginal fistula** is a medical condition where there is a fistula or abnormal connection between the rectum and the vagina.

Female urinary incontinence (FUI)

The most common types of urinary incontinence in women are stress urinary incontinence and urge urinary incontinence. Women with both problems have mixed urinary incontinence. Stress urinary incontinence is caused by loss of support of the urethra which is usually a consequence of damage to pelvic support structures as a result of childbirth.

Uterine prolapse occurs when the uterus (womb) slips out of place and into the vaginal canal due to weakening of the muscles and ligaments of the lower abdomen (called the “pelvic floor”), which normally support the uterus and other organs in the pelvis. The severity of uterine prolapse is defined as:

- First degree (mild)-the cervix (the lower opening of the uterus into the vagina) protrudes into the lower third of the vagina
- Second degree (moderate) - the cervix protrudes past the vaginal opening
- Third degree (severe) - the entire uterus protrudes past the vaginal opening

Stoma

A stoma is an opening, either natural or surgically created, which connects a portion of the body cavity to the outside environment. A natural stoma is any opening in the body, such as the mouth. Any hollow organ can be manipulated into an artificial stoma as necessary.

Ileostomy

An ileostomy is a surgical opening (or stoma) constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin. Intestinal waste passes out of the ileostomy and is collected in an external pouching system stuck to the skin.

Gregorian and Ethiopian Calendars

The Ethiopian Calendar (EC) refers to the Ethiopian Fiscal Year (EFY), starting on 8th July in the Gregorian (European) Calendar (GC). The corresponding dates between the Ethiopian and Gregorian Calendars are given in the table below.

¹ Wikipedia and World Health Organisation.

Table 1: Gregorian and Ethiopian Calendars

Gregorian (GC)	Ethiopian (EC)	Health Sector Development Plan
2010/11	EFY2004	HSDP IV
2011/12	EFY 2005	
2012/13	EFY 2006	
2013/14	EFY 2007	
2014/15	EFY 2008	
2015/16 (MDG)	EFY 2009	END HSDP (20 YEARS)
2016/17	EFY 2010	

EFY = Ethiopian Fiscal Year; GC = Gregorian Calendar; EC = Ethiopian Calendar

Map of Ethiopia

Figure 1: Active Fistula Centres in Ethiopia



Source: USAID. *Obstetric Fistula Situation Assessment 2013*.
Red circles are HFE, green circles are WAHA.

The Global Fistula Map currently displays over 175 facilities in 40 countries that provided roughly 15,000 fistula surgeries in 2010— of an estimated 50,000-100,000 new cases each year, and not including the estimated 2 million women currently living with the condition. See all facilities on Global Fistula Map <http://www.globalfistulamap.org/>

Executive Summary

Background

It is estimated that 9,000 women in Ethiopia develop obstetric fistula each year, and that up to 100,000 women are living with untreated fistula.² The combination of prolonged and obstructed labour, especially among young, poor and under-nourished women and lack of skilled attendance at birth³ are the main challenges to obstetric fistula reduction in Ethiopia.

The Addis Ababa Fistula Hospital (AAFH), now known as Hamlin Fistula Ethiopia (HFE), was established by Drs Reginald and Catherine Hamlin in 1974 to treat and provide care for women with obstetric fistula. HFE has three key institutions: the Addis Ababa Fistula Hospital with a reputation as a centre of excellence for fistula care and training which also includes five regional facilities; the Hamlin College of Midwives (HCM) established in 2007 which provides training for midwives who are subsequently deployed in government health centres close to HFE's regional facilities; and the Desta Mender centre which provides rehabilitation, training and long-term support for post-operative women with incontinence.

HFE has many donors spread over eight countries. Over the past twenty years, AusAID has provided more than AUD\$10 million to HFE and until 2009 this represented the major proportion of Australian government support to Ethiopia. USAID meanwhile has provided over US\$2.8 million to HFE since 2006 to support fistula treatment in three regional Hamlin centres; USAID has also provided support largely for preventive work related to fistula through various technical partners (Pathfinder/John Snow Incorporated, IntraHealth, EngenderHealth and Jhpiego. AusAID has also invested in the Swiss-based Hamlin Fistula International Foundation (HFIF) Trust Fund to provide a long-term assured income stream for HFE operations.

Purpose and focus of the evaluation

Since 2010, the Australian Government has been the second largest bilateral donor to the Government of Ethiopia's Millennium Development Performance Fund providing AUD\$45m over three years (2012-15) (See Annex 5). Maintaining two channels of support for maternal health in Ethiopia has prompted AusAID to commission an independent review of HFE in the context of AusAID's wider support for maternal health. The main purpose of this review is to contribute to learning and improvement, and maximise long-term benefits and sustainability (for both AusAID, other donors, the FMOH and HFE) through a better understanding of the context, successes and challenges facing Hamlin operations in Ethiopia, as well as fulfilling accountability requirements to AusAID by assessing effectiveness and value for money of the funding provided. The review was also designed to inform AusAID management decisions regarding future funding options and existing funds invested with HFIF.

USAID meanwhile commissioned a situation assessment of obstetric fistula in Ethiopia to inform its future fistula programming in Ethiopia and to provide essential contextual background for the HFE evaluation. Two international consultants were contracted to undertake the review and developed a methodology based on the Terms of Reference provided by AusAID (Annex 10). Following the USAID situation assessment in April/May (summarised in Annex 1), the consultants spent two weeks in Ethiopia in May/June to review the overall HFE program, and its management, governance and financing arrangements. This included a field visit to Tigray.

² USAID. Situation assessment. 2013.

³ Only about 10 per cent of women are attended by a skilled person during labour according to the Ethiopia Demographic Health Survey 2011

Summary Findings and Recommendations

This review has aimed for a pragmatic and fair assessment of HFE, drawing from a large body of HFE literature and in-depth interviews with current and former staff and trustees, and government and NGO stakeholders (see Annex 5). The review's findings and recommendations were presented to AusAID, USAID and HFE staff on 6th June 2013. A summary of findings and recommendations is provided below while detailed recommendations are presented in section 4 of the report.

Context

The high profile of HFE and Dr Hamlin in Australia, and priority for maternal health in AusAID policy have arguably provided a political imperative to continue funding HFE over the years. Australian support to date has been invaluable in helping to build HFE's facilities and support its quality and holistic care, from pre to post-surgery care and physical, psychological and economic rehabilitation. Now with a significant level of bilateral support to the government, however, justification for any future AusAID support through HFE is needed.

The USAID-supported fistula situation analysis suggests that in the best possible case scenario, assuming that all Health Sector Development Program IV (HSDP-IV) and Road Map⁴ targets are reached, there will be 22,400 untreated fistula cases in 2015, and 3,000 in 2020, with elimination projected in 2021. The situation analysis indicates that OF will remain a problem for the next 10-15 years and that there remain many hidden cases (See Annex 1). The number of cases presenting for surgery, however, is currently well below HFE's annual target⁵ falling from 2,395 (in five centres) in 2011 to 1,735 (in six centres) in 2012.⁶ The fall in uptake for surgery is not well understood: is it because cases are not coming forward, or that there is falling incidence? This situation needs to be understood and suggests a different approach for case detection and referral might be needed.

Currently HFE, and to a lesser extent the Women's and Health Alliance (WAHA)⁷, are the only providers of obstetric fistula (OF) surgery in the country. Although all gynaecologist/obstetricians receive 2 months' training in HFE, few, if any continue to provide fistula surgery in government facilities. Government health facilities are generally unsuitable environments for the long and specialised OF treatment and care as continuity of staff, supplies and bed space are often lacking.⁸ Obstetric fistula is not integral to the government's HSDP-IV though it is included in the Roadmap (see Annex 6a). A long-held perception however appears to be that HFE can 'take care of this problem'.⁹

Program Delivery

Fistula repair

HFE's surgery, rehabilitation and care have transformed the lives of poor women suffering from obstetric fistula. 82 per cent of women undergoing OF surgery at Hamlin centres are successfully treated and remain dry. HFE *is still* uniquely placed to meet the unmet need for the lengthy and specialised OF repair and rehabilitation. Having lost some of its most experienced clinicians, trainers and researchers over the past few years, renewed effort is

⁴ FMOH. Roadmap for Accelerating the reduction of maternal and newborn mortality in Ethiopia 2012-2015. This is an implementation plan under the HSDP-IV.

⁵ Different targets are provided: 4,000 in the Strategic Plan, 3,000 in 2011/12 report and 2,530 Annual Performance report. For the purposes of this report, the target of 3,000 will be used.

⁶ The data are not consistent in different reports. These data for the calendar years are extrapolated from the USAID situation analysis

⁷ A French NGO supporting fistula programs in various countries including Ethiopia. <http://www.waha-international.org>

⁸ Many women with OF have other infections and problems requiring treatment. Hospitals are often poorly maintained and without water and sanitation and with poor or no infection controls.

⁹ From personal communications with many health professionals and FMOH

now needed to safeguard HFE's reputation as global centre of excellence. Building capacity of staff by drawing from international expertise on offer and planning for recruitment of new staff, possibly from among the many HFE has trained over the years, needs to be given priority.

Midwife training and deployment

HFE's contribution to prevention of OF is largely through the training of highly skilled midwives in the Hamlin College of Midwives (HCM) for skilled delivery and family planning. Since 2007 when HCM – a state of the art institution - was opened, 34 midwives have graduated. There is evidence of increased uptake of services in government health centres (HC) where they are placed and their influence appears to have positive effects on other health staff. The limited coverage of this program (currently 12 out of 2,660 HCs) and the likelihood of a surfeit of midwives nationally in the near future suggest the current HFE midwife training strategy needs review. FMOH acknowledges that quality of government training and of graduates is poor and is keen for HCM to help improve midwifery training and practice throughout Ethiopia.¹⁰ Various options for HFE/HCM are presented in the recommendations section and draw on the experience of the USAID-supported JHPIEGO program which is strengthening the quality of midwifery and nurse anaesthetist education among others.

Prevention through information and advocacy

HFE's fistula *prevention* activities also cover awareness raising and education. Prevention is needed at a national level and this raises questions around HFE's role in the context of the HSDP-IV and Australian funding. The government of Ethiopia is highly committed to community health and has a national network of over 30,000 Health Extension Workers (HEWs) and 2,002,841 Health Development Army¹¹ groups working on awareness raising and prevention in key areas of primary health. USAID-funded partners have done valuable work with these networks, with evidence of an increase in case detection and referral to HFE centres. The approach used needs to be sustained and scaled up to high prevalence areas.

Rehabilitation and reintegration

HFE is the only organisation in Ethiopia providing specialised services for physical¹², psychological and economic rehabilitation; 45 women live in HFE's rehabilitation centre, Desta Mender, though this is less than capacity. HFE has done well to provide employment to women with ileostomal bags and aims for re-integration of these women into communities close to the HFE centres. Only women who are 'dry' have the option to return to families and home communities (if accepted). HFE has engaged with 33 NGO organisations to help with re-integration (though this report is not able to comment on how this works).

Organisational Effectiveness

Monitoring, evaluation and research

The quality and consistency of M&E and reporting has been a residual concern of AusAID. Data are not consistent and HFE's work is not best reflected by the current system. The M&E department, strengthened in the past year and a half, is working to improve coherence and use of data. Strengthening the M&E unit in the areas of quality assurance, analysis and interpretation of data and production of quality reports are priorities. Target setting can be reviewed and revised within the strategic planning process. All targets for work undertaken in the government health centres should be those set by government.

¹⁰ Personal communication HR Directorate, FMOH

¹¹ See Annex 6b for more information on HEWs and Health Development Army

¹² Including physiotherapy, pelvic floor exercise, correction of dropfoot, devices, diversion, ileal conduits; caesarean section for those able to get pregnant

Scientific research is important and although HFE has previously published and disseminated quality research in international forums and publications, it currently lacks skills in this area (see Annex 4b). Twinning/technical assistance from an international institution (as offered by Dundee) can help ensure that HFE's valuable work is properly documented, shared and used to advance learning and clinical practice.

Qualitative research and operations research as recommended in the situation assessment will help HFE target services appropriately in all areas to understand more about reintegration and how post-operative women can be effective 'ambassadors' for case detection and referral. It is suggested HFE seeks support from universities in Ethiopia interested in undertaking such research.

Organisation, management and governance

2005 to 2011 was a period of rapid growth with new medical facilities being established in different regions and a threefold growth in staff numbers. This process of change was accompanied by increasing internal tensions which resulted in senior staff leaving the organisation, board members resigning or being removed, and a new board appointed. Well-established relationships with key supporters were fractured and partnerships redefined. Considerable time and energy was then invested in "fire fighting" activities to deal with fallout of these changes; a period of consolidation is now needed. A new management team has been established (with an experienced chief executive recruited through an international competitive process), a new strategy is being developed, and plans for further investment in new management systems and processes are also being developed. A planned process of strategic investment in appropriate management structures and systems supported by a review of HFE's overall cost-profile is appropriate at this time.

HFE's governance has been through a number of iterations and faced considerable challenges. The new board formed in early 2012 is working to address these challenges and the demands of managing a very large and well-funded organisation. There are a number of specific proposals outlined in this report that HFE needs to consider to ensure effective governance over the coming years. HFE's plan for board development training and the introduction of governance systems will provide a useful starting point. Evidence that organisational and governance issues are being addressed will help HFE in its bid to seek funding.

Finances and financial sustainability

HFE is a well-supported organisation having succeeded in developing an impressively broad and effective funding base in eight countries through the Hamlin Partner NGOs (HPs), with total reserve funds dedicated to HFE totalling US\$33.46 million in 2011.

HFE's main revenue comes from these eight HPs and Swiss-based Hamlin Fistula International Foundation (HFIF). To maintain an assured income stream, the HFIF manages HFE's AUD\$15m of assets.

To maintain HFE's future financial sustainability it will be important to balance funding from both existing and new funding sources. Formalising the relationship between HFE and an "alliance" of Hamlin's funding partners will help to avoid misunderstandings and resolve any conflict of interest issues.¹³ This will involve ensuring clear reporting requirements, monitoring of loan provisions and clarity of roles. Obstetric fistula and the story of HFE continue to attract interest and money from public donations but this will arguably change as the problem of OF diminishes. HFE's strategy will need to consider this changing scenario in its strategy and financial planning.

¹³ Clarity on the HFE/HFA partner relationships is provided at <http://www.hamlinfistula.org.au/>

Value for money

HFE has estimated the cost per standard repair procedure at the main hospital and Bahir Dar Outreach Centre to range from US\$755 to US\$1,474 depending on location and severity of the case. This is certainly within typical international ranges for developing countries¹⁴. HFE also report an overall surgery success rate of 82 per cent, similar to an international average of 86 per cent reported by a meta-analysis of 19 studies¹⁵. Given the undoubted transformational and lasting impact of a successful fistula repair, these results signify that VfM of the donor investment has been achieved, albeit that VfM could be further improved by closer collaboration with Government for better case detection.

The cost of training a BSc midwife in HCM is US\$16,000 over the four year period which is comparable with costs in other countries. Though considerably higher than FMOH's costs of training midwives, the clinical skills and experience upon graduation are unquestionably higher at HCM. HFE's relatively low output of graduates, however, indicates that better VfM and sustainable impact would be achieved by refocusing efforts on helping to improve quality of pre-service midwifery training within the other 46 midwife training institutions and 18 universities and in-service training and mentoring to improve services and midwife retention generally.

Australian volunteers

Australian volunteers have provided valuable technical assistance to the HCM, ensuring training is consistent with international standards. Not all planned positions could be filled (such as in the FMOH) and there continues to be a need for experienced, long-term volunteers to build capacity in HCM and FMOH. Recruitment is currently underway with AVI. HCM need not limit itself to Australian volunteers.¹⁶ HFE planning for volunteers must ensure that pre-conditions for recruitment and placement can be met.

The following table summarises the detailed recommendations laid out in section 4.2.

Table 2: Summary Recommendations

Area	Recommendations
Program delivery	Maintain high clinical standards and deliver services to maximum capacity by strengthening professional and referral links with government and other NGO facilities and strengthening collaborative efforts to address case detection.
Fistula repair Rehabilitation and re-integration	Pursue current strategy to rehabilitate and re-integrate women back to communities and regions with links to regional centres (be they HFE or WAHA) for clinical support and disability NGOs where they exist and can add value.
Prevention	Conduct in-depth review of strategy for training and deployment of midwives and viability of expanding infrastructure including CEmONC.
Midwifery training and deployment	Collaborate with FMOH, UNFPA, Ethiopian Midwives Association (EMA), JHpiego to work towards national standardised curricula for diploma, degree and Masters midwifery courses and explore with FMOH (and FMOE) best ways of HFE increasing quality of training and services across the country.
	Scale up all work on fistula awareness, prevention, case detection and referral through the HEP. Encourage FMOH to scale up and evaluate best (innovative)

¹⁴ The Fistula Foundation uses an average of US\$1,000 as the average cost of fistula repair

¹⁵ S. Ahmed, S.A. Holtz. Social and economic consequences of obstetric fistula: Social and economic consequences of obstetric fistula -Life changed forever? International Journal of Gynecology and Obstetrics (2007) 99, 510-515

¹⁶ The CEO indicated that the Irish Ambassador had offered to fund some volunteers

Area	Recommendations
	practices to increase the uptake for skilled delivery in the facility and reduce the 'second delay' ¹⁷
Monitoring, evaluation and research	<p>Develop robust and strategic M&E framework consistent with national targets and indicators where possible, and which corresponds with the Ethiopian reporting time frame ensuring HFE M&E are reflected in FMOH reports.</p> <p>Collaborate with international and national institutions with research capacity to generate quality quantitative and qualitative research while building HFE's own research capacity.</p>
Organisation	<p>Finalise new strategic plan to guide long-term development, resilience and sustainability, while still ensuring that HFE's core goals and values are met: with priority for investment in appropriate management structures and systems to support reinvigorated organisational culture and renewed focus on supporting quality patient care.</p> <p>Review HFE's cost-profile and, where appropriate, make cost-savings or re-allocate costs/resources to strategically important activities</p>
Strategy, structures, staffing and systems	<p>Invest in organisational development in the areas of human resource planning and make appropriate appointments to strengthen the organization and influence and contribute to the national health program.</p> <p>Introduce a Strategic Systems Development change process and management processes to support a strategy that prioritises quality and resilience and a culture of quality assurance.</p> <p>Revise allocation of costs and overheads for more even distribution.</p> <p>Plan in-service training to build staff finance and management capacity.</p>
Finances and Financial Sustainability	<p>Embed processes to maintain and monitor the balance of different funding sources, and explore strategies designed to increase proportion of income from private sector donors/income generating activities.</p> <p>Formalise relationship between HFE and an "alliance" of HPs and support development of new HPs; clarify relations between HFE and HFIF including consideration of ways of formalising HFIF's relationship with HFE and other HPs.</p> <p>Use the new strategic plan to demonstrate strategic value of HFE in the context of the HSDP-IV and use to leverage new resources, aiming for donor coordination and streamlined reporting and M&E.</p>
Governance	<p>Invest in board processes and systems; review board working practices with sub-committees to support key areas ensuring that an enlarged board is allowed in the Ethiopian context.</p> <p>Ensure proactive engagement of the Board in strategic planning processes and helping HFE with strategic engagement with relevant government ministries (e.g. FMOH, FMOE, etc.)</p>
Donors	<p>Donors should consider support of HFE's revised strategy where it adds value to the health sector and where it can build capacity in key areas of HFE's operations. Consider a more collaborative, cost-effective and streamlined mechanism for support to HFE – including joint evaluation.</p> <p>Donors can play a pro-active role in facilitating HFE's efforts to introduce change</p>

¹⁷ The delay in transporting pregnant women to facilities which contributes to prolonged and obstructed labour. Innovative approaches include Maternity Waiting Homes and provision of important traditional ceremonies such as done in Tigray.

Area	Recommendations
	<p>and closer alignment with FMOH.</p> <p>AusAID should ensure that entities receiving AusAID funds (such as HFA), are required to assume responsibility for appropriate monitoring and TA of the organisations whom they represent.</p> <p>The USAID supported situation assessment would be a useful advocacy tool with FMOH to encourage incorporation of OF into the HSDP-IV.</p> <p>Consider strategies for scale-up and/or replication of current work related to OF identification, rehabilitation and referral for skilled delivery with the Health Extension Program</p>

The review team was also asked by AusAID to provide summary evaluation ratings against the criteria ratings framework, a summary of which is provided below.

Table 3: Summary Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)	Explanation
Relevance	5	HFE's work in OF is vitally important and it is unlikely FMOH facilities will provide these services. A privately managed centre of excellence such as HFE fits into the emerging policy context which recognises added value of public/private partnerships. ¹⁸ Review of cost v spend will indicate whether AusAID financing is needed to support OF repair services. Support for prevention activities alongside AusAID bilateral support should be reviewed as HFE's new management leads major organisational change and intensifies efforts to engage more strategically with FMOH especially in the area of skilled delivery. AusAID technical guidance for HFE at country level remains important and will help HFE at this critical time.
Effectiveness	4	HFE can be more effective and in OF, increasing number of patients through improved case detection (within the context of the Health Extension Program); improving quality of M&E will help demonstrate effectiveness.
Efficiency	4	HFE can be more efficient and is already on track to address cost efficiencies.
Sustainability	5	HFE has done well to create a strong and diverse funding base leveraging support through TV and press coverage as well as fund raising. Planned efficiencies and a revised approach for prevention with closer engagement with FMOH will strengthen long-term sustainability. With a steady increase in uptake of family planning and skilled delivery ¹⁹ and likely reduction in obstetric fistula cases – a new role for HFE will become increasingly important. Maintenance of infrastructure at HC level and running of ambulances have significant financing implications unless incorporated into FMOH budgets.
Monitoring & Evaluation	3	It was surprising to learn that for an organisation of its size and renown the HFE M&E unit has only been developed to its current level in the past 1 ½ years though service statistics have been generated for many years. TA provided earlier has not brought the unit to a sufficient level of competency as reflected in the weak 2011-2012 report prepared by a consultant and

¹⁸ Public private partnerships are incorporated into current policy dialogue and will be given greater emphasis in the 20 year visioning.

¹⁹ 2005 and 20011 DHS showed contraceptive prevalence rate more than doubled in six years from 10.9% to 23.4 %. FMOH HMIS. EFY 2004 Annual Report showed skilled delivery rose from 16.6% to 20.4% from EFY 2003-2004.

		submitted to AusAID without quality assurance. The unit is not yet sufficiently developed to provide a robust and critical assessment of the impact of donor support and to do so properly will require deeper investigation using social science research skills.
Gender equality	5	HFE addresses the needs of the most marginalised women and employs a significant body of senior women in the organisation. It also has men working with women in rehabilitation. Women occupy senior positions in the organisation including on the board.

Conclusion

HFE now has the opportunity, with new and experienced professional staff and a new board, to mend bridges where needed, put in place robust systems to support a larger organisation and grow partnerships. This will help ensure HFE will make a meaningful contribution to the HSDP-IV and ensure HFE’s reputation as global centre of excellence for obstetric fistula.

Over the past ten years, some important lessons have learnt both for AusAID and HFE. For AusAID there are lessons around the use of intermediary NGOs based in a developed country as a conduit for funds to an NGO based in the south, as there may be gaps in their ability to provide appropriate support. If establishing trust funds, endowments etc. to provide sustainable funding for partner NGOs, *how the legal instrument is framed* needs to be considered in more detail as donors have limited ability to control the way the funds are used or applied. Finally, there are lessons around how to work with, and develop, the governance of local NGOs.

For HFE (and other NGOs), rapid growth in size and income needs to be supported by systematic investment in appropriate culture change and the development of new structures, systems and management processes. International experience suggests that a specialist NGO like HFE needs to be proactive in the way it: engages and collaborates with other organisations working in the same field; develops new alliances, partnerships and collaborative relationships; aligns itself more closely with government policies; and develops strategies to enhance its comparative advantage.

HFE can multiply and sustain the effect of its contribution to maternal mortality and morbidity reduction in Ethiopia as a full implementing and technical partner of the government of Ethiopia. There is evidence that this process has started and that many of the recommendations made in this report will reinforce action already initiated. The team recognises that the process of consolidation, re-structuring and strengthening of HFE will place numerous and significant demands on the new management and board, but also provides an opportunity for cost efficiencies and renewed effectiveness. HFE currently has a strong and diverse funding base with the potential to sustain most activities while other financing options and opportunities can be sought for the long-term.

1. Introduction

1.1. Reproductive Health in Ethiopia

Ethiopia has made significant progress in improving health outcomes over the past five years. Child mortality has fallen from 123 to 88/1000 between 2005 and 2010 and 40 per cent of remaining child deaths occur in the first month of life. The contraceptive prevalence rate (CPR) has increased from 15 per cent to 29 per cent although a quarter of married women still have an unmet need for family planning (FP). The maternal mortality rate (MMR) has stagnated at 676/100,000 live births and levels of facility-based delivery with a skilled birth attendant are very low (10 per cent national, 4 per cent in rural areas); two thirds of women receive no antenatal care (ANC) and 92 per cent of women receive no postnatal care (PNC).²⁰ This unmet need for family planning and reproductive health (RH) services is greater for adolescent girls and women in rural areas.

The Government of Ethiopia (GoE) with support from its development partners is rapidly scaling up access to services through expanded health infrastructure and staff being trained under the accelerated midwifery training program. Increased access to services in rural areas is being achieved through Health Extension Workers (HEWs) based in the Health Posts and the Health Development Army (HDA) at the community level (see Annex 6b). While the GoE's investment in infrastructure and human resources for health (HRH) has been widely acknowledged, there is a concern about poor quality of personnel and services resulting in low uptake for skilled delivery, and preference for home births remains strong. The 2011 Demographic Health Survey found that 61 per cent of respondents said health facility delivery was 'not necessary' and 30 per cent that it was 'not customary'. Notably absent in the GoE's Health Sector Development Program IV (HSDP-IV) is any reference to obstetric fistula, or the many other morbidities such as uterine prolapse and female urinary incontinence (FUI) that affect the lives of mostly poor women lacking skilled obstetric care. OF is addressed to some extent in the FMOH's Roadmap/implementation plan for maternal and newborn health (Annex 6a), though there is no indication that FMOH has planned or budgeted for any of the intended activities related to OF.

While AusAID and USAID have supported HFE, both are committed to supporting health, and in particular maternal, newborn and child health through the Government of Ethiopia's national HSDP-IV; AusAID channels funds through the GoE's joint funding mechanisms and USAID through its many implementation partners working with government (see Annex 5). The question of justifying parallel funding and giving taxpayers best value for money therefore arises. There was a clear need for both agencies to review their funding of maternal health in Ethiopia and to better understand the context of obstetric fistula to inform future programming. The USAID supported situation assessment of obstetric fistula in Ethiopia and the AusAID commissioned evaluation of HFE were timely, complementary and apposite.

1.2. Obstetric Fistula in Ethiopia

The USAID commissioned situation analysis of the problem of fistula (obstetric and other) in Ethiopia included a mapping of current treatment and prevention support (both government and non-government) and gaps as well as future needs consistent with the GoE's HSDP-IV. The technical and situation analysis was intended to inform USAID's future fistula programming and to be a key preliminary component of this comprehensive joint AusAID and USAID review of support to HFE over the past twenty years.

²⁰ Ethiopia Demographic Health Survey. 2011.

The situation assessment reported fistula incidence of 3,500 per year (2010 baseline) with a prevalence of 37,500 untreated fistula and 161,000 urinary incontinence cases in 2010. Women with obstetric fistula suffer multifaceted health, psychological and socio-economic consequences²¹. One study reported that close to 70 per cent of the women had been divorced, over 92 per cent had suffered depression and 19 per cent were not allowed to eat with family members²². A comprehensive approach including treatment/repair of fistula as well as prevention of new cases is critical.

Box 1: Projected Fistula Cases

According to the best case scenario there were 3,300 new OFs at baseline in 2010 and there will be 1,300 in 2015, 400 in 2020 and 0 in 2021. The most likely case scenario, however, predicts 2,200 new cases by 2015 and 1,750 in 2020 with eradication by 2025.

Source: USAID assessment 2013

Lack of both skilled attendance at birth and access to safe emergency obstetric services are the main challenges to obstetric fistula reduction in Ethiopia. Harmful traditional practices, including female genital mutilation and early marriage contribute to the problem. Most common risk factors include rural habitat, young age, short stature (mostly resulting from nutritional stunting), illiteracy, and poverty.²³

The consultants for this AusAID-supported review concur with the findings of the situation analysis summarised in Annex 1. Highlights are presented below:

- Obstetric fistula (OF) is likely to remain a problem in Ethiopia for at least another 10 years in the best case scenario and 15 years in the most likely case scenario.
- Female Urinary Incontinence (FUI) is the presenting symptom of obstetric fistula, but which has many causes. There are about 5 cases of general FUI to every case of OF.
- Case detection remains the main bottleneck, associated with transport. The Integrated Family Health Project (IFHP) coverage is 38 per cent of all districts, and IntraHealth 19 per cent of districts in Amhara, so coverage is around 40 per cent of the country but with major gaps.
- Government is not sufficiently involved in OF and FUI and there is no national coordination.
- There has been successful reintegration into communities, with safe pregnancies post fistula repair, but the social reintegration of patients with complex fistulas has reached its limits and often fails. Hopes for ex-fistula patients with remaining dysfunctions are bleak²⁴.

²¹ Cook RJ, Dickens BM, Syed S (2004). Obstetric fistula: the challenge to human rights. *Int J Gynaecol Obstet.*87(1):72-7.

²² Murphy M. Social consequences of vesico-vaginal fistula in Northern Nigeria. *J Biosoc Sci.*1981;13:139-50

²³ Roka,ZG, Akech M, Wanzala P, Omolo J, Gitta S and Waiswa P. Factors associated with obstetric fistulae occurrence among patients attending selected hospitals in Kenya, 2010: a case control study <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3599423/>

²⁴ The situation analysis points out that fistula closure rate is nearly 93% with experienced surgeons. However, post-closure urinary incontinence, from limited to complete, is still a formidable problem in the management of vesico-vaginal fistula. Reported prevalence of post-operation incontinence varies widely - generally around 6%, but can rise to 57% for fistulas involving urethra and sphincter damage. Among the latter, many self-resolve in due course, but at least 10% of them will continue to suffer for the rest of their life and will therefore need to have bags for urine (up to three a week), requiring proximity to hospitals.

- Knowledge of the epidemiology and socio-cultural features of FUI, including fistulas of all causes, is still scanty and incomplete. Incidence and prevalence is still not well known for lack of proper studies.

1.3. Background Hamlin Fistula Ethiopia

The Addis Ababa Fistula Hospital, now known as Hamlin Fistula Ethiopia (HFE) was established by obstetricians Drs Reginald and Catherine Hamlin in 1974, to treat and provide care for women with obstetric fistula. Having seen that obstetric fistula was neglected and had a terrible impact on the lives of poor women, Drs Hamlin pioneered new methods of surgery. Since then the organisation they started has grown significantly, attracting significant publicity and public support. HFE now has fundraising bases in eight countries. Over the years there has been a shift in focus from a primarily treatment-orientated approach to one that also addresses prevention and rehabilitation.

In 2004 HFE embarked on a major expansion program with the establishment of five regional facilities (Bahir Dar [2005], Mekelle [2006], Yirgalem and Harar [2007], and Metu [2010]) aimed at increasing HFE's capacity to treat up to 4,000 women each year and improve access to services for rural communities. In 2007 the Hamlin College of Midwives (HCM) was established and in late 2010 the first 11 graduates of the college were deployed to the five regional facilities. Currently 34 midwives provide MNH services in 12 Government health centres in four regions.

In addition to its fundraising partners in eight countries, the Swiss-based Hamlin Fistula International Foundation (HFIF) is a Trust Fund established to provide an assured future minimum income stream for HFE operations.

Box 2: Hamlin Fistula Ethiopia

Vision: "To see improvements in maternal health bringing to an end Obstetric Fistula"

Mission: "Wholehearted commitment, with God's love and compassion to women with childbirth injuries.

Key Objectives:

- I. To provide compassionate holistic service to women suffering from Obstetric Fistula
- II. To be a world leader in training and research for treatment and care of Obstetric Fistula
- III. To actively participate in raising awareness & prevention activities leading to future Obstetric Fistula eradication
- IV. To work towards rehabilitation & re-integration of these women back to normal life
- V. To provide ongoing resources of skilled personnel, facilities and finances to ensure the best possible service.

1.4. Evaluation Purpose and objectives

The purpose of this consultancy is to review the results of AusAID and USAID support to Hamlin operations in Ethiopia over the past 10 years, with a particular focus on the results attained under the most recent funding Agreements. There are seven primary functions for the review: to contribute to learning and improvement, and maximise long-term benefits and sustainability; to fulfil accountability requirements to AusAID, and the people and Government of Ethiopia; to assess the cost effectiveness and value for money of the expenditure of Australian and American taxpayers' funds under the most recent agreements; to inform stakeholders of the achievements to date to which Australia has contributed in responding to the problem of fistula for women in Ethiopia; and to undertake a preliminary due diligence assessment of HFE. The review was also

designed to inform AusAID management decisions regarding future funding options and existing funds invested with HFIF. Evaluation Scope and Methods

A detailed methodology was prepared by the consultants for the two week assignment based on the Terms of Reference (Annex 10) and subsequently approved by AusAID and HFE. This included: pre-assignment interviews with key stakeholders in the UK and Australia and extensive review of documents. In-country activities included visits to the Addis Ababa hospital, the Hamlin College of Midwives and rehabilitation centre Desta Mender; a trip to Mekelle in Tigray region to visit the Mekelle HFE clinic, a Woreda Health Centre and an NGO supporting cured fistula patients, Healing Hands of Joy (HHJ). Focus Group Discussions were held with current and ex fistula patients in Mekelle centre and HHJ. In Addis Ababa, key informant interviews were held with HFE staff and trustees, AusAID, USAID, FMOH, UNFPA and various international NGOs collaborating with HFE. Interviews were held with other key stakeholders in Australia by telephone, specifically HFA and HFE(A) and in the UK (See Annexes 7 and 8). Interim findings were presented to AusAID and USAID and senior staff and trustees of HFE on 6 June 2013. The team met with Dr Hamlin at the start and end of the review.

Limitations

It has proved very difficult to capture the detailed work of a large, long-established organisation in such a brief visit. Shortage of time available was the main limitation to the review. The team only visited one (high performing) HFE fistula centre in Mekelle, Tigray and one government health centre (Adiquala HC) where two midwives were deployed. The team spoke to the head of the Tigray Regional Health Bureau by telephone and did not meet with Woreda representatives or community members, Health Extension Workers (HEWs) or members of the Health Development Army (HDA).

In addition, the data from presentations and reports were not all consistent and there was inadequate time to review raw data. It was not possible to provide a ten year retrospective review of achievement against performance targets owing to lack of available plans and data throughout that period. In the absence of an economist on the evaluation team, a detailed assessment on Value for Money (VfM) has not been provided.

The new CEO was extremely helpful and informative, but having only recently joined HFE could not be expected to be familiar with all historic details of HFE.

2. Evaluation Findings

2.1. Context

2.1.1. Donor support for prevention and repair of fistula in Ethiopia

Annex 5 provides details of donors to the government health sector program (HSDP-IV) – of which a significant proportion is spent on activities related to prevention of fistula (e.g. training of health workers, construction of health facilities, provision of reproductive health services etc.) USAID is the largest donor for activities directly related to fistula prevention, through its cooperating partners (see below) and AusAID and USAID are the two main donors to repair of fistula in Ethiopia through HFE.

- UNFPA provides support for training of doctors and midwives and contributes to equipment both for HFE and the Women and Health Alliance International (WAHA) - an international NGO based in France. WAHA, started OF surgery in 2010 in three university teaching hospitals and supported integration of fistula care into the training of postgraduate students in urology and gynaecology.

- The World Bank has contributed in a small way such as WAHA's community mobilisation project focused on the empowerment and social reintegration of fistula survivors.
- Other donors to OF in Ethiopia include the (US-based) Fistula Foundation which has provided grant support (from private donations) to HFE (US\$3.5m since 2009) and Aira Hospital and Aira School of Nursing and WAHA; others include Ethiopiaid UK (to HFE), Women Hope International.

Since the vast majority of funds to HFE are raised through its eight country partners, it could be argued that most support for fistula surgery and rehabilitation comes in Ethiopia comes from voluntary contributions in those eight countries (Annex 4a)

2.1.2. Donor support for the work of HFE

Australian Agency for International Development (AusAID)

The Australian Government through AusAID has provided more than AUD\$10 million to HFE over the past twenty years through the Australia-based Hamlin Fistula Australia (HFA). Until May 2012, HFA was the authorised fundraising entity for HFE in Australia. Channelling funds through HFA has provided an additional layer of accountability as HFA is subject to Australian corporate rules and regulations, and also protected funds from negative interest rates in Ethiopia. AusAID funding has supported many areas of HFE's work (training, services and infrastructure) over the years including major expansion work such as facilities at the main hospital, construction of the Midwifery College, Desta Mender rehabilitation centre, the Mekelle hospital and other regional centres.

With a view to reducing donor dependence, HFA, in consultation with AusAID and HFE, established the Swiss-based Hamlin Fistula International Foundation (HFIF). Between 2005 and 2011 HFA contributed AUD\$8.2 million to HFIF. AusAID contributed AUD\$4 million between 2005 and 2008. Part of the AusAID funding to HFIF is repayable under certain circumstances. HFIF was established on the basis that interest earned on the Foundation's investments would be spent solely on operational expenses of the Addis Ababa Fistula Hospital (AAFH) and its associated activities.

Between 2009 and 2011, AusAID funded Australian midwife educator volunteers to teach midwifery students and mentor local trainers at the HCM and a volunteer English teacher.

In 2011, AusAID entered into a longer-term commitment to fund an integrated fistula prevention and treatment program with a stronger focus on supporting greater alignment and coordination between HFE and the Ethiopian Ministry of Health. The contractual Agreement with HFA was to provide AUD\$3.5 million over three years from 2011– 2014, with the option of extending the Agreement by AUD\$2 million over a further two years 2014-2016, pending the outcome of a mid-term review of the project.

In August 2012, HFE indicated that it would not draw down on the remaining Australian Government funds available through the agreement with HFA and established an alternative Australia-based funding mechanism Hamlin Fistula Ethiopia (Australia).

United States Agency for International Development (USAID)

In response to a United States Congressional Earmark established in 2005 for the treatment, management, and prevention of obstetric fistula, USAID Ethiopia entered into a 6 year agreement (June 20, 2006 to August 31, 2012) with HFE for over US\$2.8 million to support activities at three affiliated regional satellite repair centres in Bahir Dar, Mekelle and Yirgalem. USAID also supports related work through:

- **EngenderHealth/IntraHealth** - Fistula Care Program, (Oct 1, 2007 – July 30, 2013). Pre-repair rehabilitation services (counseling, nutritional support, treatment for

infections and infestations) at district health centres (HCs) in Adet, Dangla, Woreta and Sekota in Amhara Region. Patients are then referred to Bahir Dar Fistula and Mekelle Centres for fistula repair.

- **Pathfinder/JSI** - Integrated Family Health Program (IFHP), (June 25, 2008 – Dec, 2013). IFHP also supports HFE by sensitising communities and training and supporting HEWs and other health service providers to refer women with OF to the Hamlin Regional Centres or the AAFH for more complicated cases. In addition, they work with communities to re-integrate women after the surgeries.

With the current cycle of USAID support to HFE having concluded in August 2012 and support to the other two programs ending in 2013, USAID commissioned a situation analysis of the current and prospective fistula situation to inform future program planning. It was planned that the study would be available for the start of the AusAID evaluation, to provide *inter alia*, all necessary background to the scale of OF in Ethiopia and to identify gaps for future programming. A summary of this situation assessment is provided in Annex 1.

2.1.3. HFE's program alignment with Ethiopia's HSDP-IV

Box 3: Mission of the Health Sector Development Program IV (HSDP-IV)

To reduce morbidity, mortality and disability and improve the health status of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services via a decentralised and democratised health system.

The over-arching 20 year Health Sector Development Plan (HSDP-IV) is now in the second half of its fourth five-year phase. This plan governs all areas of preventive and curative health and covers all support services including human resources, logistics, infrastructure etc. for the health sector. The government has demonstrated strong leadership, ownership and commitment and Ethiopia has made significant progress in improving access and coverage of services through rapid scale-up of infrastructure and human resources. Currently there are 15,095 Health Posts and 2,660 Health Centres), over 33,000 Health Extension Workers and 2,002,841 Health Development Army groups (see Annex 6b). The GoE's intention is for all programs and organisations to be integrated in the planning framework down to Woreda (district) level. This includes alignment with the Health Management Information System (HMIS), curriculum, protocols and communication. The first step is to know who is doing what and where. A resource mapping in 2012 estimated the number of not for-profit clinics providing RH services at 277 and private for-profit clinics providing RH services at 1,788.²⁵ (This conflicts with the EFY2003 report stating that there are 4,000 private for-profit and not for-profit clinics). With urbanisation the numbers of (unregulated) private providers are growing rapidly. The HSDP-IV is well supported by a wide range of donors through government-led financing modalities (Annex 5). Since AusAID has become the second largest donor to the MDG Performance Fund it is now important for AusAID to justify channelling funds through two parallel mechanisms towards the same national goal to reduce maternal mortality and morbidity.

Fistula surgery

Obstetric Fistula is not included under the HSDP-IV and there is no related indicator. The *Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (2012-2015)*, which is an implementation plan for the HSDP-IV, includes OF but also has no related indicators and it is not clear that there is any

²⁵ DFID. RH Mapping Report. May 2012.

allocated budget. Although the team was told that all doctors undertaking gynaecology and obstetrics training routinely spend two months in HFE, they do not subsequently use this training for OF repair in government facilities. The situation analysis reports that apart from HFE and WAHA-supported facilities, these “*interventions are irregularly performed in two other regional or zonal hospitals in the country, Arba Minch and Dembi Dolo, prior to 2012. There were no interventions in those places in 2012, and only one case recorded in Fiche.*” From discussion with FMOH, it would appear that HFE is assumed to be taking care of OF cases while government facilities are able to manage some of the (less complicated) cases of female urinary incontinence (FUI). The need for FUI surgery far exceeds the supply – an argument the study made for HFE to consider extending care to these cases.

It is not realistic for HFE to use its limited resources to help extend OF surgery to more government facilities as the pre-conditions for safe and quality holistic care in these facilities are largely absent. However, it is realistic for the FMOH to undertake core FUI surgery and ensure that fistula surgery is included in the National HMIS with HFE’s contribution reflected.

Planning and training of midwives

The Demographic Health Survey of 2011 reported an increase in maternal mortality from 673 per 100,00 live births in 2005 to 676. The FMOH has a priority therefore to increase skilled delivery from a low base of 10%, by rapid scale-up of midwifery training. In 2012 4,725 midwives had been trained in 46 training institutions and 18 universities. USAID has provided significant support to the FMOH’s new Accelerated Midwifery Program. HFE’s role in this wider context of rapid growth in the output of midwives has been explored in the next section.

- *There are definitely important opportunities now for HFE’s closer engagement with FMOH and the technical agencies (UNFPA, WHO, JHpiego) to work towards the development of standardised government-owned standardised curricula.*
- *There is likely to be an over-supply of midwives in the next few years.²⁶ In this context, HFE needs to consider whether it is appropriate to train new midwives or collaborate with FMOH to improve the quality of the current workforce?*

Prevention education and case detection

Both HFE and USAID-supported programs work through the Health Extension Program (HEP) (see Annex 6b) for awareness raising, case detection and referral among others. The important work of OF/FUI case detection is not however included in the HEW’s job description. FMOH is also working increasingly with traditional and religious leaders for the promotion of reproductive health, providing another opportunity for HFE to influence the messaging.

- *The HEP covers most of the country and it is through strategic engagement with FMOH that HFE can influence the content of communications at the community level.*

2.2. Program Delivery

2.2.1. Fistula repair from six HFE centres

Fistula repair is the first of the five key objectives of HFE’s results framework (see Annex 9) and the foundation of HFE’s work. Most of the fistula patients are young women, but

²⁶ Personal communication, HR directorate, FMOH

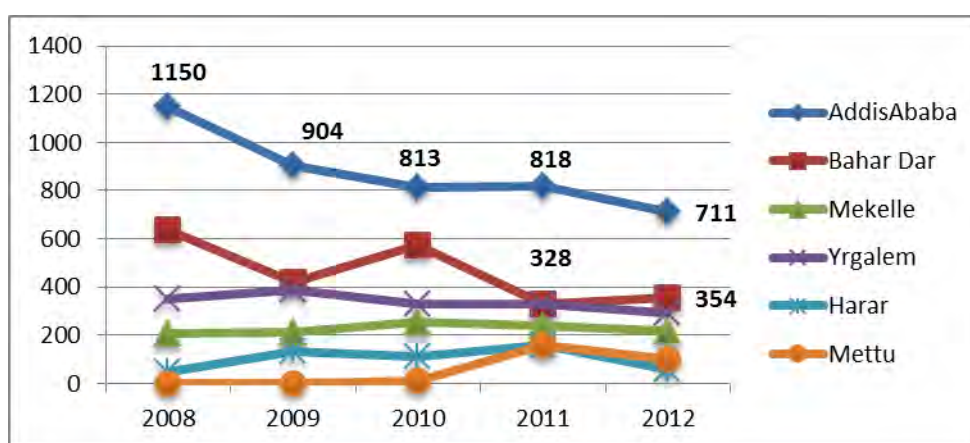
many are much older, either because they have lived in shame with their problem for many years or because they have fistula after numerous deliveries. A review of 32 years' of data from HFE found that average age at occurrence of fistula is over 20 years, but one-third of the fistula patients were under 20 years.²⁷ The team was told that centres have seen patients as young as two years of age, with fistula in some cases caused by sexual abuse.²⁸

The curative (treatment) goal is to reduce and eventually to eliminate the backlog of fistula cases by increasing the capacity of fistula centres (professional surgeons and nurses, number of beds and adequate facilities) for patients. Currently, there are six fistula hospitals/centres including the Addis Ababa Fistula Hospital, Bahir Dar, Mekelle, Yirgalem, Harar and Metu fistula centres. The number of beds (pre and post-operative) of these centres is close to 300. AAFH is not 'the only hospital currently in the world devoted to the care of these patients' as stated in the 2011 Strategic Plan, though the USAID situation analysis confirmed that HFE and (since 2010) the Women and Health Alliance are the only organisations in Ethiopia providing fistula surgery.²⁹

The team visited the Addis and Mekelle centres. Both these are in striking contrast to the typical government hospital: clean, light, well organised, well equipped and in beautifully landscaped surroundings.

As discussed under Limitations, it was not possible to provide a ten year retrospective review of achievement against performance targets owing to lack of available plans and data. HFE's current strategic plan is to repair a total of 4,000 patients per year at 'full capacity', with a critical assumption that patients are identified and transported in sufficient numbers to fistula centres. Reviewing the data across plans and reports is somewhat confusing: the Strategic Plan is based on the calendar year while donor reports use the GoE fiscal year (8 July-7 July); the presentation of data in the 2011/12 report to AusAID mixes numbers and proportions, thus creating a false picture of performance against targets. What is apparent, however, (Figure 2) is the overall decline in performance across centres from 2,395 in 2008 to 1,939 in 2012, with the exception of Bahir Dar which had a small increase in cases between 2011 and 2012. Otherwise there was wide variation in total numbers operated across regions, with Harar having 59 cases and AAFH having 773 in 2012 (See Annex 2 for further data).

Figure 2: Annual number of fistula repairs carried out by AAFH and five satellite fistula centres



²⁷ USAID. Obstetric Fistula Situation Analysis. 2013

²⁸ Anecdotal report from Mekelle. More detailed patient profiling would provide some useful information.

²⁹ The Women and Health Alliance (WAHA) is an international non-profit NGO based in France and working in 18 countries. WAHA started OF surgery in Ethiopia in 2010, within three university hospitals. Both the CEO (Mulu Muleta) and another senior surgeon were previously surgeons in HFE.

Source: USAID. 2013

The generally downward trend is due to both supply and demand issues:

On the supply side:

- Low performance in two regions is thought to be the result of having part time contract surgeons, limiting the surgeons' ability to develop credibility and links with the community. (Relationships with the Regional Health Bureau (RHB) in the respective areas are reported to be handled with care since HFE has been criticised for stealing staff).
- *Coverage of services:* remains inadequate especially in worst affected areas. In Mekelle, most patients come from the western part which is very far from the centre. For patients requiring referral to Addis Ababa, the distance is arguably a disincentive.

On the demand side:

- *Case detection:* women with fistula are often hidden away and stigmatised, and families are ashamed to declare their presence. The team were told by women that they had suffered in this way for as long as 20 years and never knew they could receive help. This is why it is important for cured patients, community based workers (HEWs, HDA etc.) and community leaders to help with case detection and encourage women to come forward for assessment.
- *Cost:* the cost of transportation and opportunity cost of being away from home is a barrier. When transport is provided such as with the intervention of the USAID-funded partners, numbers are shown to increase. It is not known how the HFE-provided ambulances, based in the Woreda, are used.
- *No cases:* two of the international NGOs were confident that the backlog of cases had been cleared in four of the Woreda where they had worked and planned to move to new areas. Interviews with women revealed that they knew very few or no women with OF in their communities. Cases referred by cured patients (from Mekelle data) are very few – arguably because some (cured) women may not wish to be identified as ex-fistula patients.

As seen in Box 4, 82 per cent of women undergoing OF surgery are successfully treated and remain dry. The concern is for women who remain incontinent after repeated efforts at surgery. The data presented suggests that 18 per cent of women remain incontinent and 8.2 per cent of other related complications cannot be treated but it is unclear if they remain incontinent. Of all these, a proportion may be cured after successive efforts. A real concern shared by HFE and others, is how to rehabilitate and reintegrate these women who must remain close to medical support indefinitely.

Box 4: HFE Fistula Repair Success Rates

Fistula treated and closed but wet or leaks flatus (8%)

Fistula treated and closure failed (10%)

Successful closure rate (82% closed and dry)

Other fistula related complications treated (8.2% failure rate)

Table 4 below shows 2012 performance against 2011-2012 targets (except for major surgery which is from the 2011-2012 report, as distinct from the data provided in Figure 2). This shows that 75 per cent of the major surgery target was met. Other targets were nearly met (OPD, cure rate) or in the case of referrals and physiotherapy were exceeded.

Table 4: Curative targets July 2011-June 2012 and achievement

Cost Centres	OPD* target	Achieved 2012	Major Surgery target	Achieved 2012	Cured** target (85% of cases)	Achieved** 2012	Referrals Target	Achieved 2012	Physio target	Achieved 2012
AA-FH	3000	3097	950	799	85%	88.9	0	0	1150	1506
Bahir Dar	1020	734	580	325	85%	82.7	20	26	550	625
Mekelle	480	439	250	233	85%	72.3	20	27	280	89
Yirgalem	520	545	350	345	85%	85.2	20	19	350	655
Harar	240	325	200	77	85%	49.1	15	31	190	261
Metu	250	327	200	132	85%	80.9	15	17	190	290
TOTALS	5510	5467	2530	1,911	85%	82.1	90	120	2710	3426
% achieved		99%		75%		82%		133%		126%

*50 OPD visits are staff.

**Dry on discharge

Obstetric fistula is not the only cause of incontinence. The situation analysis found that between 25-30% of women consulting for permanent incontinence were in fact uterine prolapses or other severe forms of pelvic floor disorders (PFDs) and that the vast majority of women with incontinence are not making themselves known to the health system. Issues of distance to care, transport, cost, and shame are the most frequently cited causes. A report by IntraHealth Woreda Pre-Repair Unit, where they screen patients presenting with incontinence before referring to the fistula centre, shows out of 50 cases of incontinence in the last year, 37 were fistula, 22 pelvic floor disorders, and 1 cervical cancer. The situation analysis argues the case for operations for non-fistula to start with one day per week in fistula centres.

“There might be as many as 161,300 women with urinary incontinence. In our opinion, these figures justify the merging of obstetric fistula and other causes of urinary incontinence in reproductive health policies and programs”

Source: USAID situation assessment.

HFE: as a global centre of excellence

Training and continuing professional education

HFE has historically provided 2 months' internship for all obstetrician/gynaecologists in Ethiopia. Given its reputation, HFE is likely to continue to be a preferred place for overseas doctors to train and training is potentially a good source of income. There is no historical or current data base on all trainees and there is no systematic follow-up but in 2012, fistula treatment and care training was given to 23 Ethiopian and 9 overseas doctors, 5 Health Officers and 30 nurses. This could well continue as long as HFE can maintain its reputation and ensure staff themselves receive appropriate technical updates and skills in training. Currently WAHA also aims to be “an international training centre of excellence for surgeons from Ethiopia and abroad” so HFE needs to ensure it remains at the cutting edge in OF surgery.³⁰

To ensure this and to avoid attrition of key staff, continuing professional development is important. Twinning arrangements with hospitals and universities overseas is arguably the best way for HFE to receive expert support where this is needed. During the review,

³⁰ <http://www.waha-international.org/?projects&id=23>

the team was informed that Dundee University has 'kept its door open' with this in mind for the past two years and is waiting to hear from HFE.³¹

- **Maintaining HFE's reputation of global excellence** must be a priority with updated surgical skills demonstrating high cure rates, provision of high quality surgical training and robust scientific research output
- It is also important that HFE keeps track of who is trained and finds a way of maintaining contact through a database system and possibly through an alumni network.

Other key questions HFE faces in the area of its surgery include:

- **How to enhance numbers of OF surgery to full capacity:** are OF cases genuinely declining in the context of increased uptake of family planning (doubling every five years), and increased access to skilled delivery? Are cases hidden and not coming forward? What is understood and what research/surveys are needed and who will do this? Are cases low in Harar and Metu because there are no full-time surgeons? Can current strategies adopted for case detection by USAID-funded partners be sustained and scaled-up in areas they do not cover?
- If HFE continues to have spare capacity (4,000 in current strategic plan and 3,000 in reports) **should HFE consider taking on more patients with female urinary incontinence (FUI)** and uterine prolapse who number approximately five for each OF case as advised in the situation analysis?

2.2.2. Midwife training and deployment

HFE's main strategy for prevention of obstetric fistula is to train midwives who will work in rural Health Centres (HCs) for a six year period providing skilled delivery and reproductive health services. The Hamlin College of Midwives (HCM) was established in 2007 and is located at the Desta Mender site outside Addis Ababa. The objective of the College is to train midwives to a high standard in a 4 year BSc Midwifery program. The students are selected from different communities in the regions where HFE has fistula centres. The training includes both classroom theoretical teaching, skill demonstration on simulators and practical clinical teaching in different health centres/hospitals to assist student midwives to develop skills to perform independently and satisfactorily. The HCM has been fully accredited by the Higher Education Quality Assurance and Accreditation Body in Ethiopia, which is a department of the Ministry of Education.

Table 5: Student enrolment HCM

Region	2007	2008	2009	2010	2011	2012
Oromia	0	7	6	12	5	8
Amhara	6	0	4	4	10	4
Tigray	2	3	0	6	4	1
SNNPR	3	3	0	2	4	3
Total	11	13	10	24	23	15

As shown in Table 5, HCM has increased its annual intake from 11 in 2007 to 23 in 2011 and 15 in 2012. 34 midwives have graduated at BSc level and are now deployed in 12 government Health Centres in four regions (Amhara, Tigray, SNNPR and Harar). There have only been 2

dropouts (dismissals) during this time. Since inception, academic staff increased from 7 to 10, with four staff at Masters' degree level. The college stresses it needs more and more highly qualified staff in future and is currently working with Australian Volunteers International (AVI) to recruit suitably qualified academic midwives.

³¹ From discussion with Lord Naren Patel Volunteer Obstetrician, Dundee University

Collaboration with FMOH and other partners in midwifery training

The curriculum for midwife training in HCM is based on the International College of Midwives' Model and was accredited by the Ministry of Education. Initially three years, it was extended to four years to be consistent with the FMOH's own BSc midwifery curriculum. The HCM model is competency-based training with small class sizes and access to computers and the internet. Training environment and quality of training are far superior to government training institutions and this is well recognised by UNFPA who have close contact with both HCM and the FMOH.

The FMOH's Human Resource for Health Strategy 2009-2020 developed in 2009 has a target of training 8,635 midwives by the year 2015. The number is expected to increase to 9,866 by 2020. To achieve this, the Government has increased the midwife training institutions from five in 2000 to 46 in 2012; 18 universities are now offering midwifery training at Bachelor level. Through the Accelerated Midwife Training Program 1,558 midwives graduated in 2012 and 1,742 are now enrolled. UNFPA, Jhpiego and the Ethiopian Midwives Association are among the agencies contributing to national curriculum development and training. Having opted for rapid scale-up and coverage FMOH is now rightly concerned about the poor quality of its training and of the graduates. While HCM midwives must deliver a minimum of 40 babies (ICM standards), HCM reports that the usual number is 60 but may be as many as 90 deliveries. Government trained midwives commonly have very few deliveries with anecdotal reports that some midwives graduate with none performed, while others become teachers directly after graduating having no experience in health centres.

Although the good performance of the HCM graduates would appear to justify the HCM approach, the annual output of 25 HCM graduate midwives (and none expected in 2013 because of a one year extension to the course) is insignificant in the context of FMOH's target to train 8,635 midwives by 2015.

Although the total number of midwives in Ethiopia is now increasing steadily, motivation and retention present huge challenges. Poor working conditions, low salaries, lack of supervision and lack of opportunities for career development are the main demotivating factors.³² Nevertheless, the FMOH predicts an over-supply in the next few years.

HCM is a centre of excellence for a limited number of undergraduate midwives but has the potential to be a national centre of excellence working with FMOH to improve quality of care in Ethiopia as a whole. The college currently aims to provide training up to Masters level; to provide courses at this level it will need to strengthen its own staffing capacity. This aim is also shared by FMOH so it would make sense for HFE to collaborate with FMOH in the development of national standardised curricula, for both BSc and Masters levels. This would have been facilitated by the planned appointment of an Australian volunteer midwifery curriculum specialist which has not yet occurred. A number of questions arose during discussions which it is suggested HFE and HCM address during the strategic planning process:

- In the context of a potential over-supply of midwives should HFE/HCM train new midwives or focus on upgrading existing midwives and improving the quality of midwifery care more widely? Could HFE consider:
 - in-service training/mentorship of midwives in the HCs
 - Providing in-service training-of-trainers for FMOH tutors
 - Contributing to pre-service training in Government institutions (as currently practiced by JHpiego)

³² Ethiopian Midwives Association (EMA). UNFPA. The State of Ethiopia's Midwifery. 2012

- How can partners work towards one national BSc curriculum which meets international standards? (This is the aim of FMOH, supported by UNFPA).

Midwife deployment

After graduation, the midwives are expected to remain in a pre-selected Health Centre (HC) for six years. An agreement is signed with the Regional Health Bureau. Currently there are two midwives in 11 HCs with a plan to extend to 25 HCs. HFE provides additional equipment, medical instruments and supplies, an ambulance for early referral of mothers with complications and fistula cases to nearby obstetric emergency care unit (EmOC) and/or fistula centre. Retention mechanisms for the midwives include a ETB500 per month top-up to the government salary they receive, which is increased by ETB500 for each year served, accommodation and mobile card expense. For each region, there is a midwife supervisor based in the fistula centre (with the exception of Tigray which has a health officer to supervise). The midwife program was originally run from the HCM with midwifery supervisors reporting to the college, leaving a communication gap and data flow gap between college and regional centres and HFE centre.

Living on site, the midwives provide a 24/7 service and their output and job satisfaction is reported to vary between regions. For some, the living and working conditions are very challenging. The team was only able to visit two midwives at one site in Tigray who were impressive both because of their knowledge and practice, and because of their performance. The trend in all services is increasing at this site. It was clear that the midwives had a good relationship with the community and an understanding of the culture, which was beneficial in providing services (see Annex 3). Two notable gaps in their service provision were intrauterine contraceptive devices (IUCDs) which were not available and manual vacuum aspiration (MVA) for post abortion care and safe abortion (for which the HFE midwives had not yet received training and which is currently not widely available at HC level).

As in more than half the HCs across the country, there was no water and intermittent electricity. (The collaboration with Addis University for water collection and solar power is a good one). The HFE constructed accommodation seen was comfortable but only partially functional. The strategy to have special housing for the HCM midwives is not successful throughout and 8 sites have not yet had special accommodation built and funds for this are not available. The HC is sometimes isolated and the superior housing and conditions (including salary-top ups) of the HFE midwife is reported to create resentment among other staff.³³ This was reported to the review team in Mekelle only, although relationships in the HC generally appeared positive and it would be difficult to generalise without more information. The first batch of midwives is now completing three years' service and questions now arise as to whether the strategy of separate accommodation and a six year commitment is realistic and sustainable. HFE is cognisant that six years is a long time to stay in situ and expects some attrition. With this in mind, discussion on career path options and continuing professional development will need to be included in strategic planning discussions as well as viability of construction of new accommodation:

- Should HFE continue to expand the outreach model of midwives in health centres to the planned 25 or is it appropriate to review the current strategy of deployment, construction and support? Some midwives have voiced a preference for living within the community in rented accommodation.
- Should midwives work in rotation, to gain experience in different parts of the country?

³³ Personal communication Director Mekelle.

- Should there be a career structure for HCM midwives? Will they stay 6 years in situ? If not, how can they be deployed? As tutors? Can HFE sustain the top-up payments? Should HFE explore career development for midwives through the FMOH model of 'task shifting' – to enable them to perform Caesarian sections and anaesthetics (in addition to MVA)?³⁴
- Who will take responsibility to ensure infrastructure is maintained and repaired?
- How are the ambulances used? Are there systems for regulating this and do the midwives have easy access to the ambulances when referrals need to be made?³⁵ How long can HFE sustain the cost of the ambulances?

HFE needs to explore options which will keep midwives in the system but at the same time address the issues highlighted above.

HFE had plans to upgrade some facilities to be able to provide Comprehensive Emergency Obstetric Care (CEmONC). This level of care can only be provided at hospital level and while this can and is being done in the HFE centres, it is not an appropriate aim for HFE to achieve in government facilities.

HFE midwives: program delivery against HFE and national targets

HFE's midwives (quite rightly), use the government Health Information Management System (HMIS)³⁶ and send a copy of their service data to HFE. Interpretation of the data is somewhat difficult as reports provide data both for the calendar year as well as for the Ethiopian Fiscal year 8 July - 7 July. The plans and reports use different measurements with contraceptive acceptance rate³⁷ used for the plan (see below), contraceptive prevalence rate (CPR) used for the 2011-2012 report and actual numbers of services provided in reports – with no clarification on whether figures related to new or continuing users or both. For antenatal and postnatal, these are (probably) number of visits – whereas it would be useful to know the proportion of women having four ANC visits and the proportion of women having PNC. Table 6 below provides 2012 performance against 2011-2012 targets which is not ideal. In future it is suggested FMOH targets be used.

³⁴ This model has had varied success in Mozambique. <http://www.human-resources-health.com/content/7/1/49>

³⁵ FMOH plans to provide ambulances to all Woredas. Experience thus far – from the HSDP-IV MTR shows that there is significant abuse and damage of the ambulances

³⁶ The HMIS lacks consistency and quality and enormous disparities are seen between data from the HMIS and findings from the 5 yearly population-based Demographic Health Survey

³⁷ It is assumed, though not made explicit by HFE, that *contraceptive acceptance rate* is the postnatal uptake of contraception.

Table 6: Preventive 2012 performance against 2011-2012 targets

Centres	ANC* Target	Achieved	Post Natal Visits Target	Achieved	Contraceptive Acceptance Rate	FMOH HMIS 2011	DHS CPR 2011	# Skilled deliveries target	Achieved
Bahir Dar	1,200	9,343	450	259	Mecha:62 Adet:82	89%	33%	1,080	991
Mekelle	1,200	5,452	120	305	Hintal: 78 Samre:83	67%	21%	1,080	864
Yirgalem	1,200	2,821	120	204	Gorich:95 Hulla:93 Loka:79	70%	25%	1,200	346
Harar	800	3,390	90	127	Metta: 94 Jarso: 87 Kurfa: 78	35%	32%	800	371
TOTALS	4,400	21,006	780	895				4,160	2,532
Percentage of target achieved		477%		115%					61%

* ANC per month

Table 6 shows significant over-achievement against targets for ANC and PNC. Otherwise, performance against all (midwife) targets is less than expected but with extreme variation between regions (see Annex 2). In one HC in Harar, there were 70 deliveries in 2012 compared with 362 in one HC in Amhara. Table 7 below suggests that there was a significant increase in the number of deliveries between July and December 2012, with the possibility that the 2013 strategic plan target could be achieved. Regional variations are inevitable – the same pattern is seen at the national level. If the trend increases from the baselines, this is the most important, hence the importance of supervisors using the data to plan their supervision schedules. The target for expansion of HCs was not met – and will need to be reviewed in the context of the forthcoming strategic planning.

Table 7: Quantitative outcomes strategic plan

Target area	End 2011	2012	2011/2012 HFE report	2013
No. midwifery clinics functional	5 + 6 new	11 + 8 new	12	19 + 6
No students in training	65	72	61 (or 68)	97
No. midwives deployed to HCs	24	40	34	40
No. births conducted by HFE midwives	700	1800	1, 218 2,532 (Jan-Dec) ³⁸	3200
No. midwives in training from other organisations	4	8	-	10

It is difficult to know with any certainty, the extent to which HFE has contributed to national performance because the quality of FMOH data is very unreliable and the total performance by region very large. Using available data from the national HMIS in EFY2004 (2011-12), HFE contributed to 0.02 per cent of skilled deliveries in the target regions in that year (1,206 out of a total of 513,816).³⁹ Of 1,264,018 postnatal visits, HFE contributed 1,206 or 0.005 per cent of the total number in the target regions. While the quality of the skilled births attended and the postnatal visits are likely to have been

³⁸ Different reports provide different data

³⁹ Using both HFE data for 2011-2012 and FMOH HMIS for EFY2004.

superior, the numbers represent a negligible proportion of the total. Presentation of the data (Annex 2) show coverage figures for skilled birth attendance of 49% within the catchment areas of the centres, which suggests HFE may have accurate data on all births including those in the community. This is possible as the midwives keep accurate data on pregnancies and in theory can follow up all births through the HEWs. Reported coverage for postnatal care of 159 per cent is unclear, suggesting that more than one PNC visit per woman has been counted. However it is equally possible that the number of pregnancies used as the denominator has been estimated by applying the birth rate to the catchment area population, rather than being based on actual pregnancies because so many pregnant women do not enter into the formal health care system. Presentation of data needs to be supported by clear explanations.

Birth kits

The evaluation did not investigate the use of birthing kits, which are distributed free of charge by local NGOs (HFE, Afar Pastoralist Development Association and Abraham's Oasis) to Health Extension Workers and traditional birth attendants (TBA) for 'safe delivery'. The kits are provided by donations from Birthing Kits Foundation Australia (BKFA). A significant number (5,879) were distributed to HEWs in 2011-2012. Outreach prevention officers developed a training manual and there is also an instruction form from BKFA on the use of the kits.

The main concerns for such an approach are the sustainability of supplies (there has been discussion regarding local production by HFE), the consistency with FMOH policy and the message the provision of the kits would arguably send: that home delivery by HEW or TBA is acceptable provided there is a birth kit. It is also not known whether or how these kits are used and with what effect. Safe delivery kits are promoted in some countries for 'accidental' home deliveries or "en route" to the health facility to prevent sepsis. However unless safe birth kits are integral to the FMOH policy (currently vague on HEW 'safe and clean' delivery), kits provided by HFE might send the wrong message, implying that home delivery and not skilled (facility) delivery is acceptable. This and more feedback on their use needs clarification.

2.2.3. Prevention of obstetric fistula: information and advocacy

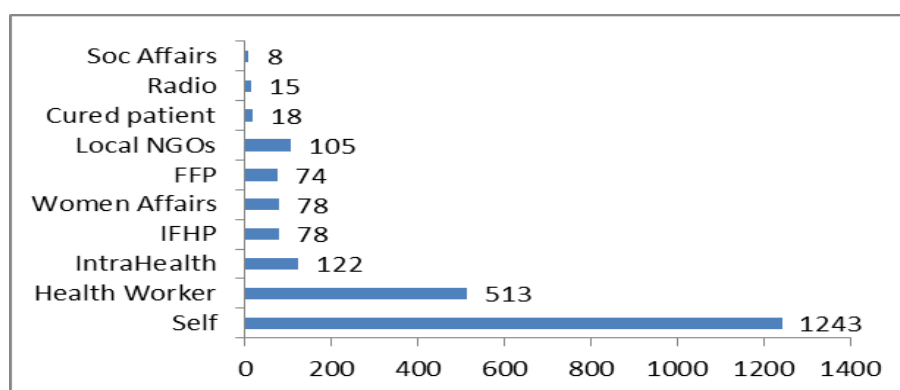
During the past year, health education and information was given to 2,583 patients on different health topics in the main hospital. HFE collaborates with USAID-funded agencies who lead on some of the prevention activities through HEWs and communities. HFE also has its own community prevention activities though it is not clear how these are planned and executed. HFE reports that they have provided training to 2,209 health professionals (including HEWs) and 6,029 participants from different sections of communities and organisations (TBAs, Community Elders, Religious Leaders, Women and Youth Associations, Government Officials etc.) in the outreach programs. Prevention is critically important but HFE needs to consider in its strategic planning whether information and advocacy at community level is a function HFE is best positioned to fulfill given the vast coverage of the Health Extension Worker and Health Development Army networks.

Box 5: Integrated Family Health Program (IFHP) experience in SNNPR

The USAID-funded IFHP office is located in the Regional Health Bureau. Their teams work in 54 out of 158 districts (33%), covering 6 million population. Together with HEWs they have identified and screened 1,956 cases of OF in the past five years, and referred 1,754 women to HFE Yirgalem centre for assessment and repair. If IFHP's model was extended to the whole of Ethiopia, (assuming comparable incidence and prevalence rates), this could have resulted in 24,200 fistula cases operated in the period 2008 to 2012, as opposed to the actual 11,400 (10,300 by HFE and 1,100 by WAHA). *Source: USAID 2013 situation analysis*

The GoE's Health Development Army (HDA)⁴⁰ albeit in its early stages, has significant coverage and appears effective. Tigray for example has 25,080 HDAs with 124,520 members; Amhara 84,285 HDAs with 379,988 members and Oromia 140,643 groups with 912,712 members. The GoE has developed guidelines for social mobilisation of these groups as well as training for political, religious and community leaders through its different directorates. In this context, it would be much more strategic for HFE to engage at the level of the directorates so that OF (and FUI) prevention messages and case detection for OF can be incorporated into the guidelines and training. Figure 3 below shows that the large USAID-funded NGOs and health workers have been important in mobilisation, but it is mainly health workers and the women themselves who need to be encouraged for referral.

Figure 3: Source of referral Mekelle Hamlin Fistula Centre 2009-2012



- *Dr Hamlin will continue to be an important and effective icon and advocate in Ethiopia and beyond as will HFE. Communication and advocacy at a strategic level can usefully be supported by powerful communication materials drawing on best practice and emphasising HFE's contribution to Ethiopia's wider efforts in maternal and reproductive health.*

2.2.4. Rehabilitation, re-integration and long term support of patients

HFE's approach is along a continuum of care – preparing the patient for surgery, providing the surgery, providing the post-operative care and then the physical, emotional, social and economic rehabilitation. This holistic approach is difficult to replicate in the less-resourced government facilities. Information and training is provided both at the hospitals and in Desta Mender with the aim of helping women become more knowledgeable on a variety of topics, more empowered about their rights and more skilled to become economically independent. Some women – those who are 'dry' (about 82%) can return to their communities, and some are accepted back by husbands and families. Among those, some women become pregnant and are encouraged to return to the HFE centres for a safe Caesarean Section delivery. (A total of 152 women were delivered by C-Section in 2012 and numbers are likely to grow). It is hoped that these women can become 'ambassadors' to help in case detection and referral of women with OF. Data from Mekelle show that very few referrals are due to ex-patients possibly because of stigma. Discussions with women confirmed that they knew of few cases.

The situation analysis reports that the fistula closure rate can be as high as 93% with experienced surgeons. However, post-closure urinary incontinence, from limited to

⁴⁰ The Health Development Army (HDAs) is a network of five households and one model family to support the Health Extension Program reach the rural population with health messages through social mobilization, mutually influence one another in practicing healthy life styles, improved sanitation, nutrition etc.

complete, is still a formidable problem in the management of obstetric fistula. The reported prevalence of post-operation incontinence varies widely and it is generally around 6%, but it can rise up to 57% for fistulas involving urethra and sphincter damage. Among the latter, many self-resolve in due course, but at least 10% of them will continue to suffer for the rest of their life.⁴¹

Physiotherapy is therefore essential – especially for patients with ‘dropped foot’ who became paralysed as a result of long inactivity. During post-operative care in the Hamlin Fistula centres, the patients partake in various classes including functional literacy and income generation. How these classes provide long-term benefits is important to know – because this will inform planning in this area. Far more complex is the social reintegration of the women who have been abandoned by their communities, or left with medical problems requiring daily medical care. The future life and working capacity of those with ileostomal bags and derivations needing daily care that they may not self-administer is problematic. The small capacity of the fistula centres to employ ex-patients as paid nurse-aides has been reached, and similarly in the Desta Mender Centre.

Desta Mender (“Village of Joy” in Amharic) is a ‘village’ of western-designed homes able to house 10 women in each, adjacent to the Hamlin Midwifery College some 17 kilometres from Addis Ababa. Desta Mender is currently home to 42 women who remain incontinent and require continued medical and psychological support, though capacity is not met. While 7 women who have serious disabilities and illnesses are likely to remain in Desta Mender permanently, 65 women are able to live outside and with training received from Desta Mender can make a small living. Many need to wear stoma bags to collect urine hence the need for them to remain close to medical support. 1,286 stoma bags were supplied in 2012. (These are special stoma or ileostomy bags adapted for tropical conditions made in Ireland at a cost of Euro15 each which are gifted by HFE/UK). Advances in urology provide hope for some women. Research and specialised care undertaken by the former medical director will undoubtedly continue and he is accepting cases for surgery, though these must be paid for.

The 42 resident women are employed in the gardens, and receive non-formal adult education, literacy and skill training as well as health information and support. A Women Self-help Association was established in 2011. The Yadano Café is owned by four beneficiaries. Desta Mender is very isolated however and apart from the very few (9) women with terminal or serious medical conditions, it is now felt that a concerted effort is needed to re-integrate residents back into their regions. Returning home to a rural area is not possible as they need to live close enough to a fistula centre for the medical care they will continue to need, including replacement of about 3 bags weekly.

In the absence of any other facilities catering for such incontinent women outside Desta Mender, HFE faces a challenge in their reintegration and follow up. The current director is working on a strategic plan to address re-integration more strategically. Priorities include among others, finding (and training) other potential partners in the regions, making best use of these women for case detection (with incentives), tracking progress using social science research which could be provided by Ethiopia universities) and maintaining the supply of the (expensive) stoma bags.⁴²

⁴¹ Carey MP, Goh JT, Fynes MM, et al. Stress Urinary incontinence after delayed primary closure of genitourinary fistula: a technique for surgical management. *Am J Obstet Gynecol* 2002;186(5) :948-53
Browning A. Risk factors for developing residual urinary incontinence after obstetric fistula repair. *BJOG* 2006;113(4):482-5

⁴² It has not been possible to ascertain whether provision of bags will continue from HFE/UK and for how long. The need is indefinite so alternative (local sources) will be important

2.3. Organisational Effectiveness

2.3.1. Monitoring, evaluation and research

HFE can demonstrate, from its data, that it is delivering services that contribute both to Ethiopia's and Australia's strategic goals.

Different data are collected: hospital data, data from the government health centres using government systems and other data related to HFE-specific programs. Data are not disaggregated for gender or disability (all patients are women and all patients have impairments). Some women are disabled from drop-foot, while others are not cured of incontinence and HFE collects data on such cases i.e. impairment which affects mobility.

Alignment of M&E Framework FMOH HMIS indicators

Systems for M&E have only been developed during the past 1 ½ years – a very short time in the history of the organisation following repeated recommendations for improvements from AusAID assessors. The M&E department is keen to do a good job and is making best efforts to improve quality, use and feedback of data. While some technical assistance was provided by an HFA consultant, there is a lack of evidence to suggest that capacity was built to the desired level where robust, reliable and consistent data are generated and used for planning, training and advocacy among others.

There is no indicator for Obstetric Fistula in the government HMIS so there can be no alignment until this is included. This is an issue deserving of advocacy with FMOH. Historically **hospital records** have been kept but not analysed and used by management. Annex 4a shows that HFE service statistics have been used for research and dissemination purposes by previous Medical Directors. There is otherwise lack of evidence of historic and on-going systematic M&E to link with strategic performance targets. This has arguably not been part of the HFE organisational culture until more recent efforts to formalise M&E. The HFE M&E department was not aware of feedback on M&E from AusAID provided to the past CEO of HFE. With improved information technology (IT) systems and staffing additions, including a statistician, routine data collection is now more systematic and the team was informed that HFE provides regular feedback to the regions on their reports. **Hospital data** generated are used by HFE but not shared with FMOH. HFE has asked FMOH to include OF as one of the HSDP-IV indicators.

- *The Regional Health Bureau (RHB) in Tigray expressed interest in having routine hospital reports and plans to include OF among its indicators. This needs to be followed up both at regional and central levels to ensure consistency between regions and to ensure that HFE hospital data are properly reflected in national reports, which is currently not the case.*

Health Centre service statistics are kept using the routine FMOH HMIS formats which go to the Woreda office and HFE. Midwives maintain all required registers. Displays of data on the walls of the HC visited suggest the midwife understood the value of the information and it provides a quick and easy way for supervisors to track trends. In Tigray, data are displayed on all pregnant women with their estimated delivery date (EDD). This is communicated to the Women's Development Groups together with the EDD to ensure that the women come to the HC for delivery. If not already practiced in all HCs, this is a useful practice to replicate more widely and to track through operations research. In this way, service coverage can be accurately assessed and women close to delivery followed closely to encourage facility delivery. Consolidated reports suggest returns are received from all HCs and results highlight the variation in performance (see Annex 2).

Use of data for planning, management and measuring impact

The M&E function in the organisation is extremely important and provides a valuable opportunity for HFE to share information and showcase its work. The consultants were provided with useful presentations by senior staff drawing on service statistics. It is not clear the extent to which data are used and disseminated effectively through the organisation for supervision, planning, management and advocacy.

Positive changes have been made to the flow of data such as the system whereby HC data (deliveries, ANC, PNC, FP etc.) used to be sent directly to the HCM rather than through the regional centres for use by the supervisors. The M&E department now receives copies of HC data (as well as HCM and FMOH). Monitoring quality of regional data is done at central level, without periodic checks and balances at source. The 2011-2012 report sent to AusAID, prepared by a local consultant, is full of errors and of poor quality. It appeared not to have been quality controlled by HFE and was sent to HFA too late for QA on their side before submission to AusAID.

Current targets were set during the 2011 strategic planning meeting. It is difficult for HFE to set accurate targets on a self-selected population (most patients are self-referred), in a context where data on incidence and prevalence of a problem remain speculative. But with a long history of fistula surgery, HFE knows its capacity and the situation analysis suggests there is still a significant unmet need for surgery. In the absence of OF in the HSDP-IV, government has no indicators or targets. HFE's hospital targets are largely appropriate but need to be reviewed on the basis of a) regional data from the situation analysis and b) any decision HFE may make on whether to extend surgery to FUI cases more generally.

Health centre performance targets should be the government targets which are region-specific. Currently the targets are well below current performance. If HFE-supported HCs exceed the government targets, this will reinforce the idea that quality of services increases uptake.

- *The future M&E framework, to be produced after the forthcoming strategic planning, needs to have a clear performance hierarchy with realistic targets and indicators, consistent wherever possible with government HMIS. Disaggregation of the data (for age, origin, education, type of disability etc.) would be useful. Well selected technical assistance, arguably on a call-down basis⁴³ is needed for the M&E department to identify how it can be strengthened to ensure quality, consistency and robust analysis of data, including the streamlining of reports and indicators.*

HFE's contribution to knowledge and technical developments

Both quantitative and qualitative knowledge generation are important to document the work of HFE and to better understand how to improve case detection and empowerment of fistula patients among others.

Quantitative research

The International Society of Obstetric Fistula Surgeons (ISOFS) provides an umbrella for the relatively few surgeons skilled in fistula repair. The annual scientific meetings are important to share knowledge and to ensure participation in a dynamic scientific network. The previous HFE Medical Director presented 8 papers at the 2010 International Fistula Conference in Senegal. Research outputs from HFE have not continued since the departure of key clinical staff, possibly because research skills are lacking. It is not recommended that HFE necessarily undertakes its own research under current staffing

⁴³ The TA should not only be strong on HMIS but familiar with the FMOH system and interpretation of data.

arrangements because there are others able to do this using the information HFE generates. Published papers will not only help contribute to national and international knowledge about treatment and care of fistula but also help to keep HFE in the public mind and provide a 'shop window' without which it will be more difficult to demonstrate that HFE remains a centre of excellence. Emphasis should therefore be on seeking appropriate partnerships to undertake this research drawing on HFE service statistics.⁴⁴

Qualitative research/operations research

Some of the big questions that HFE (and others) need to address – such as whether there are hidden cases of OF and how to reach them - can only be answered through *targeted qualitative research*. The same is true for measuring impact of HFE's work around awareness raising and understanding. The situation analysis refers to a 2004 report by the World Bank in association with the Ethiopian Roads Authority to evaluate the obstacles to accessing maternal health services at the health centre level and interventions needed to remove those obstacles in four woredas.⁴⁵ It is studies such as this which need to be collected and analysed, in order to identify gaps in knowledge that are needed. *It is not suggested that HFE conducts its own research but draws on local expertise in the universities to assist.*

- *The plan to build research expertise within HCM is appropriate for operations research purposes. Midwives (as well as doctors) should be encouraged to use the service statistics they generate for operations research. It was planned and would still be relevant to have an AVI volunteer placed in the HCM to train in this area.*

M&E related to due diligence and risk assessment: see 2.11

2.3.2. Organisation and management structure

Growth, crisis and consolidation

HFE went through a period of rapid growth and expansion between 2005 and 2011. A new Chief Executive was recruited in 2005, the management team was restructured, and new systems introduced. There was considerable capital investment in new buildings and infrastructure – the new College of Midwives was established and built, five new Outreach Centres were built in different regions of Ethiopia, and there was continued renovation of the Addis Ababa Fistula Hospital. Staff numbers trebled from c.180 staff in 2006 to over 550 in 2012. Income nearly trebled between mid-2009 and mid-2012 from EB44million to EB113million, and in the same period the value of fixed assets rose from EB58million to EB118million.

By 2012 the pressures of such rapid growth became apparent with governance, management and associated systems coming under increasing strain. Experience and research suggests that at times of such rapid growth there needs to be commensurate investment in new management structures and significant support for organisational development processes to facilitate organisational change. If such investment is not forthcoming then it is likely that tensions will appear that may lead to organisational dysfunctions and an associated management crisis. The experience of HFE appears to reflect this pattern.

⁴⁴ The London School of Hygiene and Tropical Medicine based in WHO is a research partner on a DFID funded program on maternal health – *Evidence for Action (E4A)*. There will be other potential and interested technical partners.

⁴⁵ World Bank. Preventing Fistula: Transport's role in empowering communities for health in Ethiopia. August 30-September 13, 2004.

2012 saw significant management changes with senior staff leaving the organisation, board members were removed or resigned and a new board was appointed, while long-standing relationships with key supporters were jeopardised. Considerable time and energy was then invested in “fire fighting” activities to deal with fallout of these changes. This in turn led to a management vacuum with key decisions being delayed, investments put on hold, oversight of reporting schedules and processes allowed to slip, and planned development of management systems and processes delayed.

HFE’s new Board and its interim management became increasingly aware of these issues and an international recruitment process was initiated which resulted in the appointment of a new CEO who took up post in January 2013. Other key medical staff have been recruited to replace those who left in 2012. By May 2013 a new management team was established. It has filled the management vacuum and begun to tackle the overhanging issues from the “crisis” of 2012. It has addressed outstanding issues in HFE’s management systems and processes, and started a process of reviewing HFE’s strategic plans. The new management team appears to be viewed positively by staff and key stakeholders, and there is a sense of optimism as to the way HFE is developing.

2.3.3. Strategy, structures, staffing and systems

The strategic planning process only began in 2006 in a meeting of senior management and Trustees and still appears relatively undeveloped. There has been a pattern of preparing time-bound operational plans and calling them strategic plans. HFE’s strategic planning processes need to be developed and clarified. Time needs to be invested in developing a strategic plan that outlines the direction and scope of HFE over the long-term which matches resources to its changing environment so as to meet stakeholder expectations. The new CEO intends to engage an appropriately skilled and experienced consultant to assist HFE with a three day strategic planning process in mid-2013. In this way the CEO will be able to participate fully in the process. The product of this process should result in clear strategic goals supported by SMART objectives and indicators. These in turn can be used as the basis of more effective monitoring and performance evaluation.

Such a strategic planning exercise should go beyond identifying short-term objectives and targets, and should address wider issues around the position, relevance, sustainability and focus of the organisation. Questions need to be addressed as to whether HFE’s current theory of change is still realistic and relevant? How best can HFE add value? Where should it focus its energies and resources? How best to deliver relevant and cost-effective decentralised health care? How to recruit, retain and develop staff of sufficient standard and experience? Such a strategic plan should also identify how HFE will respond to contextual changes and challenges. These include the projected decline in fistula cases, the pressure for closer alignment to government health policies, changing donor priorities and the need to ensure greater financial sustainability, and the wider impact of political and regulatory challenges facing NGOs in Ethiopia.

HFE’s organisational structure is clear, and has been graphically represented in an appropriate organogram. Lines of authority, responsibility and communication are established, and a new management structure with a clearer responsibility matrix is to be adopted. There is also an established pattern of regular management meetings (including medical planning, finance, purchasing and promotion committees). The current unitary structure and associated systems is centred on the AAFH. HFE’s subsidiary activities (such as the Outreach Centres or Desta Mender) operate as independent cost-centres with their own management teams. This unitary centre/subsidiary model ensures a degree of oversight and cohesion, but also creates some distortions as to the way overheads are allocated. Currently AAFH (where most core services are based) carries the burden of such overheads. A more equitable or representative cost-sharing or allocation model needs to be devised so that all subsidiaries carry more realistic

overhead allocations – this in turn will empower them to have greater say and control over the way such core services operate or serve their needs.

Staffing levels seem appropriate to support HFE's decentralised health provision although there are concerns about the retention of specialist medical staff and others with specific skills. The majority of staff are women and there is an appropriate gender mix across the organisation. There are women in leadership roles (including the Director, the Chief Operating Officer, the Desta Mender Manager, the IT Manager, and senior medical staff) and there is an appropriate culture of empowerment.

A competency and staffing audit needs to be commissioned to help HFE assess the appropriate balance between professional and support staff, and identify whether staffing levels are appropriate and cost-effective. HR strategies need be developed to support the recruitment and retention of key staff – this is not merely a matter of offering more money but also reinforcing HFE's values and culture, and offering targeted training, secondments or exchange opportunities through which staff can develop their skill-base, access new learning and innovative practices. Consideration should also be given to the appointment of a dedicated HR Director to help develop and implement this strategy. In light of the increasing complexity and scale of HFE's activities, its developing relationship with other partners and FMOH, and its growing international profile, it is proposed that two new management positions be considered: a Program Director to help coordinate HFE's in-country activities and relations, and an International Relations Director to facilitate the development of HFE's international links and partnerships.

There has been on-going investment in basic systems. A framework of appropriate systems is now in place (HR, IT, Finance, M&E, etc.) and works effectively considering the pace of recent growth and associated management issues. (See Section 2.11 on Due Diligence and Risk Assessment for an overview of efficacy of systems and other capacity considerations including risk management, financial viability, fraud controls and anti-corruption protocols). A process of investment and systems upgrade is being put in place to address matters of immediate concerns and bottlenecks. These include completing the revision of the HR manual, upgrading computer servers, and renewing power-surge affected computers, aligning financial data with strategic goals, and increasing the capacity of the M&E team. As part of this upgrading process consideration should also be given to the introduction of a Systems Development Strategy that:

- Is predicated on need to support HFE's new strategy and the continued decentralisation of health care provision
- Prioritises quality & resilience, and is underpinned by a focus on cost-efficiency & performance management.
- Is supported by a shift in culture to ensure timely and relevant provision of core services designed to support internal clients & meet strategic goals.

2.3.4. HFE finances and financial sustainability

In financial terms HFE is one of the largest registered local NGOs in Ethiopia. Review of past financial records provides evidence of consistent financial growth. Reserves and cash-at-bank levels seem appropriate for an organisation of this size. HFE has an established track record of presenting fully audited financial reports and making them available through their Annual Reports. As already noted HFE has appropriate financial systems that are in the process of being upgraded to better fit strategic imperatives. (See the following Section on Due Diligence and Risk Management for comment on financial systems and controls). In general, HFE has a secure financial position with rigorous oversight over expenditure. An indication of this is the way that HFE is projected to come in under budget in the current financial year. HFE's international profile and reputation

suggests that it has the potential to continue to attract significant funds from a range of philanthropic and charitable donors.

One of the major challenges currently facing NGOs globally is how to ensure financial sustainability and how to develop strategies to build a diversified funding base with a mix of different funding sources. HFE has a well-established record of fundraising both at a personal level but also through a diversified set of institutional sources. HFE income for the year June 2011-June 2012 was a total of ETB113,870,662 (c.AUD\$6.37 million). This came from an impressive mix of international and local sources, including official donors (e.g. AusAID, USAID), Hamlin Partner NGOs (e.g. HFA, HFUK, HFIF), other NGO donors (Women's Hope International, Ethiopian Aid), and some from local income generating activities. This mix of funding from official, non-profit and its own income generating sources reflects a well-developed, diversified funding base and a funding strategy that other NGOs could learn from. Highlights include:

- The diversity of donors (twenty-five different international donors from twelve different countries)
- The spread of contributions (of the NGO donors, Hamlin partners and others, twelve gave over one million ETB)
- The use of private sector sources (Johnson & Johnson) and the spread of its own income generating activities (farming, catering, poultry production, dairy products and grinding mill sales).

Annual reports show excess of income over expenditure as AUD\$4.433m in 2010 and AUD\$1.469m in 2011.

Over the years a number of Hamlin Partner NGOs (HPs) have been established. Hamlin Fistula Australia was incorporated in 1996 and since then seven other national HPs have been established in Germany, Japan, the Netherlands, New Zealand, Sweden, US, and the UK. In 2011-12 these HPs contributed cash and in-kind donations totalling ETB 59.7 million (AUD\$3.3 million) – over half of HFE's total income. Each of these HPs is an autonomous non-profit organisation registered under national non-profit legislation with their own governance and management structures – as such they are legally independent of HFE.

The relationship between the HPs and HFE has traditionally been managed through personal contacts or through the HFE-hosted Partners' Meetings which have been held intermittently over recent years. These meetings provided an opportunity for progress to be reviewed, donations coordinated and funding pledges allocated. The next Partners Meeting is in the Netherlands in September 2013. The relationship with HPs is evolving and needs to be further formalised. Expectations need to be managed and areas of agreement or strategic alignment documented. Consideration needs to be given to some form of partnership agreement, memorandum of understanding, or institutionalising relations in an "alliance" model. There have been issues and misunderstandings in the past between some HPs and HFE, and there needs to be more structured liaison and communication between HPs and HFE with less reliance on personal contact or relations. In this regard and in order to avoid potential conflict of interest issues and associated reputational risks it would be beneficial that HFE board members should not be on multiple boards.

Another indicator that a well-developed sustainable finance strategy has been initiated was the establishment in Switzerland of the Hamlin Fistula International Foundation (HFIF) with the intention of providing long-term support for the Addis Ababa Fistula Hospital. HFIF was registered in May 2005 with Swiss charity status to provide a secure location for long-term investments, mitigate the impact of currency fluctuations, and help manage the cash flow fluctuations associated with the work of HFE. As noted above

there is need to formalise relations between HFE and its “alliance” of support partners – similarly consideration needs to be given to how to involve HFIF in such a strategic relationship or “alliance”. The Foundation is an autonomous Swiss legal entity with its own formally constituted board, and a newly appointed Chief Financial Officer (from a reputable Geneva-based bank). It is audited as per Swiss law by one of KPMG’s Zurich-based Licensed Audit Experts whose report is issued annually (the 2011-12 Audit Report was somewhat delayed in 2012 due to the resignation of the previous CFO. It was signed off in January 2013). This report noted that at June 2012 the Foundation had total assets of CHF12.3 million (approx. AUD\$ 14.46 million), and had an income of CHF 992,687 (AUD\$ 1.167 million)⁴⁶. HFIF also produces an Annual Report which outlines results, distributions, costs, assets, and liabilities. These reports are prepared, audited and accessible as per Swiss law. It should be noted that there are some inconsistencies between the HFIF’s 2012 Annual Report and what is recorded in the 2011-12 Audit Report that may need to be addressed. These include the value of total assets and the amounts distributed to HFE. There has also been some concern about the distribution of funds to a new HFE fund raising entity in Australia. These were partly addressed at the March 2013 HFIF Board meeting with the provision of a loan to this new entity, along the same lines as a loan made to Hamlin Fistula USA to develop its fundraising platform. There are plans to develop the Foundation through a strategy of more proactive fundraising in Switzerland – already an estimated CHF200,000 has been pledged in 2013 and it is projected that an additional CHF0.5 million could be raised to support the Foundation’s work over the next year.

While there remains significant opportunity for funding through the HPs in different countries, there is also opportunity in Ethiopia, through development partners and possibly through GoE sources. The new Strategic Plan provides an opportunity for HFE to get donor partners to buy into the plan, into one M&E framework and one reporting system.

Progress in developing an MoU with South Sudan

Since 2010, in collaboration with the Ministry of Health and UNFPA in Southern Sudan, HFE has provided OF surgery and in-service training for doctors and nurses in South Sudan with the aim of establishing three fistula centres and a formal link for ongoing technical assistance. While the training provided some useful income (US\$9,000 per trainee), with expenses paid by UNFPA, this arrangement ended with the departure of the former Medical Director. Very recently, a revised draft MOU was sent to South Sudan with a view to renewing relationships and to agree on a Memorandum of Understanding (MOU) on training. The CEO asserts that because of competing organisational priorities in HFE, this is not an appropriate time to enter into new agreements.

2.3.5. HFE governance

HFE’s Board has been through a process of renewal. A new Board of Trustees was appointed in early 2012 with a spread of competencies including business and medical experience. In general, the new trustees have considerable experience of board membership and have a good understanding of board practices. The Board holds regular meetings in quorum supported by detailed minutes. In light of the demands being placed on them and the time constraints they face there is recognition among the Trustees that they need to develop Board processes and systems which have hitherto been lacking. Issues to be addressed include: ensuring that appropriate policies and procedures are in place (risk management policies, child protection, etc.), and sufficient time is allocated to allow them to engage in the development of HFE’s new strategic plan.

⁴⁶ www.oanda.com at current exchange rates

The 'Trustee Manager' is the Chair of the Board of Trustees under Ethiopian Charity legislation. This position is currently held by a UK-based family member. This position is critical and the requirements must include *inter alia*, frequent liaison with, and support for, the CEO, and ensuring the development of HFE's governance processes. The development of a board manual will define and clarify these. For example: board code of conduct; a conflict of interest register; trustees' roles and responsibilities (including the role of the Trustee Manager and office bearers); trustee nomination procedures and rotation protocols; identification of core agenda items (these might include review of accounts and a dashboard of financial indicators, assessment of the risk register, update on international HP relations, etc.), and standards for distribution of board papers.

This process of governance renewal and board development could be supported by a review of board working practices including: a board appraisal process; a mechanism to follow up whether board decisions are implemented; allocation of members' roles (including oversight by specific members of particular areas of activity); and addressing the efficacy of multi-board membership in other HP NGOs which is a matter of concern given the independence of the HPs and potential conflict of interest issues and associated reputational risks.

The issue of the *size of the Board* is a matter of some concern. Ethiopia's 2008 Charities and Societies Proclamation allows for only five Trustees. This not only puts considerable pressure on board members, but also limits the spread of competencies and restricts the possibility of different board members sitting on specialist sub-committees. It would be useful to seek legal advice to see if there is any flexibility on the number of trustees that HFE can appoint.

The *number of Trustees* is also a specific issue for the Board of HFE. This is an issue of concern in light of the number of board members involved in recent decisions. A review of recent board minutes suggests that HFE has six trustees acting as board members – in other words it is in breach of Ethiopia's Charities legislation. One option to resolve this issue would be to pursue the proposal made in the 22 March 2013 Board meeting that Dr Catherine Hamlin takes on the role of Patron. This role would be commensurate with her stature, and allow her to continue to play an active role in HFE, promote its work and enhance its reputation. Many NGOs and charities have such high profile Patrons. This role enables the Patron to institutionalise their interest in the charity without the legal encumbrance of being a trustee. Alternatively one of the other board members may have to resign to ensure that the HFE board is not in breach of the law.

The *number of board members* is also an issue given the increasing complexity of the issues that HFE is facing. These are partly the result of the size and decentralised nature of its operations in Ethiopia, but also partly because of the increasing contextual challenges facing all NGOs and the moves to develop HFE's international profile and formalise relations with its international partners. There is a need to ensure that the HFE's relatively small board (by international standards) optimises its performance. This can be achieved by adopting and implementing appropriate governance processes and board practices as described above.

At this critical juncture, board skills and experience are vitally important to put HFE's governance on track and to provide the CEO with an appropriate level of support as he puts in place robust systems and procedures and introduces a new strategic plan.

2.3.6. Due diligence and risk assessment

This section provides a brief overview of HFE's internal capacity based on the capacity domains outlined in AusAID's 2013 draft Due Diligence Assessment Standards for CSOs:

Table 8: Organisational Capacity

Organisational Capacity		
1	Entity Details	HFE is an independent legal entity appropriately registered under Ethiopian NGO legislation with a functioning governing body that meets regularly, with plans to engage in a process of board development.
2	Past Performance	HFE has a well-established track record of implementing and completing projects with identifiable outcomes, is known and respected both in Ethiopia and internationally for the work it does. The gradual decline in the number of fistula repairs performed across centres needs to be investigated – which the new management aims to address through a rigorous strategic review and planning process.
3	Technical and Operational Capacity	HFE has appropriate technical capacity appropriate to the scope of its work, which is in the process of being developed and upgraded. This is supported by suitable budgeting and reporting systems with plans for further investment in these systems. An appropriate range of plans, organograms, and policies are available, and appear to be in the process of being revised and developed.
4	Financial Viability	HFE has appropriate financial systems and audited accounts, and has a strong diversified funding base with adequate reserves. It has appropriate financial statements and budgets for the current financial year. Board minutes are available. Any discrepancies between KPMG and HFIF audits are not in the remit of this due diligence assessment.
5	Results & Performance Management	HFE is in the process of developing its M&E systems, establishing a timely and systematised approach to documenting results and evidence of effectiveness and impact, and developing quality assurance systems and processes. (See M&E Section)
6	Cost & Value Consciousness	HFE has appropriate project planning and budgeting processes and systems in place to monitor, manage and contain costs against a documented project budget, with appropriate procurement, travel and expenses policies in place. Recent focus on cost control is reflected in the recent cycle of expenditure coming in well under-budget.
Risk Management		
7	Fraud Control	HFE has established over the last ten years – partly with HFA's support and intervention - financial systems to mitigate fraud with a range of checks and balances to deter and identify fraud. It has a well-established Audit Process, a Procurement Policy and Process, an Asset Management Process, Petty Cash Control System, Store Management and Stock Control Mechanisms. HFE has developed a policy and has procedures in place to investigate fraud.
8	Anti-Corruption	HFE has a range of anti-corruption systems in place (see above) overseen by established committees such as the Purchasing Committee to ensure multiple involvement in procurement decisions supported by multiple quotes, or the Promotion and Remuneration Committee to ensure multiple involvement in HR decisions. Recent contracting commitments related to HFE(A) staff have prompted justified concerns regarding conflict of interest. While this review is not focused on the HFE partners, it is anticipated that HFE's fundraising partners follow good governance practices.
9	Sanctions Lists	This is monitored as part of future risk management risk register policies
10	Counter-Terrorism	HFE operates under Ethiopian law, and specifically the 2008 Charities and Societies Proclamation, which provides Ethiopian authorities with sufficient legal redress to handle such activities

Organisational Capacity		
11	Criminal Records Check	There is no formal policy except in recruitment process (see updated HR Manual) and that is determined by the vicissitudes of undertaking criminal record checks through Ethiopian Police and the haphazard nature of record systems.
12	Risk Management	Currently undertaken on an informal basis, but there is recognition that a risk management policy and risk register need be established, that risk analysis needs to be integrated in program design, and that periodic risk assessment needs to be undertaken at both board and management levels. Ambulance expenses are covered by HFE in target Woredas. In the absence of strict controls, there is evidence of misuse of ambulances which could prove costly to HFE. Additional risks to be managed include maintenance of buildings constructed by HFE in the HCs and lack of adherence by government of cost sharing
13	Fiduciary Risk	Established financial management, audit, accounting and reporting systems are in place (see 7&8 above), as are regular reconciliation processes and authorisation procedure. Budgets are prepared at all levels and appropriately tracked.
Safeguards		
14	Child Protection	HFE commissioned a new child protection policy in 2012, but this needs to be rolled out across the organisation and incorporated in recruitment and induction processes. HFE reported a few OF cases among children as young as 2 years of age as a result of sexual abuse. It is suggested that these cases are documented and communicated to the relevant government ministry to inform policy and programs related to child protection. HFE might also consider a routine practice of informed consent for use of women's pictures and stories in HFE's publicity materials.
15	Displacement & Resettlement	Not applicable
16	Disability	By the nature of HFE's work, it is fully aware of the issues around disability. A significant proportion of its support staff are recovering from fistula and other associated disabilities. Women with <i>continued incontinence</i> post-surgery all have disabilities and many or most ex-patients are given employment and training in HFE. This includes Desta Mender where staff work with the most disadvantaged women in what appeared to be a well informed and sensitive way. The director of Desta Mender undertook a review of the sexual health needs of the residents which is laudable and will undoubtedly help with rehabilitation and identify the women's needs for specialised counselling and support. Some women (currently 9), have conditions which will require them to remain in Desta Mender indefinitely while for others, there is a policy for re-integration either in their communities or in their regions. In the 2012 report, HFE indicate links with 33 local organisations to help with rehabilitation and reintegration. A detailed review of the facilities using a disability lens was not undertaken but it appeared that the Addis Ababa Hospital and Mekelle – being the only other hospital visited - have addressed the physical needs of disabled patients to ensure buildings are accessible. HFE's disability inclusion policy in the HR manual is in the process of being revised and further consideration is to be given to how it is applied. Ethiopia's first law (2009) governing registration and regulation of NGOs (CSP Article 14j-n) restricts participation in activities that include the advancement of human and democratic rights, promotion of equality of

Organisational Capacity		
		gender and religion, and promotion of rights of disabled and children's rights. It also restricts NGOs receiving >10% of financing from foreign sources from engaging in human rights and advocacy activities. In this context, it is not expected of HFE that they engage in rights-based activities.
17	Environmental Safeguards	HFE has commissioned environmental impact studies and with the University of Addis Ababa is now working on a comprehensive environmental management policy. (This is not an overarching organisational policy and does not cover all the facilities). Though not yet formally accepted, HFE has invested heavily in solar power in all its Centres, introduced reed sewage system and biogas converter at Desta Mender; installed a Monte forte High temperature incinerator in the Addis hospital as well as solar refrigerators and autoclave.
Policy requirements		
18	Transparency	Information about HFE, its work and its financial status is in the public domain through annual reports, brochures, website, research publications, and a range of public events, media exposure and training courses. It is suggested that HFE ensure that all relevant reports are available through its website, and that access to these reports is monitored.
19	Branding	There is evidence that HFE acknowledges AusAID and other donors' support in its reports and through plaques on buildings or other capital projects.
20	Policy Compatibility	HFE has a mission statement and set of objectives which is compatible and consistent with the objectives of official donors such as AusAID and USAID and which are in the public domain.

2.3.7. Relationships management

HFE partners overseas

As has already been explored in some detail in Section 2.3.4, HFE has close relations with Hamlin Partner NGOs (HPs). These are autonomous non-profit organisations registered in Australia, Germany, Japan, the Netherlands, New Zealand, Sweden, USA, and the UK. These partner organisations have made a considerable contribution to the success of HFE and in 2011-12 provided over half of HFE's total income. The relationship between the HPs and HFE has traditionally been managed through personal contacts or through the HFE-hosted Partners' Meetings which have been held intermittently over recent years.

As has been clear from our analysis, the relationship with HPs is evolving and needs to be further formalised. There needs to be more structured liaison and communication, and consideration needs to be given to how best to institutionalise their relationship through some form of an "alliance". Relations would be mediated through a mutually agreed code of practice and conflict resolution process. The success of such an "alliance model" would be premised on the principles of mutual agreement, co-partnership, and alignment to common strategic goals.

Federal Ministry of Health

The FMOH provides robust leadership of the health sector, expecting donor and implementing partners to work within the context of HSDP-IV and following the principle of one plan and contributing to the HMIS. Although Dr Hamlin has maintained a close relationship with the previous Minister of Health, and FMOH holds both Dr Hamlin and HFE in high regard, AusAID has rightly continued to advocate for closer engagement by HFE with FMOH.

HFE has responded to this, planning to recruit a midwifery curriculum adviser through AVI, which has not yet materialised, and appointing a member of staff to be HFE's liaison person for communicating both with the FMOH and other NGOs with maternal health programs. Activities to date have reportedly resulted in the setting up of partnerships for fistula patient identification through NGOs and religious institutions and HFE participated in the recent Mid Term Review of the HSDP-IV. A recent proposal by HFE made on World Fistula Day was for a networking/coordination group or technical committee to be led by FMOH (possibly under the Urban Health Directorate). This is a good initiative. There also needs to be closer engagement on health information systems to ensure that all HFE's contributions (curative and preventive) are properly reflected in the FMOH reports. At sub-national level, where individuals know each other and where relationships are less formal, there is closer engagement.

Donor relations

AusAID and USAID are currently the only bilateral agencies funding HFE and in the context of the overall funding base represent only about 20 per cent of HFE's income. While there has been some programmatic monitoring by both USAID and AusAID, this has not contributed to governance and M&E which do not meet international due diligence requirements. Since AusAID funds have been channelled through HFA – it would usually be the responsibility of HFA to ensure that appropriate levels of technical and managerial oversight were given to HFE which has not always been the case. Since the appointment of an AusAID technical adviser in-country however, there is an opportunity to engage with HFE in strategic discussions on HFE's future direction and options for funding and technical assistance. If donors to HFE agreed on a common time frame, reporting and M&E system, it would reduce the opportunity cost for HFE and help ensure consistency of data.

HFE is a place of learning. We appreciate the quality of care they are giving and how they empower women and manage the patients."
UNFPA, Addis 2013

3. Value for Money

In the absence of an economist on the evaluation team, a detailed assessment on Value for Money (VfM) has not been provided. However looking at *Value for Money* (VfM) in a holistic way, it is possible to make observations and draw some conclusions about AusAID's investments over the past ten years.

In terms of *economy* (lowest possible costs of resources used), the review team found that HFE has appropriate project planning and budgeting processes and systems in place to monitor, manage and contain costs, with appropriate procurement, travel and expenses policies in place. In general, HFE maintains rigorous oversight over expenditure.

In terms of *efficiency* and *effectiveness*, the review team looked at HFE's unit costs and outcomes for both fistula repair surgery and midwifery training. The experience of using Australian Volunteers is also considered within this section.

3.1. Fistula Repair

OF care (preparation, surgery and rehabilitation) requires different inputs for different women depending on the severity of the case. HFE has estimated the cost per standard repair procedure at the main hospital and Bahir Dar Outreach Centre including standard length of stay and recovery. Costs range from US\$755 to US\$1,474 depending on location and severity of the case (see Table 9 below). It should be noted that the facilities and quality of care in the HFE centres are excellent.

Table 9: HFE Unit costs of fistula repair

	Main Hospital	Outreach centre
Basic Fistula operation	\$848	\$624
Overhead 21 %	\$178	\$131
Total including Overhead	\$1,026	\$755
Pre & Post op services including physio, rehabilitation	\$251	n/a
Indirect treatment including labs, pharmacy, x-ray etc.	\$119	n/a
Overhead on above	\$78	n/a
Total	\$1,474	\$755

Source: Data based on annual costs of FY 2011/2012 Cost Centers' Trial Balances

There is not a great deal of comparative data as GoE does not provide fistula care. The only other organisation supporting comprehensive fistula care in Ethiopia is WAHA, who work in government hospitals, so do not have the same overhead costs. WAHA indicated that with all country level costs (administration, salary, transport etc.) divided by number of cases treated, the cost per OF patient is about US\$350, reduced to US\$225 when removing costs for prevention.⁴⁷ It is not clear whether this includes all pre- and post-operative services. HFE's costs certainly align with the developing country average figure of US\$1,000 per repair used by the Fistula Foundation⁴⁸.

Looking at effectiveness, HFE reports an overall surgery success rate of 82 per cent. This is similar to an international average of 86 per cent reported by a meta-analysis of 19 studies⁴⁹. There is considerable variation within HFE facilities, however, from 88.9 per cent in Addis Ababa to 49.1 per cent in Harar. This would indicate that overall fistula repair is done effectively by HFE, though with some pockets of lower effectiveness where attention is required.

HFE's objectives relating to fistula repair are realistic and appropriate – however annual targets are inconsistent across different documents⁵⁰ which is counter to a culture of achieving shared objectives. It has also not been possible to provide a ten year retrospective review of achievement against performance targets owing to lack of available plans and data throughout that period; improving the quality of M&E will better demonstrate effectiveness. Moreover the recent shortfall in achieving targets requires enhanced collaboration with FMOH for better case detection and consideration of using HFE capacity to treat other women with problems of FUI, if VfM is to be maximised.

It is hard to imagine an intervention with a more transformational, positive and lasting impact than a successful fistula repair, which takes women out of isolation and misery and provides them with the opportunity to resume a normal, productive family life. That HFE have undertaken so many successful repairs and continue to monitor their success rate, is ultimately a testament that aid resources have been spent well.

3.2. Midwifery Training

The VfM of Hamlin's current strategy for midwifery training and subsequent deployment is something HFE needs to examine carefully in the context of the government's rapid scale up of midwife training and training institutions. There has been a substantial increase in the number of midwifery training institutions from 25 in 2008 to 46 in 2012. Ethiopia now has 46 midwifery training institutions located in all the regions except

⁴⁷ Provided by WAHA, CEO.

⁴⁸ Fistula Foundation letter to GiveWell team, 9 February 2012

⁴⁹ S. Ahmed, S.A. Holtz. Social and economic consequences of obstetric fistula: Social and economic consequences of obstetric fistula -Life changed forever? International Journal of Gynecology and Obstetrics (2007) 99, 510-515

⁵⁰ (4,000 in the Strategic Plan, 3,000 in 2011/12 report and 2,530 Annual Performance report).

Gambella. 18 universities are offering midwifery training at BSc level. The private sector is contributing substantially as 8 of the 46 institutions (17 per cent) are private. Seven provide diploma level and one (HCM) both diploma and degree courses.⁵¹ A meeting with HR directorate in FMOH suggested that there would be a glut of midwives in a few years. Attrition is high because of poor conditions and inadequate training which the FMOH is only too aware of. In this scenario, it is important for HFE to define its role and added value. (See Annex 4b for further detail on midwives).

The cost of training a BSc midwife in HMC is US\$16,000 over the four year period. FMOH indicated that the cost of training each Diploma midwife is US\$630 and US\$42,000 for each Health Officer doing the Accelerated Training in obstetric care owing to the cost of contracting consultants for supervision. Table 10 below provides some comparative costs of midwife training across countries. HCM costs look reasonable and efficient by comparison, except when compared with Government costs in Ethiopia (though these costs do not include living costs).

Table 10: Unit costs of BSc midwife training in different countries

Country	Duration of training	Scope of costing	Student cost per year: US\$
Afghanistan	2 years	All expenses including housing, food, training materials etc.	8,000 - 9,000
Burundi	4 years	Tuition, transportation, accommodation and living fees, registration fee, internet fees, library charges	3,250
Ethiopia (GoE)	4 years	School fees (class room learning and clinical experience in the field)	1,630
HCM (Ethiopia) ⁵²	4 years	Training, housing and expenses (Source: HCM website)	4,000
Southern Sudan	3 years	Scholarship, full board, books , and transportation fee	11,800
Tanzania	-	Recurrent expenditure	3,236

Source: Friedman H et.al back ground paper for The State of the world's Midwifery report. April 2011.

Considering the “value” aspect of VfM, the quality in HCM is undoubtedly much higher and so it is difficult to make strict comparisons with Government training. It is widely acknowledged (e.g. by FMOH, UNFPA) that the quality of the training in HCM is significantly better than training provided in government institutions in terms of staff to student ratios and numbers of deliveries that are performed by students.

The HCM midwives are providing good services in their respective health centres though the costs of sustaining them in situ, which include salary top-ups of ETB500 per midwife each year incrementally, accommodation, equipment and supervision costs cannot be taken on by government. The 34 midwives to have graduated to date are, however, a “drop in the ocean” compared to the needs in Ethiopia, suggesting that the objectives of preventing fistula may not be achievable. This stream of work would benefit from clearer alignment with Government efforts to make a more meaningful impact.

The FMOH indicates that there will be an adequate number of Government midwives within a few years, but remains concerned with their lack of experience and overall quality. As already discussed, this is where HFE has an opportunity to provide VfM

⁵¹ Ethiopia Midwives Association. State of Ethiopia Midwifery 2012.

⁵² See breakdown of costs in Annex 4b

through its 'centre of excellence' midwifery training by working closely with FMOH and the training institutions to improve undergraduate and graduate training and offering professional development to midwives, midwife tutors (and possibly doctors). This will, indirectly, provide VfM for AusAID who contribute to FMOH's midwifery training program, but will require, as already recognised, a strengthening of HCM's current professional capacity of 5 Masters level tutors (see below).

3.3. Australian Volunteer Program

AVI has supported two volunteers in the midwifery college – one English tutor and one midwifery tutor. This arrangement was not as successful as hoped due to a lack of staff leading to the Midwife Tutor Volunteer and other College staff taking on additional roles and responsibilities in the areas of specialised tutoring and clinical practice development. The students indicated they would prefer an Amharic-speaking English tutor. AVI has recently advertised two midwifery posts and HCM has (rightly) indicated that volunteers must have the requisite qualifications and experience to provide added value to the current staffing to increase the capacity in HCM. Plans for a midwifery training expert to be seconded to the FMOH have not been realised owing to difficulties in obtaining a work permit and the proposed candidate not having the requisite qualifications. Another volunteer position was planned for development of national staff in research techniques.

There is clearly a need for additional expertise in the midwifery college and AVI now has advertisements for 2 midwifery tutors. The UK-based Voluntary Services Overseas (VSO) is another source of volunteers which the Irish ambassador has reportedly offered to fund. Other volunteers come on a regular basis for short visits – such as 2 physiotherapists. A number of surgeons used to come, but none recently. Volunteers are useful when they add value, fill gaps and help build local capacity. HFE is rightly mindful of the need to be selective in use of volunteers as there are plenty of offers of help from well-meaning people, but which may not all be possible to manage for effective results. In terms of VfM, this component has had mixed results but does have the potential to be effective with the provisos above.

Overall

In terms of *equity*, HFE accepts all OF patients regardless of faith – and most if not all the patients are poor and among the most disadvantaged in society. Where case detection is falling, this may be because those fistula patients living within coverage areas of case identification/referral activities have already been reached. Scaled up efforts and national coverage through Government systems may identify “harder to reach” women and thus improve not only equity but VfM.

Other factors affecting VfM at the organisational and governance levels are considered in sections 2.3.1 - 2.3.7.

In summary, the HFE program overall provides services to a very high standard and with strong consideration given to the empowerment of the patients who are, to a large extent, disenfranchised and abandoned by their families and communities. If the trend in OF patients continues on a downward path, however, value for money will decrease.

In addition, the number of midwives trained in HCM is small when compared with the FMOH's own training program and the number of midwives deployed in health facilities is minimal which suggests that this intervention may not have the intended impact. The quality is unquestionable. The challenge for HFE is to now achieve greater VfM through expanding quality of midwifery services and training in the national program and by increasing case detection of OF sufferers - there will be better VfM.

4. Conclusions and Recommendations

4.1. Conclusions

Following rapid growth and internal crisis, HFE now has the opportunity, with new and experienced professional staff and a new board, to mend bridges where needed, put in place robust systems to support a larger organisation and grow partnerships. This will help ensure HFE will make a meaningful contribution to the HSDP-IV and ensure HFE's reputation as global centre of excellence for obstetric fistula. The following conclusions and recommendations are made in support of those aims and rating provided where this is required by AusAID:

Table 11: Conclusions and Recommendations

Criteria	Conclusions
<p>Relevance</p> <p><i>Appropriateness of support from AusAID to HFE</i></p> <p>Rating: 5</p>	<p>HFE's high quality and specialised fistula work fills a need that is not met by FMOH and unlikely to be met in the future. <i>The situation analysis confirms a continued need for fistula repair which in the best case scenario will not be eliminated until 2021.</i> It is unlikely that government facilities, other than those supported by WAHA, will take on fistula cases as they require not only specialised surgical skills, honed with practice, but all the necessary equipment and support as well as bed space for the entire period from pre to post-surgical care. Govt facilities could arguably take on more of the less complicated female urinary incontinence cases but experience shows they are not always accepted.</p> <p>There is no other organisation providing the specialised range of services of HFE and training for OB/GYNs. WAHA is still relatively new and working in only 3 sites. Desta Mender is the only centre in Ethiopia to provide rehabilitative (including continued medical support) support for incontinent women. HCM provides added value to services in selected health centres and has the potential to provide significant added value to the country as a whole. More could be done: The UNFPA Annual Report 2010 indicates that Ethiopia had 15 doctors trained in fistula repair compared with Kenya's 96.</p> <p>HFE's contribution to maternal mortality and morbidity reduction through midwife training and deployment is very limited in coverage and AusAID funding for skilled delivery and reproductive health through both HFE and FMOH channels is therefore difficult to justify, especially given HFE's strong financial base.</p> <p>Closer collaboration with FMOH in midwife pre-service, in-service and specialised training will help enhance HFE's wider relevance and cost effectiveness and <i>has the potential to have a cascade effect with far-reaching benefits.</i> Helping FMOH improve quality of services can also help safeguard AusAID's investment in the HSDP-IV. With its new strategic planning, HFE has an opportunity to demonstrate how this can be done and why continued Australian support could be justified.</p>
<p>Effectiveness</p> <p>Rating: 4</p>	<p>HFE's overall effectiveness over the past decade, and the past two years in particular, has been affected by lack of robust management, governance and M&E systems, compounded by the internal 'upheaval' and lack of strategic engagement with GoE at national level. This has also affected consistency and quality in reporting.</p> <p>It is difficult for HFE to set accurate targets because predicting uptake of a service for unknown numbers of sufferers is not easy. The 2011 strategic plan Results Framework provides performance against 2011-2012 targets and shows that 75% of the major surgery target was met. Other targets were nearly met (OPD, cure rate) or in the case of referrals and physiotherapy were exceeded. The overall cure rate was 82% against the target of 85%.</p> <p>For the midwives, HC targets have mostly been well exceeded though it is unclear whether HFE uses GoE targets (as ought to be the case). It is not possible to measure these against the FMOH HMIS targets because the</p>

Criteria	Conclusions
	<p>denominators are not the same. This is the same for family planning so it is not possible to draw comparisons. What is important and measureable is the trend. In the one health centre visited in Tigray, the trends were very encouraging. The situation analysis rightly indicated that prevention is the best option. There are various national programs (some supported by USAID-funded INGOs) focused on different areas related to OF: eliminating child marriage and female genital mutilation, promoting female education, advocating for family planning (FP) and skilled delivery among HEWs, Health Development Army and religious leaders. HFE's best efforts towards OF prevention are in improving skilled delivery and increasing family planning uptake.</p>
<p>Efficiency: 4</p>	<p>Serious concerns have been expressed in AusAID reports regarding efficiency. Reporting has been delayed and is of poor quality, offers for technical assistance have not been taken up. Only 63 per cent of the 2011 tranche of funds were acquitted.</p> <p>AusAID funding for HFE has been used both for capital development and running costs. The hospitals are well built, functional and appear to be in excellent condition. The Hamlin College of Midwives and Desta Mender have been built to exceptionally high standards. A comment was made to the team that the Western design of houses of Desta Mender was not ideally suited to the women's needs and houses in local style (e.g. Tukul) could have been made at less cost. This said, the land for all HFE's infrastructure has been donated, thanks to the efforts of Drs Hamlin and could arguably be used to generate revenue. The residents of Desta Mender grow food which is consumed on site with some going to AAFH. The women also run the small centre with café that is rented out for meetings to generate revenue.</p> <p>HFE acknowledges that cost cutting is needed for cost efficiencies. Current infrastructure plans include expansion of the residential buildings in the College of Midwives and accommodation for midwives in the HCs. The former could have greater potential for cost recovery by increasing the number of students while the latter has significant cost implications and alternative arrangements (such as renting accommodation) might be more cost effective.</p>
<p>Sustainability: Rating: 5</p>	<p>HFE has been highly successful in raising money through its partners in eight countries and AusAID contributions over the years amount to less than a quarter of HFE's total income. There are indications that recent fundraising both by HFIF and HFE(A) have been successful suggesting that fundraising through HFE's eight country partners can raise substantial revenue. Increasing revenue from training of surgeons is possible provided there are adequate trained trainers on staff and marketing of training for the Africa region.</p> <p>HFE can explore other ways in which revenue can be sustainably increased such as charging fees for operations (from FMOH budget), hiring out facilities, and applying for grants from other sources in Ethiopia and globally. Partnership with GoE could increase access to national resources and GoE ownership of the fistula program. A realistic vision for the future functioning of both HCM and the fistula centres is also critical and FMOH needs to share this vision.</p>
<p>Monitoring and Evaluation Rating: 3</p>	<p>M&E is a vitally important area to monitor and evaluate progress, outputs, contribution to national targets and to inform planning, human resources, the scientific community and the health sector more widely in Ethiopia. It was surprising to learn that for an organisation of its size and renown the HFE M&E unit has only been developed to its current level in the past 1 ½ years though service statistics have been generated for many years. An offer of TA from AusAID was not accepted and TA provided earlier has not brought the unit to a sufficient level of competency as reflected in the weak 2011-2012 report prepared by a consultant and submitted to AusAID without quality assurance. The unit is not yet sufficiently developed to provide a robust and critical</p>

Criteria	Conclusions
	assessment of the impact of donor support and to do so properly will require deeper investigation using social science research skills which could be provided by national (and international) institutions interested in research opportunities.
<p>Cross Cutting Issues</p> <p>Gender rating: 5</p>	<p><i>Gender Equality, Disability Inclusiveness and Environmental Protection:</i> HFE does not have policy in all these areas but is addressing them in different ways:</p> <p><i>Gender:</i> HFE provides quality care to the poorest, stigmatised women who face social exclusion and many of them years of isolation within communities. Gender discrimination related to obstetric fistula (e.g. poor nutrition, early marriage, lack of access to services etc.) is being addressed at national scale through the GoE's Health Extension Program and the HEWs and HDA. HFE understands the underlying causes of OF and it is appropriate to focus their attention on areas where they have a comparative advantage (e.g. clinical services and rehabilitation). Many midwives in Ethiopia are male, owing to the lack of educated females. Lack of female midwives is a disincentive to skilled delivery. HCM is adding to the number of female midwives.</p> <p>An institutional gender policy to cover all aspects of gender (e.g. staffing, information/education, employment rights, data disaggregation etc.) would provide an appropriate and necessary framework.</p> <p><i>Disability inclusiveness: See organisational policy table</i></p> <p><i>Environmental protection: See organisational policy table</i></p>
Coherence	The program is consistent with AusAID's investment in MNCH in Ethiopia and those of other organisations – government and non-government as it focuses on reducing maternal mortality and morbidity which is a priority for the GoE's HSDP-IV.
Equity	HFE helps the poorest and most disadvantaged of women. All those presenting with OF are assisted and HFE does not discriminate on any grounds, with patients from all religious groups receiving services. What is not clear is whether patients who are not Christian have dedicated space for prayer and if training is conducted with multiple religious groups in mind. Another question is posed by the review as to whether women with incontinence due to other reasons (e.g. uterine prolapse) should also be assisted.
Ethics	It is not known whether there is a routine system for patients to give their permission for photographs to be printed in HFE publications. HFE encourages people to request permission of patients for photographs and does not encourage photographs taken on the ward.

4.2. Recommendations

The following provide more detailed recommendations to those provided in the executive summary:

Fistula centres: maintaining quality and expertise, generating numbers of patients and providers

1. HFE (in collaboration with FMOH and WAHA) needs to consider how to address the question of falling numbers of OF patients and increasing case detection. Options to be considered include:

- a. HFE to advocate for FMOH to include case detection in HEW and HDA tasks⁵³
 - b. HFE to help FMOH incorporate messages on fistula prevention and treatment in FMOH's communication on reproductive health among all religious (including Imams) and political leaders.⁵⁴
 - c. HFE to ensure that women with OF or needing referral for skilled delivery (using Woreda-based ambulances) are given priority.
 - d. HFE to maximise use of mobile phone technology both for case detection and follow up of cases.
2. HFE could collaborate with universities on socio-economic/cultural analysis of patients to help identify OF "hot spots" and special needs that might attract more patients and draw expertise from universities to assist with this and any relevant research needed.
3. In order to build and sustain clinical expertise and excellence, and strengthen referral, HFE should;
- a. ensure adequate number of full time surgical staff in all centres
 - b. build capacity in HFE to provide continuous skills update for doctors and nurses; including assessment and follow up:
 - c. take up/explore offers for affiliation with international partners e.g. Dundee University for TA (surgery, training TOT and research) as already offered
 - d. maintain database on all trainees and provide routine follow up of trainees with feedback to ensure this feeds in to the training
 - e. consider appropriate (cost effective and sustainable) incentives (e.g. training to retain and build capacity of staff)
 - f. strengthen referral linkages and locum arrangements with WAHA such as when there are high numbers of patients in any particular facility
 - g. discuss with FMOH a policy to ensure ambulances are appropriately managed and used⁵⁵
4. HFE should consider provision of surgery for female urinary incontinence (FUI) and uterine prolapse cases *while continuing to give priority to OF*; supporting/advocating for government facilities to operate on general FUI and prolapse cases. HFE might negotiate with FMOH for a fee for OF cases treated.

Fistula Rehabilitation

It is recommended that HFE:

5. Pursue current strategy to rehabilitate and re-integrate women back to communities and regions with links to regional centres (be they HFE or WAHA). Continue to develop links (as already done with 33 organisations) with local NGOs. This might be facilitated through the Ethiopian Centre for Disability and Development Association which has 66 Association members promoting inclusion of disability issues and

⁵³ FMOH must determine this. It is not advisable for organisations outside government to work directly with HEWs or HDAs or to add to their tasks or training.

⁵⁴ The FMOH already engages with Imams and other religious leaders for Family Planning sensitisation and promotion of skilled delivery.

⁵⁵ A policy for appropriate management of ambulances is on the agenda for FMOH

people with disabilities in mainstream government and NGO development projects and programmes;⁵⁶

6. Develop robust system for follow up and support for reproductive health needs as already started, linking with other RH organisations (e.g. Family Guidance Association of Ethiopia, Marie Stopes etc.) where this can provide added value and support;
7. Explore strategy for data-base and/or continued follow-up and support of more independent women with possible incentive (e.g. mobile phone) for OF cases identified and referred.

Fistula Prevention

8. HFE is advised to stick to what it does best, not spread itself too thin (i.e. 'national outreach' and to promote and encourage FMOH to include fistula prevention messages in the package of HEW and HDA tasks.
 - a. Current collaboration with USAID-funded INGOs is very appropriate. If these programs end, case detection, preparation of patients and referral to fistula centres will be affected. Explore with these organisations, options for sustainability and replication/scale-up of their programs within the context of the HEP.
 - b. HFE can inform Behaviour Change Communication messaging by HEWs, HDAs and NGOs with focus on skilled delivery at the health centre or hospital. Any plans for continued provision of safe birth kits should be reviewed in this context.
 - c. HFE can pursue current HFE-initiated proposal for FMOH-led coordinating body for obstetric fistula prevention, repair and rehabilitation with this integrated into HSDP-IV

Midwife training and deployment

9. HFE needs to explore with FMOH (and FMOE) best ways of using HCM as a centre of excellence to increase quality of services across the country such as in-service mentoring, pre-service training; training of trainers etc. This could be part of career *development* of HFE midwives for whom 6 years at the HC may be too long.
10. It would be useful for HFE to review the current strategy and future expansion for deployment of midwives in health centres: Options might include:
 - a. Access to Masters level training (through HCM or other institutions)
 - b. Ensuring all midwives are skilled to provide IUCDs and manual vacuum aspiration
 - c. Task shifting especially in under-served areas for midwives to enable them to perform Cesarean sections and anaesthetics as already started in the FMOH⁵⁷
11. HFE can consider collaboration with Marie Stopes for midwives wishing to leave government/HFE service to join the Blue Star social franchise network as an alternative to working as solo (unregulated) health providers.⁵⁸ HFE is advised to collaborate with FMOH, UNFPA and Jhpiego to work towards national standardised curricula for diploma, degree and Masters midwifery courses.

⁵⁶ http://www.abilis.fi/index.php?option=com_content&view=article&id=88

⁵⁷ This model has been successful in Mozambique, increasing access to services in rural areas and with good outcomes.

⁵⁸ The Blue Star Social Franchise includes health providers (mainly doctors, midwives) and pharmacists who are accredited to provide subsidised services which are regulated and provided with technical assistance by Marie Stopes International.

12. HFE staff should encourage best practices which increase the uptake for skilled delivery in the facility such as those seen in Tigray (e.g. coffee ceremony, porridge). Encourage building of maternity waiting homes adjacent to hospitals/health centres especially where access is a problem using local materials and support from the community. (Evidence of the benefits of this approach is seen in Attat hospital among others.⁵⁹ See Annex 3 for details).
 - a. These experiences need to be monitored and evaluated, and written up to share with the health community for replication elsewhere. Use of masters or doctoral students from Ethiopia or overseas is advised.

Monitoring and evaluation

13. The M&E unit needs to be supported with an appropriate level of technical assistance to make it fit for purpose to produce quality, timely and relevant M&E outputs. Both AusAID and USAID have made offers to provide technical assistance to build capacity in the M&E department. It is suggested TA is included in the HR plan and a Terms of Reference for M&E TA developed.
14. HFE needs to aim for an M&E framework which is consistent with national targets and indicators where possible, and which corresponds with the Ethiopian reporting timeframe. HFE should collaborate with the FMOH HMIS department to ensure HFE M&E are reflected accurately in the FMOH reports and to collaborate more generally in M&E. HFE donors should be encouraged to support one framework.
15. Some of the big questions that HFE (and others) need to address – such as whether there are hidden cases of OF, and why and how to reach them can best be answered through targeted qualitative research. It is not suggested that HFE takes this on but draws on local expertise in the universities to assist.
 - a. HFE can establish partnerships with universities interested in social science research related to reproductive health services and also discuss with current INGO partners their own contribution to qualitative measurements related to community mobilisation, case detection etc.
16. Information must flow in different directions:
 - feedback must always be given to the regional centres and supervisors to be used for targeted supervision
 - HFE M&E can be used to generate regular factsheets which can inform policy and reinforce advocacy

Research

The strategic plan has as a key objective for HFE to “be a world leader in training and research for treatment & care of Obstetric Fistula”. This is clearly not the case currently as HFE does not have the capacity to carry out such research. It is important nevertheless, that research is generated from HFE’s work, *both quantitative scientific research and qualitative research* to understand more about community behaviours, reintegration of patients etc.

17. It is suggested that HFE not create its own research department, but draws on the expertise of universities nationally and internationally to work with the information generated from the HFE program and at the same time help build capacity of HFE including the Midwifery College. Results can inform planning, management, HR and training and advocacy among others.

⁵⁹ Kelly, J et al. The role of a maternity waiting area (MWA) in reducing maternal mortality and stillbirths in high-risk women in rural Ethiopia. DOI: 10.1111/j.1471-0528.2010.02669.x www.bjog.org

Organisation: growth, crisis and consolidation

After such a period of growth and “crisis”, a period of consolidation is needed. Experience and research suggests that there should be a focus on quality and strategically-driven investment. Consideration therefore needs to be given to:

18. The development of new strategic plans to guide long-term development, resilience and sustainability, while still ensuring that HFE’s core goals and values are met.
19. A planned process of strategic investment in appropriate management structures and systems.
20. The introduction of new management processes to support a reinvigorated organisational culture and a renewed focus on supporting quality patient care.
21. A review of HFE’s overall cost-profile and, where appropriate, making cost-savings or re-allocating costs/resources to strategically important activities

Strategy, structures, staffing and systems

In light of HFE’s rapid expansion and the strategy of decentralising its operations, consideration should be given to the renewal and development of a range of organisational and management structures, systems and processes. These include:

22. Investment in an organisation development (OD) process to promote HFE’s organisation culture. This would emphasise such issues as shared values, alignment to common vision, transparency and mutual trust, and an emphasis on quality, resilience & sustainability. This process would also work to enhance positive relations and lines of communication between management, medical and support staff, promote internal leadership and facilitate the delegation of responsibility and decision making.
23. Undertaking a competency and staffing audit, which may help HFE assess the appropriate balance between professional and support staff, and identify whether staffing levels are appropriate and cost-effective.
24. Introduction of a Systems Development Strategy that is both strategic, prioritises quality and resilience, and is supported by a culture change process that emphasises service provision and an internal market (see above).
25. Continued investment in management processes to support quality assurance procedures particularly in respect of data, reports, proposals used externally. Linked to this HFE should ensure that all relevant reports are available through its website, and that access to these reports is monitored.
26. Revising the way that costs and overheads are allocated – currently 23 per cent of expenditure for all of HFE is on administration – a realistic ratio for a complex decentralised medical organisation of this nature. However, such costs need to be distributed more evenly across different cost-centres and not all carried by AAFH.
27. Appointment of a Program Director to have an overarching view of HFE’s programs and activities, with the role of coordinating activities and acting as a focal point for issues concerning the Outreach Centres. The Program Director would also facilitate liaison with the Ministry of Health and ensure alignment of HFE’s work with government policies.
28. Appointment of an International Relations Director to promote HFE’s international profile, liaise with HFE partners, and develop relations with international contacts, networks, exchanges, etc.
29. Delinking the HR function from the Administration function, and appointing a dedicated HR Director. This would highlight the importance of HR in an organisation

with nearly 550 staff and the HR challenges that HFE faces (recruitment, retention, appraisal, policy oversight, etc.). Specifically the HR Director would develop an HR strategy, enhance levels of expertise, reduce the attrition of key staff, and oversee the development and implementation of the HR Manual. Such a structural change would enhance HR's strategic role in the organisation and help ensure that people management is seen as a core capability.

30. Planned program of in-service training to build staff capacity both in areas of specific needs (IT, HR, Finance) but also to develop key leadership and management competencies (including improving the skills of managers and team leaders to handle performance issues and facilitate communication).
31. Creation of a local network or forum of organisations concerned with OF to share learning, coordinate activities, liaise over issues of common concern, and build a wider constituency of support.
32. To deal with the few OF cases among children as a result of sexual abuse, it is suggested that cases are documented and communicated to the relevant government ministry to inform policy and programs related to child protection.
33. HFE might also consider a routine practice of informed consent for use of women's pictures and stories in HFE's publicity materials.

Finances and Financial Sustainability

In order to maintain HFE's future financial sustainability and address recent issues that have been raised around HFE's relations with HPs and HFIF, consideration should be given to:

34. Embedding processes to maintain and monitor the balance of different funding sources, and explore strategies designed to increase the proportion of income from private sector donors/income generating activities to around 10 per cent of income.
35. Formalising the relationship between HFE and an "alliance" of HPs, including the use of some form of partnership agreement or/and memorandum of understanding to guide relations and facilitate structured liaison and communication across the "alliance" of HPs. This might include conflict of interest and conflict resolution protocols with a code of practice to facilitate relations between HPs, and minimise the impact of membership on multiple HP boards.
36. Support for the development of new HPs (for example in Canada).
37. Clarifying relations between HFE and HFIF including consideration of ways of formalising HFIF's relationship with HFE and other HPs, and reviewing whether joint board membership is appropriate in meeting good governance and accountability guidelines. HFIF trustees need to ensure timely provision of the annual audit statement, address queries of accounts and inconsistencies between the Audit Statement and HFIF's Annual Reports, monitor loans provided to/from HFIF and identify projected repayment schedules.
38. Inviting donors to support its new Strategic Plan and buy in to the concept of one plan, one M&E framework, one time frame and joint evaluation.

Governance Action Points/Recommendations

In light of the challenges facing HFE's board, its governance function, and its relationship with the rest of the organisation, consideration should be given to:

39. Dealing with the issue of board numbers, including seeking legal advice to see if board membership can be expanded to seven or nine members, and consideration be given to Dr Catherine Hamlin taking on role of HFE Patron.

40. Appointing a locally-based chair/trustee manager to facilitate liaison with, and support for, the CEO, and support HFE's governance processes
41. Investing in the development of board processes and systems.
42. Establishing a process to review board working practices
43. Creating specialist sub-committees to deal with specific matters (e.g. an audit committee, remunerations committee, etc.) – these committees could be run virtually
44. Investing in improved video-conferencing equipment to facilitate engagement of international Board members and reduce travel costs (this equipment would have wider application in HFE in terms of supporting its international contacts and relations with HP NGOs)
45. Ensuring proactive engagement of the Board in strategic planning processes, including scheduling a two-day workshop attended by all Board members to fully address key strategic issues and which can be linked with the strategic planning process, as well as address any board working practices issues.

Volunteers

AVI has advertised for midwife volunteers. A review of HR requirements more generally, as is planned, will help determine in which additional areas volunteers can play a role. It is important that volunteers meet (academic) criteria of FMOH to avoid any placement problems and that HFE has good systems for briefing and support to volunteers once in country. It is recommended that HFE:

46. Consider recruitment of suitably qualified volunteers from other organisations such as Voluntary Services Overseas.

Managing external relations

47. The program director position, already recommended above, will ensure that HFE's plans and programs are consistent with FMOH priorities, plans and guidelines.
48. Formalisation of relations between HFE and the Hamlin Partner organisations in the eight countries through some form of partnership agreement or memorandum of understanding is recommended. Relations would be mediated through a mutually agreed code of practice and conflict resolution process. To facilitate this international set of relationships it is proposed that an "alliance" be formed between HFE and the HP organisations which is based on the principles of mutual agreement, co-partnership, and alignment to a common strategy.
49. HFE might consider joining the Ethiopian Hospital Alliance for Quality (EHAQ) launched in 2012 - designed to create a network of hospitals committed to helping one another improve services <http://news.yale.edu/2012/04/17/alliance-aims-improve-hospital-leadership-patient-care-ethiopia>.
50. It is also important for HFE to maintain and build on its relationships with other countries, such as South Sudan, sharing its expertise and generating revenue from training. But, this should only be done within the context of an agreed plan and subject to the availability of staff.

Donors

51. Donors should consider support of HFE's revised strategy where it adds value to the health sector and where it can build capacity in key areas of HFE's operations. They could also consider a more collaborative, cost-effective and streamlined mechanism for support to HFE – including joint evaluation

52. Donors can play a pro-active role in facilitating HFE's efforts to introduce change and closer alignment with FMOH, particularly around case identification and support to midwifery training.
53. AusAID should ensure that entities receiving AusAID funds (such as HFA), are required to assume responsibility for appropriate monitoring and TA of the organisations whom they represent.
54. Donors should use the USAID supported situation assessment as a useful advocacy tool with FMOH to encourage incorporation of OF into the HSDP-IV.
55. Donors should consider strategies for scale-up and/or replication of current work related to OF identification, rehabilitation and referral for skilled delivery with the Health Extension Program and Health Development Army.

4.3. Lessons learned

The following section highlights three lessons derived from AusAID's experience of supporting HFE, and three lessons for HFE drawn from the challenges it has faced over the last ten years.

Lessons for AusAID

1. There are lessons around the use of intermediary NGOs based in a developed country as a conduit for funds to an NGO based in the south. One of the lessons learnt from AusAID use of HFA as such an intermediary is that, while there are obvious advantages in terms of fiduciary planning and foreign exchange compliance, there can be high transaction costs that counteract these advantages. Specifically where the intermediary NGO has limited experience in such areas as capacity building, project planning or monitoring and evaluation there are likely to be gaps in their ability to provide appropriate support. There are lessons here around the need to assess the indirect costs involved and undertake more holistic risk analysis and due diligence when assessing the comparative capabilities of transferring funds through such intermediaries as against providing direct support to local NGOs.
2. There are lessons for donors around the establishment and governance of trust funds, endowments or foundations to provide long-term, sustainable funding for partner NGOs (as was the case with HFIF). There has been a trend among donors to establish such autonomous funds, but there is also a growing understanding that in certain circumstances or legal jurisdictions donors have limited ability to control the way the funds are used or applied. Details in the way the legal instrument is framed need to be considered in more detail, and the implications of the legal autonomy of such trusts should be factored in when assessing the long-term sustainability of such funds, the risks and costs involved and the way the investments are managed or funds dispersed.
3. There are lessons around how to work with, and develop, the governance of local NGOs. Specifically that the perspectives on what is "good governance" or "effective board practice" should not be predicated by the experience of non-profits in the developed world. Donors need to factor in such issues as the local regulatory environment, cultural dimensions, the experience of the pool of potential board members, their availability in terms of time and willingness to contribute, and their understanding of the distinction between governance and management. There are lessons for donors as how best to work with local NGOs to enhance governance practice and develop the competencies of board members.

Lessons for HFE

1. Any organisation that grows at the speed and complexity as HFE did between 2005 and 2011 needs to ensure that such growth and increase in staff numbers is supported by systematic investment in appropriate culture change and team building initiatives, and the development of new structures, systems and management processes.
2. HFE must see itself as an integral part of a wider network of organisations and agencies concerned with fistula and other obstetric issues. International experience suggests that a specialist NGO like HFE needs to be proactive in the way it:
 - a. engages and collaborates with other organisations working in the same field;
 - b. develops new alliances, partnerships and collaborative relationships;
 - c. aligns itself more closely with government policies; and
 - d. develops strategies to enhance its comparative advantage.
3. The lessons from other specialist or niche NGOs like HFE are that they are strategic in the way that they ensure future sustainability by developing sufficient public profile and organisational capacity to attract sufficient resources. This includes developing a strategy to diversify funding sources and generating funds through income generating activities, commissions and sub-contracted work.

Annexes

Annex 1: Summary: situation assessment of obstetric fistula in Ethiopia

A comprehensive technical and situation analysis of the problem of fistula (obstetric and other fistula) in Ethiopia was undertaken in April 2013 by an independent consultant team at the request of the USAID mission in Ethiopia. This has provided essential contextual information for the Hamlin review.

PURPOSE AND QUESTIONS

The comprehensive technical situation analysis includes a mapping of current treatment and prevention support (both government and non-government) and gaps, as well as future needs consistent with the Government of Ethiopia's (GoE) targets (if they exist) for fistula reduction.

This report has two main objectives: a) It will inform USAID Ethiopia's decisions about future fistula programming, and b) it is a key component of a comprehensive Joint AusAID and USAID review of support to Hamlin Fistula Ethiopia (HFE). The findings of this analysis will inform the review.

The report describes the current scale of the fistula problem in Ethiopia (both obstetric fistula and other fistula including uterine prolapse); discusses Ethiopia's policies and strategies for addressing the problem; identifies gaps; describes trends and provides estimates of future prevalence and incidence of all types of fistula in Ethiopia. It also maps current efforts by the GoE and development partners to both treat and prevent obstetric and other fistula and gaps. It discusses likely future medium and longer term fistula support requirements based on current trend data and future case estimates, with the help of projection scenarios.

Finally, it recommends future programmatic strategies to effectively address the problem of both obstetric and non-obstetric fistula in Ethiopia

BACKGROUND

In Ethiopia, it is commonly estimated that approximately 9,000 mothers develop obstetric fistula annually and up to 100,000 women are living with untreated fistula. Lack of both skilled attendants at birth (only about 10% of women are attended by a skilled person during labour) and access to safe obstetric services are the main challenges to obstetric fistula reduction in Ethiopia. Potentially harmful traditional practices, including early marriage and home delivery, contribute to the problem. A comprehensive approach including treatment/repair of fistula as well as prevention of new cases is critical.

The response to this scourge, largely neglected until the early 1970s when Catherine and Reginald Hamlin established the Addis Ababa Fistula Hospital, is multifaceted. The Addis Ababa Hamlin Fistula Hospital (now Hamlin Fistula Ethiopia [HFE]), the charitable organization that was founded by the Hamlins in 1974, has grown significantly over the years with sizable international and domestic support. There has been a shift in focus from a primarily treatment orientated approach to one that also addresses prevention and rehabilitation issues. In 2004, HFE embarked on a major expansion program with the establishment of five regional facilities focusing on fistula repair, community mobilization and prevention. In 2007, they also opened the first private midwifery training college in Ethiopia.

The MoH, in 2010, launched a human resources strategy to accelerate the training and deployment of midwives to each health centre and to deploy health officers with emergency surgery skills.

USAID has been supporting the Government of Ethiopia's efforts to address fistula problems through various projects including through support to: Hamlin Fistula Ethiopia; the Fistula Care Program (Oct 1, 2007 - Sept 30, 2013) with EngenderHealth and IntraHealth; the Integrated Family Health Project (IFHP), Evidence to Action (E2A), (June 25, 2008 – Dec, 2013) with Pathfinder/JSI.

The Australian Government through AusAID is a longstanding and significant supporter of HFE, having contributed more than AUD\$10 million over the past 20 years. Funding has supported major expansion works including increased facilities at the main hospital and the construction of the Desta Mender rehabilitation centre.

In 2011, AusAID entered into a longer-term commitment to fund an integrated fistula prevention and treatment program with a stronger focus on supporting greater alignment and coordination between HFE and Ethiopia's Ministry of Health.

FINDINGS

The incidence of obstetric fistula (OF) has been the subject of speculation since it is not possible to follow births prospectively in a country with such a low rate of institutional birth and skilled attendance (no more than 5% institutional births and 1% SBA in home deliveries in the rural areas). As a proxy, the team used the proportion of obstructed labour as a base for high-risk births, and applied the WHO-established rate of fistula incidence for neglected obstructed labours, removing the (small) proportion of those that benefitted from Caesarean section. The computation resulted in an incidence between 3,300 and 3,750 new cases per year during the baseline year of 2010. The range takes into account different assumptions and regional variations, and is centred around 3,500, which is far below the previously reported number of 9,000 new cases per year, found in the Frances Donnay. UNFPA: Oral presentation of the Campaign to End Fistula, New York 2003" and/or "Media advisory documents: Launch of the Campaign to End Fistula, New York, 2003." For examples, see the website:

<http://www.endfistula.com/natalie/Ethiopia.htm>.

The prevalence can only be obtained by a community-based survey. Two representative surveys conducted in 2005 included questions about female urinary incontinence (FUI). The Ethiopia Demographic Health Survey (EDHS 2005), which did not comprise a clinical confirmation of the cause, reported the prevalence of FUI in the nationally representative sample as 7.2 per 1000 women 15-49 years old, while the other survey, which comprised a clinical confirmation of the cause, reported the prevalence of untreated fistula as 1.7 per 1000 women aged 15 years and above. The extrapolation of these rates to the baseline figure for 2010 provides a number of 37,500 untreated fistula cases (all causes, range 36,000-39,000), and a number of 161,000 women with FUI of all causes. These findings imply that public health programmers must take into account the broader symptom of FUI, and not the narrower syndrome of OF, when planning how to address the physically unbearable and socially ostracizing effects of incontinence. While the incidence of obstetric fistula is mostly among young women, the incidence of other FUI is skewed towards older ages, but the lack of skilled birth attendants remains the key factor in both cases. Surveys indicate the presence of OF and FUI in all regions of the country with slightly higher prevalence of OF in Afar, BSG, and Amhara regions and a slightly higher prevalence of FUI in the peripheral regions (Tigray, Afar, Somali, SNNPR, BSG).

Most of the curative work for fistula in Ethiopia is undertaken by two private NGOs: a) Hamlin Fistula Ethiopia (HFE), working on their own premises in the Addis Ababa Fistula Hospital and in five satellite centres scattered in five regions, and b) the Women and Health Alliance (WAHA), operating within the gynaecology departments of three university teaching hospitals. In the current circumstances, these nine centres cannot cover the needs of backlog and new cases country. The HFE centres have experienced a decline in their annual number of repairs in the last three years, on the other hand,

even if WAHA has increased their number of repairs in the same period, their coverage remains limited. Both WAHA and HFE centres perform interventions of high quality, with low failure rates not exceeding 6%, and take the patients in charge throughout the continuum of needs from the pre-repair period to the post-repair period.

Case detection and referral remain the main bottlenecks to achieving greater access to treatment. The IFHP-Pathfinder and IH-Fistula Care provide support in 40% of all districts to government Health Extension Program and village-based volunteers organized as a Health Development Army (where they exist). While it appears that the great majority of all fistula cases repaired have been detected by these two projects, this coverage is insufficient to detect all cases and pay for their transport to fistula centres.

Physical rehabilitation of ailments caused by fistula is provided in all the fistula centres. The social reintegration of patients who had simple forms of fistula is showing encouraging results with successful pregnancies following the cure. However, the demand for social reintegration of fistula patients who had complex forms of fistula, requiring daily medical care for the rest of their lives, exceeds the available capacity.

Prevention, as usual, is the best approach. Because most MNCH services are delivered through the public health system in Ethiopia, the opportunities and challenges of prevention lie largely with government policies and programs, significantly assisted by international agencies and civil society. Primary prevention is mostly about implementing the Family Code limiting the age at marriage to 18 years (not yet universally applied), improving education and nutrition of the girl child, delaying first pregnancy when the mother is immature (not yet accepted everywhere), and preventing high parity through family planning (long-acting methods). Secondary prevention, i.e. ensuring all pregnancies are safely delivered, is progressing (albeit relatively slowly) due to the placement of midwives and surgically skilled health officers in upgraded health centres. However, the coverage of births attended by skilled attendants was still less than 5% in rural areas in 2011 according to the EDHS, and the Caesarean section rate not higher than 1%. Tertiary prevention through the use of bladder catheterization after prolonged labour is still far from being generalized.

Projections for the short (2015) and longer (2020) terms have been the subject of complex computations, taking into account the demographic growth, the past and current rates, and the progress of health services and human resources for health since 2005. In the best possible case scenario, assuming that all HSDP-IV and Road Map targets are reached, there should remain only 22,400 untreated fistula cases in the country in 2015 and 3,000 in 2020, with a projected elimination in 2021. In the worst case scenario, assuming no progress in the performance of the health services, there will remain 25,800 untreated fistula cases in 2015 and 13,800 in 2025, with no set date for elimination. It is likely that the true situation will fall between these extremes, with a remaining number of untreated fistula cases of 24,000 in 2015 and 8,400 in 2020. In this case, the elimination is envisaged in 2025.

CONCLUSIONS AND RECOMMENDATIONS

Thirty recommendations are presented in eight sections in the table below:

Conclusions	Recommendations
1. Fistula will continue in Ethiopia for at least another 10 years in the best case and 15 years in the most likely case (see scenarios).	<ul style="list-style-type: none"> • Increase the operational capacity of existing fistula repair centres • All partners addressing fistula in Ethiopia should collaborate with the MOH to develop a strategy for expanding access to fistula repair services • Cover the “emerging regions” through “campaigns” in the first years
2. FUI is the calling symptom, with many causes, not to be neglected.	<ul style="list-style-type: none"> • Integrate the treatment of all causes of FUI (requires additional funding) without compromising OF. Operations could start with one day per week in fistula centres
3. Case detection remains the main bottleneck, associated with transport. IFHP (in 38% of districts countrywide) and IntraHealth (19% of districts in Amhara) cover around 40% of the country.	<ul style="list-style-type: none"> • Improve/increase/extend case detection in rural areas – exploit HEP and HDA– use ICTs, cellphones and SMS • Expand IFHP to cover “emerging regions” and non-covered districts of the big regions • Evaluate and redeploy the IntraHealth comprehensive model
4. Prevention remains the objective. GoE plays a key role in primary and secondary prevention and civil societies and partners support the government’s efforts in this regard.	<ul style="list-style-type: none"> • Support implementation of the Family Code • Support HEW and HDA to promote institutional delivery when facilities are well staffed and well equipped for EmONC • Promote the use of the partograph • Involve the civil society in awareness and use of SBA, birth planning and transport systems • Generalize the fight against GBV
5. Midwives are key to the whole chain. Their production and deployment have been accelerated in last three years. Institutional delivery depends on them.	<ul style="list-style-type: none"> • Invest in midwifery training in quantitative terms, but with a greater attention to the quality of education, particularly practical training at the bedside • Invest further in retention mechanisms and improvement of quality of life and work in rural Health Centres • Involve EMA in maintaining continuous education and motivation, and disseminating new practices. Use cellphones networks • Use the opportunity of EMA annual congress, as well as International Midwives Day, May 5, to raise awareness on fistula and FUI • HCM midwives have good standards of quality, but too limited in numbers for an effect at scale. Reconsider the role of HCM
6. National coordination needs improvement and there is a need for stronger partnership by development partners with the Government to ensure ownership and leadership by the MOH.	<ul style="list-style-type: none"> • Create an FUI chapter of the Inter-agency TWG on RMNH, chaired by FMOH, and have more regular meetings • Plan a National Seminar on FUI, involving all partners, chaired by GoE. • Promote and facilitate contacts between MoH and partners at central and regional levels, and between partners. • Use the opportunity of the International Fistula Day 23 May, to raise national awareness at all levels
7. While reinsertion in life, with safe pregnancies after fistula repair shows successes, the social reintegration of patients with	<ul style="list-style-type: none"> • Promote expansion of current efforts for reintegration of ex-fistula patients with remaining dysfunctions • Support MoWA in their awareness raising programs • Offer privileged employment in health facilities (incl.

Conclusions	Recommendations
<p>complex fistulas has reached its limits and often fails. Hopes for ex-fistula patients with remaining dysfunctions are bleak.</p>	<p>government) for ex-fistula patients needing daily medical care</p>
<p>8. Knowledge of the epidemiology and socio-cultural features of FUI, including fistulas of all causes, still scanty and incomplete. Incidence and prevalence still not well known for lack of proper studies</p>	<ul style="list-style-type: none"> • Invest in knowledge • Promote research on FUI (epidemiology and medico-surgical aspects), EMA to integrate operations research on FUI • Integrate a revised FUI module in the next EDHS to assess prevalence • Ask ESOG to conduct research into all other causes of fistula • EMA/ESOG to engage in research about early bladder catheterization • Evaluate the IntraHealth model of PRUs in Amhara • Bring sociologists and medical anthropologists to the table, for better understanding of behaviors • Look into psychological and psychiatric features of fistula and FUI

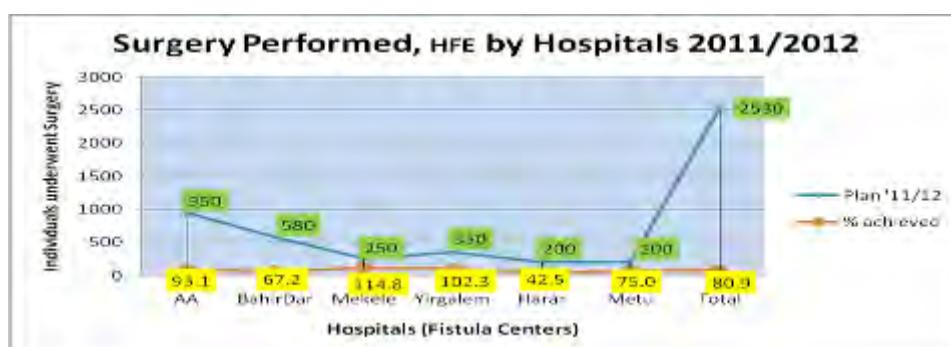
Annex 2: HFE Performance: Fistula centres and midwives in health centres

The following figures and tables, are taken directly from HFE’s reports or extrapolated from HFE service and training data.

Fistula Surgery

The figure below from HFE’s Annual report to AusAID (2011-2012) does not accurately reflect performance against the plan as it erroneously plots *percentage* of target achieved on an axis representing the numerical total of individuals undergoing surgery, resulting in a meaningless and misleading graph. Such quality problems in reporting are indicative of the weak M&E systems.

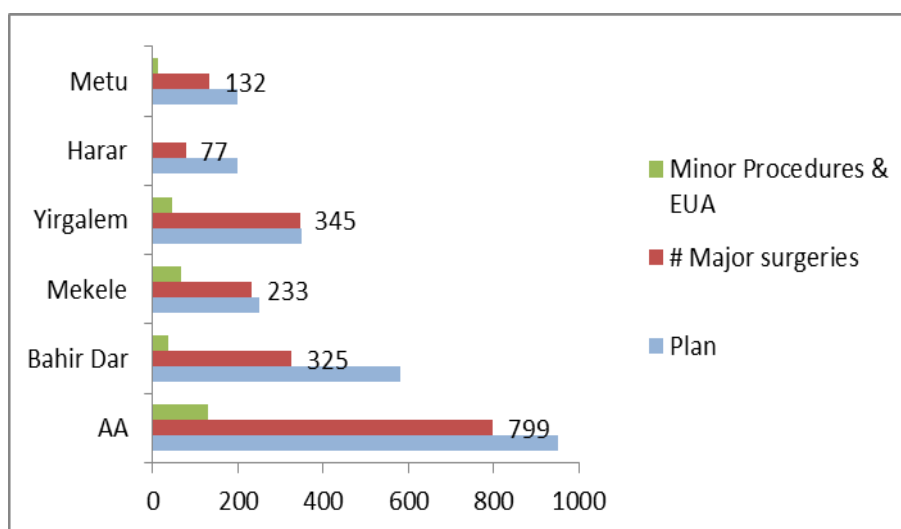
Figure 1: % Surgery performed against plan by hospitals 2011-2012



Source: Annual report to AusAID 2011-2012

Figure 2 below using data from a different Annual Report for the same period provides a more accurate picture. It can be seen that performance against targets is quite good especially in Mekele and Yirgalem where minor and major surgeries added together exceeded the planned targets.

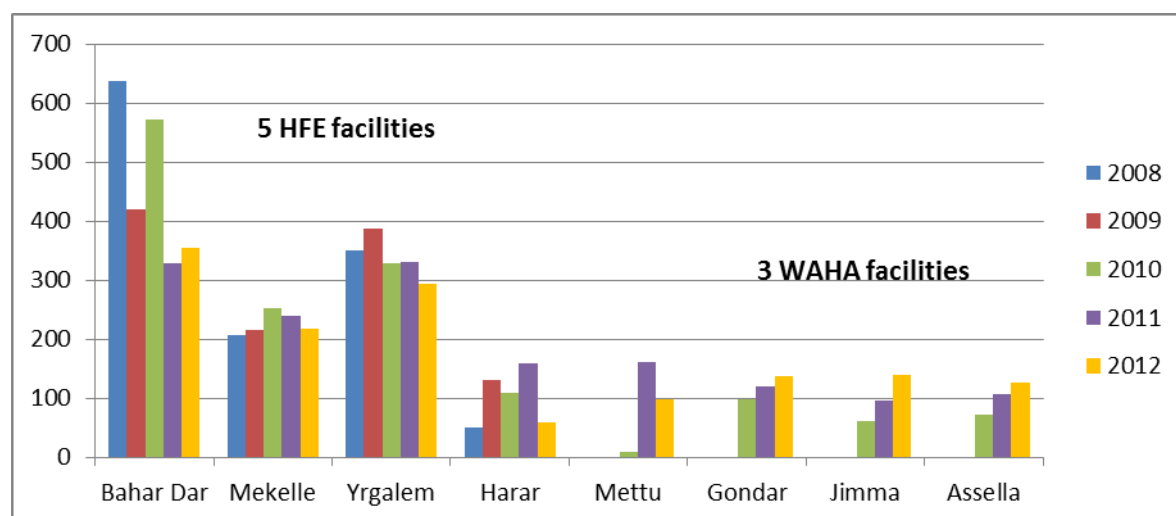
Figure 2: Number of surgeries performed by hospital 2011/2012



*Additional surgeries are 3rd/4th degree tear, Urethral stricture, Bladder stone removal, Lengthening and shortening for stress incontinence, closed vagina, colostomy, Hysterectomy, Caesarean section related to fistula, etc.

Source: Data from HFE Annual Report 2011-2012

Figure 3: Trends in fistula repair HFE and WAHA



Source: USAID Situation assessment OF in Ethiopia

Figure 3 above shows trends in fistula repair in 5 HFE and 3 WAHA facilities. Both Harar and Mettu show a declining trend following an increase in 2011; In Bahar Dar, Mekelle and Yrgalem, where the trend is declining, it is also true that uptake for family planning is higher than in most other areas. Having part-time surgeons in Mettu and Harar is thought to be a reason for low levels. Community mobilisation provided by the various NGOs in Bahir Dar and Yrgalem help in case identification and transfer to hospitals. In the 3 WAHA facilities, numbers are still low, but the trend is showing a steady increase. It is important to understand the trends and to explain these in reports and take action where possible to ensure that cases are identified and referred.

Figure 4: Admissions and Surgeries in Fistula repair for all centres 2009-2012

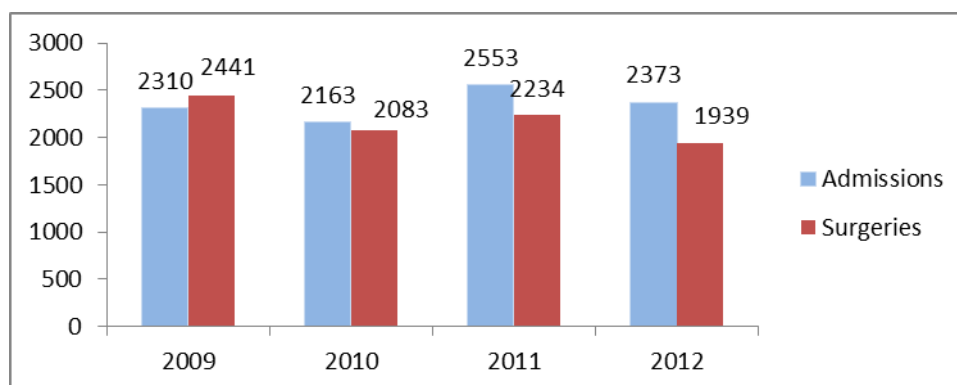


Figure 4 above shows that there is a reduction in the number of cases admitted which are operated on without any explanation.

Midwife deployment in government health centres

The HFE midwives provide the required services at Health Centre level which include antenatal care, safe delivery, postnatal care, family planning and all other maternal and newborn health related services.

Skilled delivery

The HFE deliveries shown in Table 1 are extrapolated from the 2011-12 Annual Report to AusAID (consultant report) and cumulative data provided by HCM from each of the health centres (see Figure 5). These are *completely different*. The totals show how HFE's numbers compare with total number of skilled deliveries in the entire region for 2011-2012 taken from FMOH HMIS.

Midwives' performance in Health Centres 2011-2012

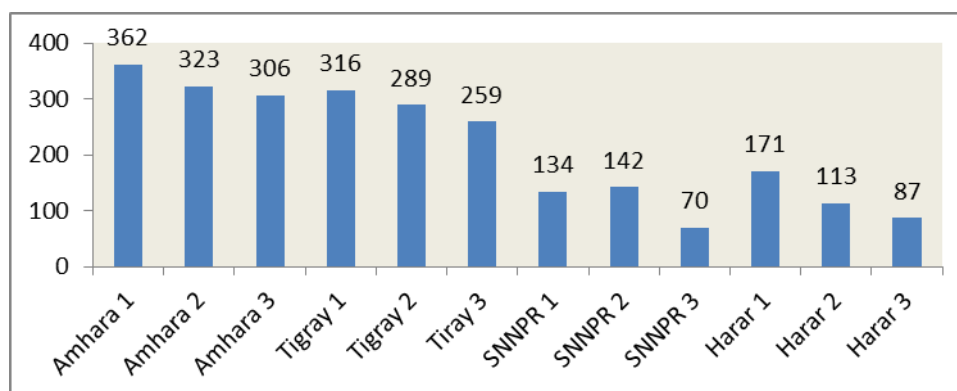
Table 1: Skilled deliveries by health centres

<u>Region</u>	<u>HFE 2011/12 AR</u>	<u>HFE HCM report</u>	<u>MOH SBA</u>
Amhara	446	991	85,793
Oromia	139		290,300
SNNPR	173	346	89,044
Tigray	448	864	48,679
Harari		371	4,734
Total	1,206	2,532	513,816

Sources: HFE data and FMOH HMIS (EFY 2004)

Figure 5 below shows the number of deliveries in all HFE supported health centres during the calendar year of 2012. There is a significant variation between regions.

Figure 5: Deliveries in 11 HFE supported Health Centres Jan-Dec 2012



Source: HCM data Jan-Dec 2012

Figure 6 below, from the EFY 2004 (GC 2011-2012) Annual Report of the HSDP-IV, provides an interesting contrast with the HFE performance data above. In this report, Amhara is a low performing region for skilled delivery overall and Harar one of the highest.

Figure 6: Skilled delivery: comparison of baseline, 2012 performance against plan

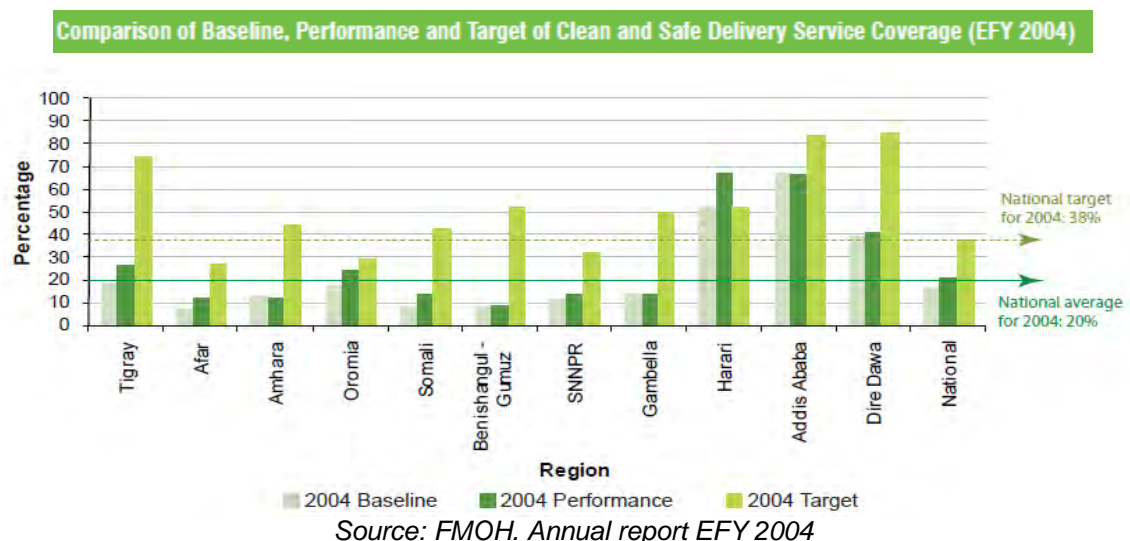


Figure 7: Total services provided by 12 HCs, 2011-2012

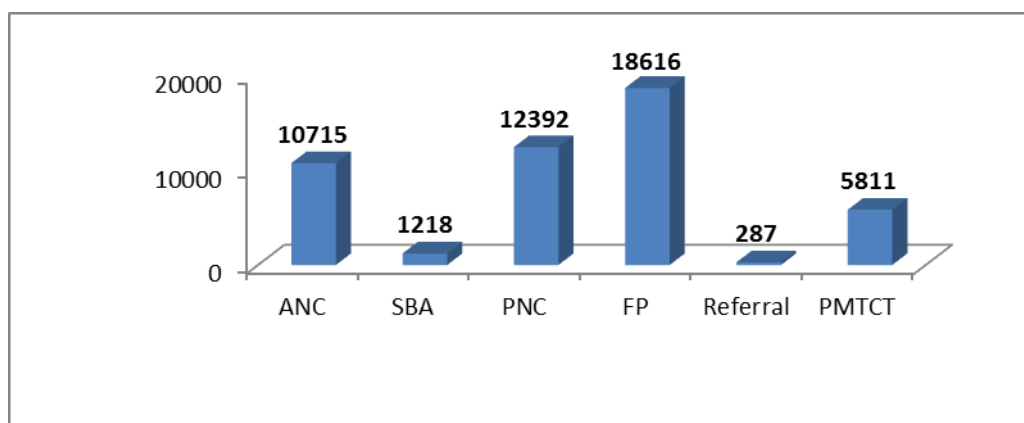
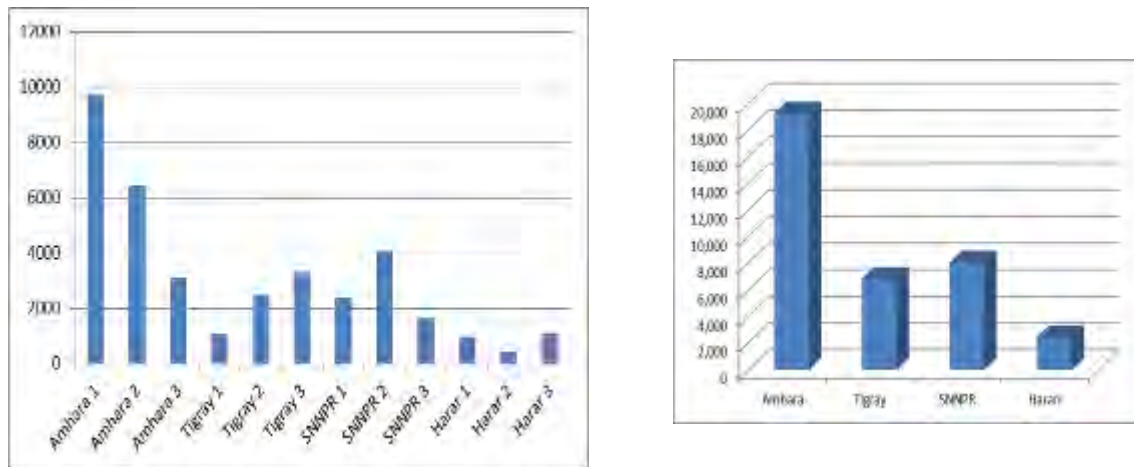


Figure 7, shows the total number of services provided by the 12 Health Centres with HFE midwives. It is not clear from this or from Figure 8 below, whether the family planning acceptors are all new or a combination of new and continuing users. This distinction is important to make. What is very apparent from Figure 8 is the unrealistically low targets which will need to be adjusted in future (it is arguably best to use the MOH targets).

Antenatal care is very important and few women have the four recommended visits aimed for by FMOH. Number of postpartum visits is high compared with antenatal and skilled birth. It is excellent they are high but no interpretation of this can be made such as timing (within the first week) and/or at 6 weeks. Another useful statistic (not provided) is the proportion of postpartum family planning users i.e. women adopting an FP method within six weeks postpartum.

Figure 8: Family planning performance by HC and Figure 9: Total regional performance



Source: HCM data 2011-2012

It is worth noting consistent contraceptive performance nationally from the HSDP-IV review for the regions during the same period.

Figure 10: Target and performance contraceptive acceptance rate by region

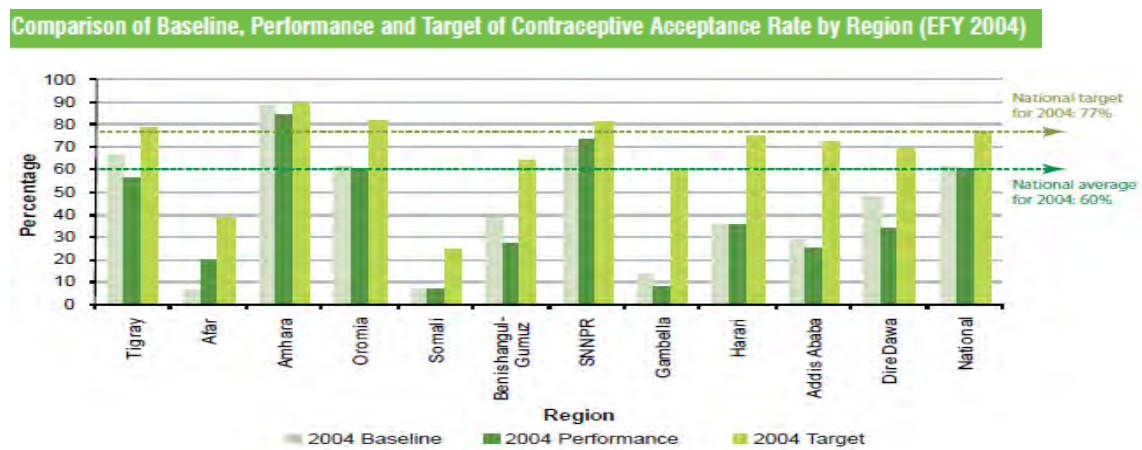
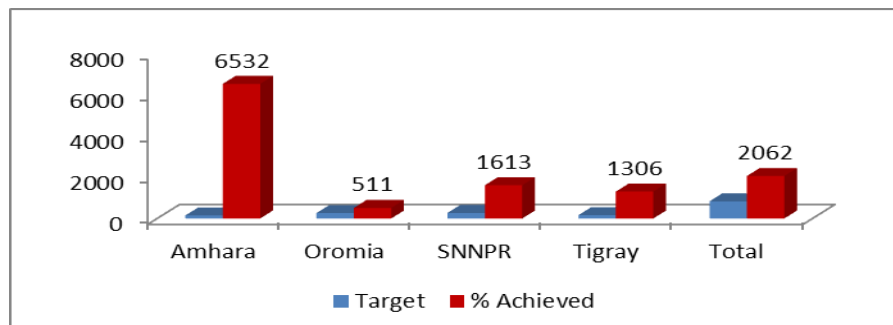


Figure 11: FP acceptors against HFE targets



Source: HFE performance data Annual Report 2011-2012

Fig 11 above, illustrates the disparity between HFE FP performance and targets – this is an extreme example but it is suggested that FMOH targets are used instead.

Annex 3: Increasing skilled attendance – Hamlin midwives in Tigray

It is known that the preferences for home births in Ethiopia is partly because of a negative perception of the health services but in strong part to the importance given to some traditional practices and ceremonies, and preference to be among family at this important time. The perception of risk is not well understood and too many referrals are only made very late after the woman has obstructed labour and a long and uncomfortable journey to the health facility often with negative outcomes for mother and child including obstetric fistula.

In Tigray – it was encouraging to see how some of these barriers were being addressed – evidently to the satisfaction of the women, and as reflected in the rising number of facility deliveries.

During birth, the midwife encouraged the pregnant woman to adopt any birthing position she felt comfortable with and after delivery the baby was put onto the breast quickly. The relatives had coffee prepared and porridge which has been donated by the community.



The coffee ceremony and porridge traditional ceremonies after delivery

A tin shed had been constructed next to the HC as a Maternity Waiting Home to provide space for (4 at the time) pregnant women waiting to deliver their babies. This meant they could avoid making a long journey in labour. The shed is not ideal as it is hot and stuffy but the idea is good as Dr John Kelly, a long-time friend and visiting surgeon in HFE, attests in his study on 24,148 deliveries in Attat Hospital. He concluded that maternal mortality and stillbirth rates were substantially lower in women admitted via MWA.⁶⁰

⁶⁰ . J Kelly et al. The role of a maternity waiting area (MWA) in reducing maternal mortality and stillbirths in high-risk women in rural Ethiopia. BJOG 2010; DOI: 10.1111/j.1471-0528.2010.02669.x.

Women's Hope International, one of HFE's donors, has since 2009 has been funding the waiting areas at two hospitals in rural Ethiopia, southwest of Addis Ababa, thus reinforcing its commitment to preventing fistula. Around 900 women a year can take advantage of the waiting areas of the St. Luke Catholic Hospital in Wolliso and the Attat Hospital near Wolkite. The pregnant women in the waiting areas have round-the-clock medical assistance on hand. Dr. Rita Schiffer, the Attat Hospital's Medical Director, states: "We rarely see fistula anymore in our region."⁶¹



The Maternity Waiting Home in Tigray for pregnant women – a good idea but not the best design

It was suggested in Tigray that tukuls built from local materials with the community involvement would be preferable - but consulting the community first is essential.

⁶¹ <http://www.womenshope.ch/en/projects/ethiopia/maternity-waiting-areas/>

Annex 4a: Hamlin Fistula Ethiopia: general information

Name of Organization	Hamlin Fistula Ethiopia
Established	August 21, 1970
Founders	Drs. Reginald and Catherine Hamlin, both Gynaecologist-Obstetricians
NGO registration/Licence	Ethiopian Residents Charity; Reg. No. 1362, April 03, 2013 renewed
Licensing Agency	Charities and Societies Agency
Focus Area	Maternal and Reproductive Health
Geographical areas/locations/Implementers	Addis Ababa Fistula Hospital Bahir Dar Hamlin Fistula Centre in Amhara Region Mekelle Hamlin Fistula Centre in Tigray Region Yirgalem Hamlin Fistula Centre in SNNPR Harar Hamlin Fistula Centre in Harari Region Metu Hamlin Fistula Centre in Oromia Region (East) Hamlin College of Midwives in Burayu Woreda, Oromia Desta Mender Rehabilitation & Reintegration in Burayu
Number of staff	7 Surgeons, 1 practitioner, 3 contract doctors, 40 Nurses, 151 Nurse Aides, 8 Health Officers, 7(lab technicians, pharmacists, anaesthetics), 10 tutors, 4 midwife supervisors, 323 non-clinical staff (accountants, administrators, drivers, clerks, guards, messengers, etc.)
Cooperating Partners	Hamlin Fistula Australia Hamlin Fistula UK Hamlin Fistula Sweden Hamlin Fistula Netherlands Hamlin Fistula Ethiopia (Australia) Hamlin Fistula Germany Hamlin Fistula USA Hamlin Charitable Fistula Hospitals Trust-New Zealand Fistula Japan Hamlin Fistula International Foundation
Other Major Donors	AusAID USAID Fistula Foundation USA Ethiopiaid UK, Ireland, Canada, Australia Women Hope International, Switzerland

Annex 4b: HFE research output

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Annex 4c: Hamlin College of Midwives

The accelerated midwifery training program has contributed to the increase in the number of midwives in Ethiopia as 33 per cent of midwives were trained through this program.

In Ethiopia, there are more female midwives (3,662) than male midwives (1,063). However, more male midwives are trained at the degree level enabling them to get a better salary than female midwives. The gender disparity in the midwifery training institutions is very striking with universities training almost 100 per cent males and regional colleges training females.

The tutor/student ratio is very high and the classrooms are overcrowded. Some classes have more than 120 students, making teaching and learning very difficult. This is more prominent in the colleges. The health facilities for the practical area are very crowded with large numbers of students while the number of women delivering in the health facilities is less. This has affected the quality of training as midwives graduate without getting the required skills and number of deliveries.

32 per cent of midwives in Ethiopia are practicing without licensure. This is a critical issue as they are not protected and can also endanger the lives of women and children. There is no clear mechanism for re-licensure. The midwives are required to renew the license after 5 years of practice. However, there is no follow-up to ensure that this is done. The regulatory body has started to work on the mechanism.

Table 1 shows the number and regional origins of student intake at HCM. This only includes midwives sponsored by HFE. Additionally 5 midwives sponsored by other organizations were also trained and graduated in 2012. Currently HCM has 68 first, second and third year students enrolled in the 4 years program. Two students were dismissed for academic reasons from the 2012 intake.

Table 1: HCM Student intake and graduates

Region	Year 2007		Year 2008		Year 2009		Total
	Intake	Graduate (2010)	Intake	Graduate (2011)	Intake	Graduate (2012)	
Amhara	6	6			4	4	10
Tigray	3	2	3	3			5
Harar			7	7			7
Metu					3	3	3
SNNPR	3	3	3	3	3	3	9
Total	12	11 (1 academic dismissal)		13	10	10	34

Source: HCM, August 2013

Table 2 shows the breakdown of midwifery training costs at the HCM.

Table 2: Breakdown of Midwife Training Costs

Expense description	%	Amount in USD	Remark
Salaries and benefits of full and part time, instructors, 2 Deans, registrar	37	1,480	
Supplies including medical, uniforms	11	440	Students receiving full medical coverage once they are enrolled
Food and accommodation	8	320	
Insurances motors, buildings, staff	8	320	
Transport (motor expenses)	5	200	Students transported from and to the clinical area and field
Utilities and communication	3	120	Personal cleaning materials and 24 hrs internet access provided
Maintenance & upkeep	4	160	
Printing and stationeries	2	80	
Per diem and travel to sites	5	200	
Staff training	2	80	
Other support services & Admin	15	600	
Total	100	4000	

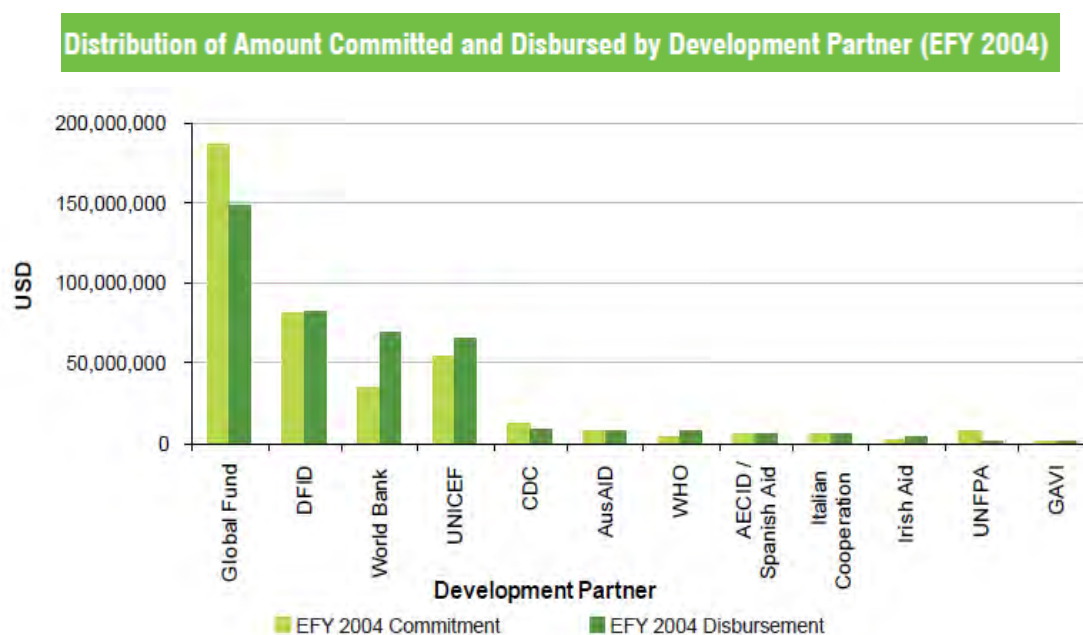
Source: HCM, August 2013

Annex 5: Australian support to the Ethiopian Health sector⁶²

The FMOH Annual Performance Report for 2012 (EFY 2004) provides details of the contributions to the different funding streams. In EFY2004, a total of USD 409.35 million was committed by Development Partners through public modalities (Channel 2), and a total of USD 411 million (100.4 per cent) was disbursed. The tables and figures below show the contribution made by AusAID to the health sector for EFY2004. These pooled funding modalities provide more flexibility and ease of stewardship for the GoE and by agreeing to use these, development partners are not able to attribute funding to specific line items. USAID, while a significant contributor to the health sector, does not provide financing through these mechanisms.

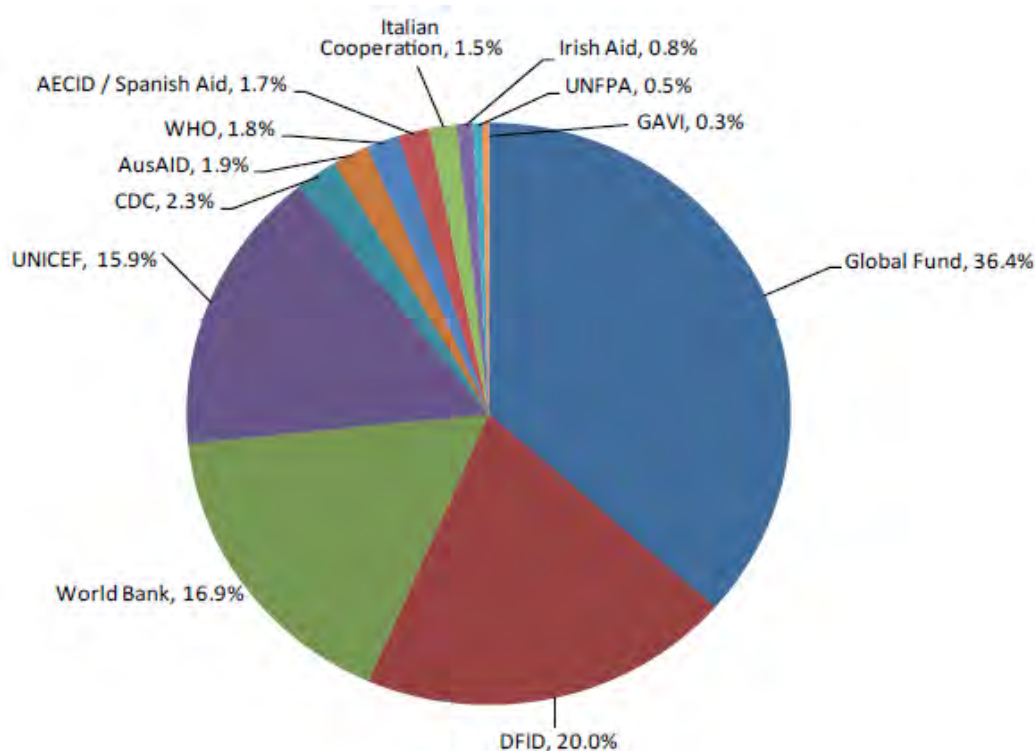
The MDG Performance Fund (MDG PF) is a mechanism managed by the FMOH using the Government of Ethiopia's procedures. In the framework of the Ethiopia International Health Partnership (IHP) compact, it provides flexible resources, consistent with the "One Plan, One Budget and One Report" principle, to secure additional finance to HSDP. It is one of the GoE's preferred modalities for scaling up DPs' assistance to support HSDP implementation. AusAID contributes 1.9 per cent of the total.

Figure 1: Development Partner Contributions



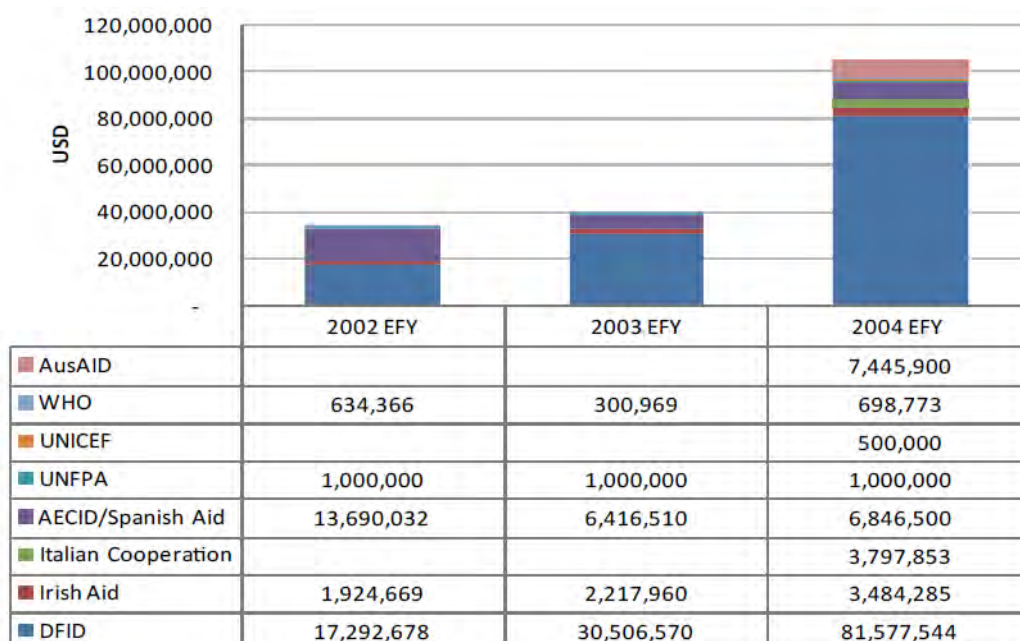
⁶² FMOH. HSDP-IV Annual Performance Report. EFY 2004 (2011-2012)

Figure 2: Development partner disbursements (percentage of total)



In EFY 2004, there was substantial growth to the MDG Performance Fund with major contributions from DFID (77.4 per cent) followed by AusAID.

Figure 3: MDG Performance Fund disbursement



Annex 6a: Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality in Ethiopia

The following sections of the FMOH's implementation plan for accelerating the reduction of maternal and newborn morbidity and mortality in Ethiopia are included to provide clarity on where OF is addressed in FMOH policy.

Strategy 1: Ensure access to a core package⁶³ of maternal and neonatal health services at all levels of the health system including the health extension program⁶⁴.

Targets

By 2015:

- increase national antenatal care coverage (at least once) levels to 90%
- increase national antenatal care coverage (at least four) levels to 86%
- increase the proportion of women and newborns receiving postnatal visit within 48 hours and 7 days of birth to 80%
- increase the proportion of deliveries attended by HEWs from 11% to 38%
- increase deliveries attended by skilled birth attendants from 18.4% to 62%

Activities

- Provide training to enhance HEW's skills on maternal and newborn health.
- Avail misoprostol for prevention of post-partum hemorrhage (PPH) for deliveries attended at community level.
- Facilitate provision of Postpartum FP information and services (condom, oral, injectable and implants, referral for IUCDs and permanent methods).
- Build capacity for recognition of pregnancy complications at community level, including abortion complications, and make arrangements for early referral.
- Create mechanisms such as redesigning health facilities, establishing mobile service outlets and outreach services to make services accessible to vulnerable and marginalized groups (disabled, displaced, out of school youth etc.)
- Establish a mechanism for midwives, along with the HEWs, to be engaged in educating the community on pregnancy/birth and its complications, including birth preparedness and estimated date of delivery by creating forums at kebele level.
- Provide in-service training for service providers to enable them acquire appropriate competencies/skills, and proper attitudes and ethics.
- Strengthen pre-service training institutions to equip graduates with the necessary skills and competencies by
 - updating pre-service curricula to address current changes in MNH including FP and Nutrition
 - developing and providing an orientation package and other educational materials to tutors and clinical instructors
 - updating and standardizing knowledge, clinical and teaching skills of tutors and instructors.
 - providing schools and clinical practice sites with necessary teaching and clinical practice and equipment
- Link health posts with health centers and health centers with hospitals with a functional referral system
- Establish mechanisms for communications and feedback among different levels of health institutions.

⁶³ Core Package of maternal and neonatal health services includes antenatal care, skilled attendance at birth, clean and safe delivery, postnatal care and neonatal care.

⁶⁴ HEW's MNH functions include health education, antenatal care, family planning, clean and safe delivery and postnatal care, diagnosis and treatment of malaria, Vit A supplementation, and referral of obstetric complications.

...

- Train resource persons (HDAs , ambulance drivers) in emergency response and preparedness
- Ensure Provision of FANC including PMTCT to all pregnant women
- Introduce performance improvement system
- Promote early initiation of breastfeeding through media messages, group education and training of maternity staff
- Ensure provision of comprehensive PNC including treatment of post natal complications
- Ascertain essential newborn care services are routinely provided at all levels
- Make sure that women with all forms of puerperal problems including infections, psychosis & fistula are appropriately cared for.
- Expand the fistula treatment outlets to include all CEmoNC facilities
- Revise the current policy on the fee structure of MNH services to come up with a uniform policy on waiving fees and payment

Strategy 2: Strengthen human resources to provide quality skilled care for maternal and newborn health

Targets

By 2015:

- Staff all HCs with at least two midwives each by training and deploying 8635 midwives
- Staff all hospitals with at least two clinicians trained on CEmoNC by training and deploying 1868 Integrated Emergency Surgical Officers and Physicians
- Staff all CEmoNC facilities with at least 2 anesthesia professionals by training and deploying 1868 anesthetists/anesthesiologists

Activities

- Capacitate midwifery schools in terms of adequate staff, equipment and training materials to increase the number of midwives trained per year.
- Support implementation of midwifery curriculum so that graduates can satisfy the requirements of a “skilled birth attendant”.
- Provide coaching and mentoring to enhance skills of providers at different levels
- Train anaesthetists to ensure adequate staffing for provision of CEmoNC
- Train health officers and physicians on IEOS and comprehensive EmoNC respectively.
- Improve in service training of skilled attendants through capacity building of faculty, supporting establishment of skill laboratories and others based on EmoNC and midwifery school situation assessment.
- Increase motivation of skilled health workers by providing a package of incentives and give special emphasis to deployment and retention of skilled attendants especially in hard to reach/underserved areas
- Provide pre or in-service training to obstetrician-gynecologists to build capacity for treatment of fistula

Annex 6b: The Health Extension Program – HSDP-IV

Ethiopia launched the Health Extension Program (HEP) in 2003. The program's objectives were to reach the poor and deliver preventive and basic curative, high-impact interventions to the population. The introduction of HEP in Ethiopia was a government-led community health service delivery program, with innovative and cost effective approaches, designed to improve access and utilisation of preventive, wellness and basic curative services. The HEP basically consists of a Health Post which is operated by front-line community health personnel, called Health Extension Workers. On average, a Health Post has a catchment population of 5,000. The Health Post is under the supervision of the Woreda (equivalent of district) health office and Kebele administration and receives technical and practical support from the nearby Health Centre. A Health Centre is a primary health care unit that serves 25,000 people and functions as a referral centre and logistic hub for a health post and also offers technical support.

The HEP focuses on four major areas of preventive healthcare and provides 16 different packages to reach the rural community at large and address inequities (Table 1). In a short period, the government deployed more than 30,000 Health Extension Workers (HEW). These Health Extension Workers are posted to rural communities across Ethiopia, where they provide equitable access to health services for the poor, women and children in a sustainable manner. Health Extension Workers are recruited from the same communities in which they will work following set criteria. The criteria include: female, at least 18 years old, have at least completed secondary school education and speak the local language. Females are selected because most of the HEP packages relate to issues affecting mothers and children; thus communication is thought to be easier between mothers and a female HEW and more culturally acceptable. Upon completion of one year training, pairs of HEWs are assigned as salaried government employees in each Kebele, where they staff health posts and work directly with individual households. Each Kebele has a health post that serves 5,000 people and functions as an operational centre for the health extension workers.

Table 1: HEW program packages (FMOH 2009)

Hygiene & environmental sanitation	Disease prevention & control	Family health services	Health education & communication
Proper and safe excreta disposal system	Prevention and control of tuberculosis	Family planning	Health education & communication
Proper and safe solid and liquid waste management	Prevention and control of malaria	Maternal & child health	
Water supply safety measures	Prevention and control of HIV/AIDS	Adolescent reproductive health	
Food hygiene and safety measures	First aid	Nutrition	
Healthy home environment		Immunization	
Arthropod and rodent control			
Personal hygiene			

In general, the HEWs are expected to conduct household visits to deliver the 16 different packages of healthcare prevention and promotion messages. The promotion of appropriate breastfeeding and infant and young children feeding practices (IYCF) is one of the packages within the nutrition category. In addition, HEWs identify cases, refer cases to Health Centres, perform a home-based follow up on referrals, manage operations of health posts and submit regular reports to Woreda Health Offices. They are also expected to identify, train and collaborate with voluntary community health workers called Women's Development Army.

HEWs have been effective, providing 27 per cent of all contraceptive services, helping to double contraceptive prevalence (2005-2010). They are now trained to undertake 'safe and clean' delivery (not *skilled delivery* which is the domain of doctors, nurses and midwives). The policy on this is however unclear.

The Ethiopian Government has put the implementation of **Health Development Army** (HDA) among its top priorities in order to attain HSDP and Growth and Transformation Plan (GTP) objectives as well as health Millennium Development Goals (MDG). Each village is divided into development units of thirty households and all the women of reproductive age from each development unit make up different groups of the HDA. From each group, five women are selected to be leaders, one of whom is a Community Health Worker. Each leader is responsible for an average of five women. The women leaders visit the group of households they are responsible for to check and follow-up on the status of hygiene, childcare practices, health, nutrition, referrals to the health post, and to give any advice and help to the mothers as needed. Overall, a total of **2,002,841** one-to-five networks have been established at national level. The HDA is recognised as playing an important role in health and environmental health.

In Tigray Region for example, 25,000 WDGs were established, with 124,520 one-to-five network formations. The WDGs are taken as a "blood line" for the successful implementation of HEP. So far, WDGs have been established in all kebeles, and 25 per cent of them have already prepared local based plans for improving maternal health through regular Antenatal Care (ANC) follow-up and promotion of skilled care at birth. As a result, improvements in outcome have already been registered in areas where the HDA is actively engaged.

Annex 7: Individuals met or interviewed by telephone

Name	Position	Organisation
Lisa Filipetto	Ambassador	Australian Embassy in Ethiopia
Sue Moore	Head of Development Cooperation	AusAID Ethiopia
Anne Nolan	Senior Regional Health Adviser	AusAID Ethiopia
Kate Brow	Senior Program Officer	AusAID Canberra
Rebecca Yohannes	Program Officer	AusAID Ethiopia
Lisa Filipetto	Ambassador	Australian Government
Dr Catherine Hamlin	Founder	Hamlin Fistula Ethiopia
Martin Andrews	Chief Executive	Hamlin Fistula Ethiopia
Ato Kassahun	Programme Manager	Hamlin Fistula Ethiopia
Dr Fakade	Medical Director	Hamlin Fistula Ethiopia
Ato Asfaw	Finance Manager	Hamlin Fistula Ethiopia
Kebede Oli	Trustee	Hamlin Fistula Ethiopia
Tesfaye Abayeh	Acting Administration Manager	Hamlin Fistula Ethiopia
Elleni Aschalew	IT Manager	Hamlin Fistula Ethiopia
Ato Megerssa	M&E	Hamlin Fistula Ethiopia
Dr. Melaku Abreha	Medical Director Mekelle	Hamlin Fistula Ethiopia
Ato Zelalem	Dean of College	Hamlin College of Midwives
Marit Legesse	Vice Dean	Hamlin College of Midwives
Ato Aknanaw Bezawin	Administrator	Hamlin College of Midwives
Ato Solomon Abebe	Deployment Manager	Hamlin College of Midwives
Atp Yohannes Tadesse	Research & Quality Audit Unit	Hamlin College of Midwives
Beletshachew Tadesse	Manager	Desta Mender
Gutu Soboka	Training & Development officer	Desta Mender
Kassehun Negatu	Café & Conference Centre Supervisor	Desta Mender
Dr Melaku Abreha	Medical Director	HFE, Mekelle
Ato Tesfahun Haregot	Prevention Officer	HFE, Mekelle
Belatu Tekay	Midwife	Adiquala Health Centre
Zufan Baraki	Midwife	Adiquala Health Centre
Dr Muna Abdullah	Focal person MNCH services	UNFPA
Dorothy Lazaro	Focal person Midwifery training	UNFPA
Dr Wondemagne	Human Resource Development	FMOH
Dr.Tewodros Bekele	Health Promotion and Disease Prevention General Directorate	FMOH

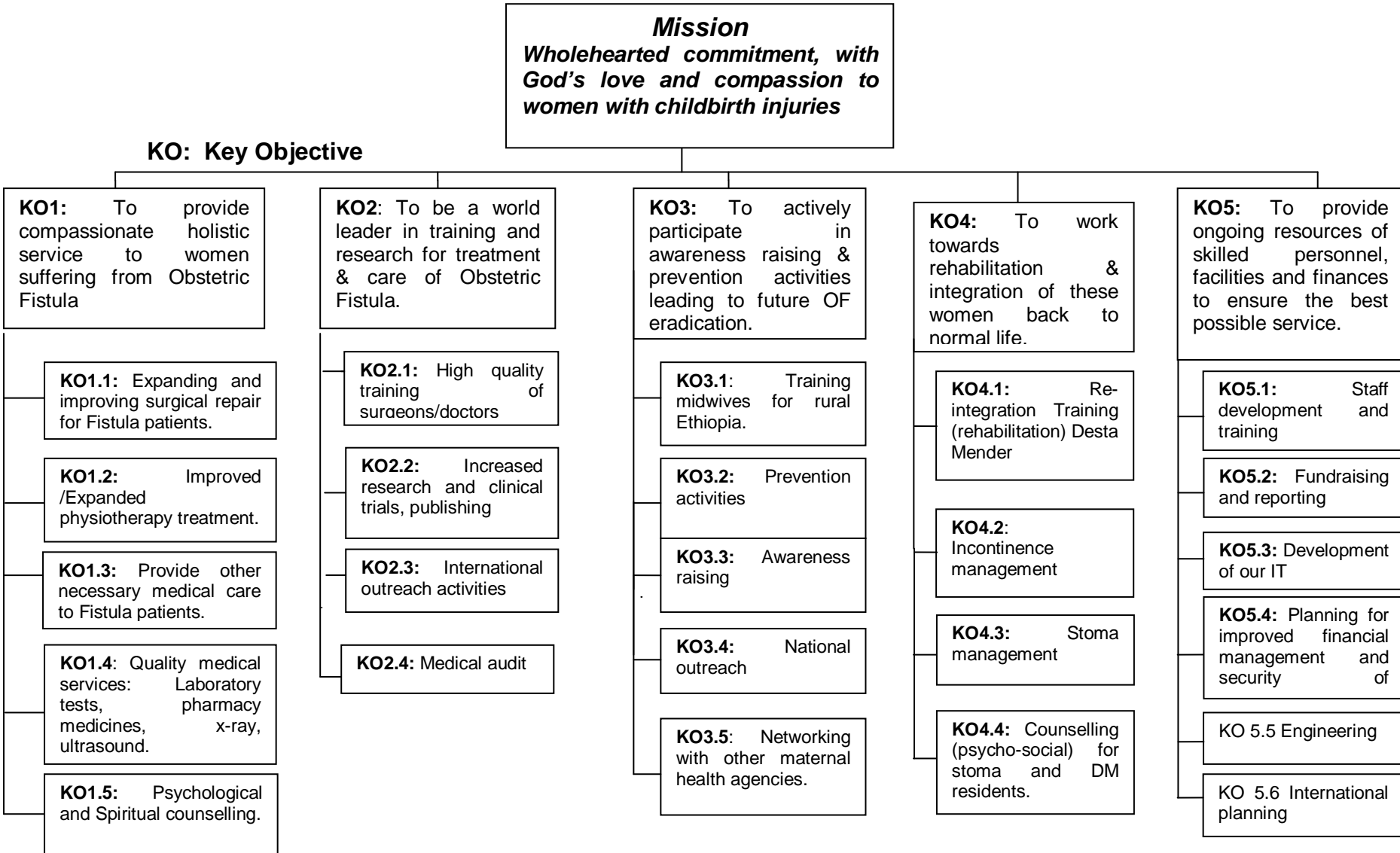
Name	Position	Organisation
Elise Jensen	Chief, Health, Population and Nutrition	USAID
Zewditu Kebede	RH Specialist	USAID
Defa Wane	Senior RH Adviser	USAID
Jemal Kassaw		Engender Health
Dr Kidest Lulu	Deputy Technical Director	Pathfinder
Aynalem Yigzaw	Senior Programme Manager	IntraHealth
Misrak Makonnen	Country Director	IntraHealth
Alemnesh Tekleberhan	MNH Team Leader	JHPIEGO
Senait Tareyegn	Manger	Healing Hands for Joy, Mekelle
Chaina Alemayehu	Financial Manager	Healing Hands for Joy
Dr Mulu Muleta	CEO	WAHA
Prof Gordon Williams	Previous Medical Director	HFE
Dr Lia Tadesse	Trustee	HFE
Telephone interviews		
Margaret McKinnon	First Assistant Director General	AusAID, Canberra
Emma Stone	Program Manager	AusAID, Canberra
Margaret McKinnon	First Assistant Director General	AusAID, Canberra
Peter Duncan Jones	Former Head of Development Cooperation	AusAID, Addis Post
Stuart Abrahams	Former EO	HFA
Mark Bennett	Former CEO	HFE
Annette Bennett	Former Dean	Hamlin College of Midwives
Richard Barnsdall	Accountant, Credit Suisse, Former Board Member	HFIF
David Barnsdall	Former HFA Board Member	HFA
James Grainger	Former EO	HFA
Dr Ruth Lawson	Previous Board Member	HFE
Richard Hamlin	Trustee Manager	HFE
Doug Marr	EOFD	HFA
Robert Tong	Board Member	HFA
Lucy Perry	CEO	HFE(A)
Antonio Perez	CFO	HFIF
Dr Pieter-Joep Huige	Trustee	HFE
Tony Legg	Office Manager	Hamlin Fistula UK
Lord Naren Patel	Volunteer Obstetrician	University Dundee, UK

Annex 8: Schedule

Date	Time	Place	Who	Purpose of meeting	Who meeting
Monday 27 th May	09.00 -10:30	AusAID Office	F/J/K	In-briefing, review schedule/logistics	Sue Moore, Kate Brow, Rebecca Yohannes
	10:30 –11:00	DFAT	F/J/S/R	Introductions & briefing Head of Mission (HOM)	Ambassador Lisa Filipetto
	01:30 –14:00 14:00 -17:00	HFE	F/J/S/R	Courtesy call to Dr Hamlin Presentations by Hamlin Staff Schedule one to one meetings for Wed and Thurs. Tour of the facility	Dr Hamlin Martin Andrews – CEO Ato Kassahun – Program Manager Department Heads
Tuesday 28 th May	9:00 - 11:00	UNFPA	F/J/K	Discuss fistula in Ethiopia. Seek info on midwifery	
Wednesday 29 th May	09:00 –12:30	HFE	J/F	Tour of Hamlin Fistula Hospital Then continue with one-to-one meetings with key staff	
	14.00- 15:00	USAID	F/J	Joint AusAID/USAID In-brief	<u>AusAID</u> – Sue, Kate & Rebecca <u>USAID</u> – Elise Jensen, Zewditu Kebede, Defa Wane
	15:00- 16:00		F/J	Key informant interviews with USAID only	
	08:00-08:30	Hotel	J/F	Interview with former Head of Development Cooperation, AusAID, Addis Post	Peter Duncan Jones - Skype: pduncanj mobile:+61 481 437393
	09.00 –11:00	AusAID meeting room	F/J/K	Overview of USAID Fistula partner programs and links to HFE	USAID partners - Engender Health, Pathfinder, Intrahealth JHPIEGO
	11:30 –12:15	AusAID	F/J	Telecom with CFO of HFIF	Antonio Perez – Skype: tonioperezdiaz
	12:15 – 1:30			Telecom with HFE Trustee Manager	Richard Hamlin – Skype: Watford.Gap
	14.00 -15:30	HFE	F/J	One-to-one key staff meetings	Dr Fekade (Medical Director) Ato Asfaw (Finance)
Friday 31 st May	9:00 – 12:00	Field trip Mekelle Regional Health facility	F/J/K	Visit Hamlin Fistula facility Mekelle	Dr. Melaku Abreha - Medical Director Ato Tesfahun Haregot-Prevention Officer
	11:00-11:30	Phone	J	Discussion with HFE Trustee	Professor Kebede, call mobile 0911 21 24 72
	14:00 – 17:00	Woreda Health Centres	F/J/K	HCM graduates deployed here. Visit maternity units in Woreda Health Centre(s) and discuss with site officers and women	Dr. Melaku Abreha - Medical Director Ato Tesfahun Haregot - Prevention Officer Site Midwives (2) deployed in health canter
Saturday 1 st June	9:00	Holding Hands	F/J/K	Organization giving support to women who have	

		for Joy		undergone fistula operations	
Monday 3 rd June	09.30- 11:30	Hamlin College Midwifery	F/J/K	Visit to the Hamlin College of Midwives and Desta Mender	Desta Mender Manager-Beletshachew Dean of College – Ato Zelalem
	15:30-16:30	AusAID	F/J/K		Dr Mulu Muleta – CEO WAHA
Tuesday 4 th June	07:30– 08:30	Hotel	F/J F/J	Interviews with HFE Trustees	Pieter-Joep Huige (in France) Dr Lia Tadesse (at workplace)
	13:30 –15:00	HFE		HFE one-to-one discussions	
Wednesday 5 th June	9:00 – 10:00	UNFPA	F/K	Discuss fistula in Ethiopia. Seek info on midwifery	Dorothy Lazaro - Focal person for Midwifery training AND Dr. Munna Abdullah - Focal person for MNCH services
	11:00 -12:00	FMoH	F/K	Discussions with FMoH/GoE	Dr Wondemagne – Human Resource Development
	12:45 – 14:00	Bethel Hospital	F/J	Past Medical Director	Professor Gordon Williams
	14:30 – 15:30	FMoH	F/K	Discussions with FMoH/GoE	Dr.Tewodros Bekele - Health Promotion and Disease Prevention General Directorate

Annex 9: Fistula Results Framework



Annex 10: Terms of Reference

Purpose and Objectives

The purpose of this consultancy is to review the results of the Australian and United States Governments' support to Hamlin operations in Ethiopia over the past 10 years, with a particular focus on the results attained under the most recent funding Agreements (*Prevention and Treatment of Fistula in Ethiopia*, Agreement 59430 and *Fistula Treatment and Prevention*, Grant No. 663-G-00-06-00418-00). The most recent Australian Government Agreement with HFIF (Agreement 45260) will also be referenced.

There are seven primary functions for the review:

- To contribute to learning and improvement, and maximise long-term benefits and sustainability (for both AusAID, other donors, the MoH and HFE) through a better understanding of the context, successes and challenges facing Hamlin operations in Ethiopia;
- To fulfil accountability requirements to AusAID, and the people and Government of Ethiopia;
- To assess the cost effectiveness and value for money of the expenditure of Australian and American taxpayers' funds under the most recent agreements;
- To inform stakeholders of the achievements to date to which Australia has contributed in responding to the problem of fistula for women in Ethiopia; and
- In line with AusAID's increasing focus on delivering effective and efficient aid outcomes through robust risk management, undertake a preliminary due diligence assessment of HFE using the AusAID NGO Accreditation Criteria to inform AusAID management decisions regarding future funding options and existing funds invested with HFIF.
- Capture impacts of United States Government (USG) support in broad terms, and within the more detailed scope of review of AusAID activities.
- Provide USAID with findings of the review to inform thinking regarding its future support to HFE

The review will cover the following key areas:

Relevance – of AusAID-funded HFE activities to the Government of Ethiopia's health priorities and the needs of intended beneficiaries.

Effectiveness – the extent to which intended results have been achieved, or are expected to be achieved; and program performance.

Efficiency – whether resources provided by Australia have been utilised in the most appropriate ways to achieve expected results and represent value for money.

Sustainability – the extent to which the work of HFE is sustainable given the level of current funds available (including all sources), alignment with Ethiopian government health sector planning, anticipated future financing, capacity to adapt to changing needs, and management capabilities.

Impact – assessment of the positive and/or negative changes (directly or indirectly, intended or unintended) produced by the Australian support.

Added Value – the extent to which the program has added benefits to what might otherwise have been achieved by others.

Cross Cutting Issues – including Gender Equality, Disability Inclusiveness and Environmental Protection.

Risks – assessment of how successfully risks have been identified and managed, and whether there are any new risks emerging that need to be managed.

Governance and Management Arrangements – are governance and management arrangements appropriate and effective? Should any changes be made? Does the program co-ordinate activities with the programs and interventions of others? How successful has this been?

Monitoring and Evaluation – is an appropriate system in place which provides sufficient information and is being used to assess progress towards meeting objectives? Does the project design demonstrate robust program logic and clearly defined end-of-program outcomes?

Learning and Analysis – the extent to which HFE's programs are based on learning and analysis and how learning is disseminated.

Coherence – the extent to which the program is consistent with / complementary to other AusAID investments in MNCH in Ethiopia and those of other organisations – government and non-government.

Scope

Context

- Analyse the problem of fistula (obstetric and other fistula) in Ethiopia including the current scale of the problem, estimates of future prevalence and incidence; current efforts to prevent and treat fistula, including government and non-government organisations and likely future requirements. This analysis should be attached as an Annex to the main report. USAID shall field the technical assistance required to undertake the substantive part of this work which will ideally be undertaken in advance of and feed into the main review. Separate, but closely linked, terms of reference will guide this part of the review.
- Document the contributions that AusAID and USAID support have made to the work of HFE and comment on the appropriateness of the levels and types of support.
- Assess HFE's program alignment with Ethiopia's Health Sector Development Plan IV.
- Review the types and extent of HFE's engagement with the FMoH, including HFE's role in national planning for midwives, including training and placement, and make recommendations on how integration of services could be further enhanced.
- Comment on how HFE collaborates with UNFPA and WHO and other stakeholders on midwifery training and fistula prevention.
- Briefly map out other donor support for prevention and repair of fistula in Ethiopia.

Program Delivery

- Evaluate program delivery, management and supervision modalities; including assessing efficiency and effectiveness including value for money, in the context of AusAID's Aid Effectiveness Policy, making recommendations for improvement.

- Identify the reasons why key targets (number of obstetric fistula cases cured and births attended by a skilled birth attendant) in the design document for AusAID's most recent funding could not be met. Review the strategic plan to address the issue of identification and referral, which was prepared by the Medical Director and comment on the extent to which the strategy has been implemented, the barriers to its effective implementation and whether it is likely to achieve its goal.
- Review HFE's plans to construct 25 MCH clinics⁶⁵ and midwives' accommodation and seek assurances as to how the sustainability of these constructions and the approach will be ensured.
 - The review will also consider how the expansion strategy aligns with the future health sector strategy of the Ethiopian Government and links the clinics with government run health centres.
- Review whether the strategy of using Australian volunteers remains the most appropriate, given the difficulties encountered and which has delayed key activities, including mentoring of academic staff and collaboration with FMOH.
- Review progress in developing an MoU with South Sudan on collaboration for Training of Fistula repair in South Sudan.
- Assess the value for money of HFE's operations considering the following:
 - Does the program have realistic and appropriate objectives and a clear plan as to how and why the planned interventions will have the intended impact?
 - Does the program have robust delivery arrangements that support the desired objectives and demonstrate good governance and management through the delivery chain? Are robust risk and fraud management strategies in place and practiced?

Is the program having a transformational, positive and lasting impact on the lives of the intended beneficiaries, and is it transparent and accountable?

Monitoring and Evaluation

- Review the current monitoring and evaluation framework in the context of AusAID's guidance on Quality, Performance and Results and the Comprehensive Aid Policy Framework (CAPF).
- Comment on the degree to which the M&E Framework aligns with Government of Ethiopia indicators and contributes to targets and the extent to which HFE has made use of, and supported development of Ministry of Health monitoring mechanisms and capability.
- Assess whether sufficient improvements to the M&E Framework were made as requested following approval of AusAID funding in 2011.
- Assess the quantity and quality of available data and make recommendations to improve data collection, analysis and use.
 - Does data enable HFE to report on the effectiveness of its work and how it is contributing to meeting national targets, including how the impact of the prevention and awareness work?

⁶⁵ As outlined in the *HFE funding request to AusAID* submitted 24 March 2011

- Is data collected on prevalence and types of disability among patients at the facilities (eg mobility, vision impairment) to plan for future services for women with disabilities?

Organisation and Management Structure

- Review the organisational and governance structure of HFE and make recommendations, as necessary, to improve effectiveness and performance to ensure sustainability of the organisation, not just financially but also in terms of organisational sustainability and quality of output and delivery of programs;
- Make recommendations on any actions that can be taken now that will increase the sustainability of HFE's work. Advise whether there are any areas of the activity that are clearly not sustainable and what actions should be taken to address this.
- Identify any significant strengths and/or weaknesses in HFE's organisational capacity, systems, policies and processes that might inform a risk management or due diligence assessment.
- Undertake a preliminary due diligence and risk assessment of HFE and HFIF. This assessment should draw on the AusAID NGO Accreditation Criteria. The purpose is to assess if assure the Australia Government is funding professional, well-managed, community-based organisations that are capable of delivering quality development outcomes. **Note** - these criteria are exhaustive and HFE, HFA and HFIF have not sought accreditation. For this reason, the criterion should be used as a guide only for this assessment.
- Provide advice on the expenditure of Australian Government funds invested with HFE and HFIF over the period January 2010 - December 2012 inclusive (as per clause 3.16, Agreement 45260). Advise on the appropriateness of governance arrangements of these entities.

Methodology

The methodology should include a review of key documents listed in Annex A.

The team will develop draft detailed methodology for undertaking the full scope of the review in line with AusAID M&E Standards including: context, program delivery, M&E, organisation, governance and management structure, including the preliminary due diligence assessment. It should be submitted to AusAID at least 2 weeks prior to commencement of the review. The team will hold interviews with key stakeholders including HFE current and past management and staff, AusAID staff in Canberra and Ethiopia, USAID staff in Ethiopia, the Ethiopia Federal Ministry of Health and other relevant stakeholders. The consultants will also hold discussions with other key organisations working in Ethiopia in this area, such as EngenderHealth, IntraHealth, Pathfinder International and UNFPA.

An initial briefing meeting will take place with AusAID in Canberra to be followed by meetings with HFE(A) and HFA (these meetings could be via telecon depending on the location of consultants). They will then meet with AusAID Ethiopia and HFE before meeting with other stakeholders.

HFE will liaise with the review team in arranging meetings and site visits. Site visits will include meetings with in-country donors, implementing partners and counterparts in the respective government structures as appropriate. Background documents will be shared with the review team at least one week before the actual start date of the review.

The consultants will visit at least one AusAID funded regional facility with the HFE Project Coordinator and the AusAID Regional Health Adviser and one USAID funded regional HFE Centre with USAID Ethiopia staff to assess the progress of fistula prevention and treatment activities carried out with Australian and U.S. Government funds. During the visit the consultants will interview health providers as well as women who use the services.

At the final review meeting on (Thursday 6 June 2013), the consultants will present the preliminary key findings, recommendations and conclusions to AusAID Addis Ababa, USAID Ethiopia and the HFE Board (AusAID Canberra and HFA will participate by teleconference) prior to drafting the final report.

Reporting

The review team will be responsible for the deliverables:

- Draft detailed methodology for undertaking the full scope of the review including: context, program delivery, M&E, organisation, governance management structure including the preliminary due diligence assessment. It should be submitted to AusAID at least 2 weeks prior to commencement of the review.
- A PowerPoint presentation of key findings (no more than 8 slides).
- A narrative report not exceeding 20 pages that:
 - Describes overall progress on project implementation - highlighting any design alternations necessary to achieve appropriate objectives, should funding resume.
 - Provides a summary of a comprehensive fistula situation analysis in Ethiopia including the current scale of the problem, estimates of future prevalence and incidence, current efforts to prevent and treat fistula and likely future requirements. A brief summary of the analysis should be included within the body of the main report with a more comprehensive analysis (max 5 pages) attached as an Annex to the main report.
 - Discusses current governance and management arrangements at HFE, highlighting any areas that need to be addressed to meet due diligence requirements, using the AusAID accreditation criteria to guide this assessment.
 - Evaluates current risks for the program and how they are being addressed.
 - Describes whether the current financial management arrangements for HFE (including consideration of HFIF) comply with AusAID accreditation criteria.
 - Describes lessons learned.
 - Presents clear recommendations.

The report should include an executive summary (maximum 2 pages) and a summary of key recommendations.

Timing

This assignment will take place in May 2013 and is expected to take up to a maximum of 52 consultancy days in total. This is based on 26 for the team leader and 23 days for the other consultant - 4 days reading preparation and meetings in Canberra (if appropriate given location of consultants); 5 days report writing and debriefing with 3 additional days for team leader to consolidate the report; 2 weeks (13 working days) in country and up to 4 days for travel.

Specification of the team

The review team will comprise two consultants:

- 1) Independent consultant – Institutional/Organisational Development Specialist
- 2) Independent consultant - Sexual and Reproductive Health Specialist

The team leader will be determined once consultant proposals are received. The team leader will demonstrate exceptional people skills, maturity and leadership experience, and both consultants will demonstrate experience and skills in diplomacy.

Expertise required:

- At least 10 years of international development experience.
- Familiarity with East or Horn of Africa conditions and the development context particularly with regard to Maternal, Neonatal and Child Health (MNCH)
- Extensive practical experience in carrying out appraisals, evaluations and reviews of donor funded programs
- Experience of working with non-governmental organisations
- Experience of comparable projects or similar programs nationally, regionally or internationally
- Excellent demonstrated report writing skills in English

One consultant should have a background in institutional/organisational development with significant (at least 10 years) experience in assessing and strengthening governance and management arrangements of NGOs in developing countries. They should be experienced in assessing organisational compliance with due diligence requirements and advising on same.

At least one consultant should be experienced in assessing cost effectiveness and value for money of MNCH and training interventions.

One consultant should have at least 10 years' experience in international maternal and child health development including at policy and program implementation levels.

Administration

The consultant will be reporting to Kate Brow, Senior Program Officer, Ethiopia and NGO Programs in AusAID Canberra. While in Ethiopia, the consultant should liaise with and report to Anne Nolan, Regional Health Adviser.

The consultants should send any reports electronically to Kate Brow: kate.brow@ausaid.gov.au and Anne Nolan: anne.nolan@ausaid.gov.au.

All financial reporting and invoices should be sent to Kate Brow.

Annex 11: Key documents

Hamlin funding submissions to AusAID

HFE Annual reports, 2010, 2011, 2012

AusAID Design Summary and Implementation Document

AusAID Quality at Entry and Quality at Implementation reports

AusAID's guidance on Quality, Performance and Results and the Comprehensive Aid Policy Framework (CAPF).

Historical reporting documentation

HFIF and HFA audit reports

Copies of relevant grant agreements

AusAID Aid Effectiveness policy

AusAID's guidance on Quality, Performance and Results

AusAID's Comprehensive AID Policy Framework (CAPF).

AusAID guidelines on NGO Engagement

AusAID's draft due diligence framework

HFIF annual reports

Central Statistical Agency (2011) Ethiopia Demographic and Health Survey 2011. Final Report, Addis Ababa.

Federal Ministry of Health. Ethiopia Health Sector Strategic Plan (HSDP-IV)

Federal Democratic Republic of Ethiopia (2010) Health Sector Development Programme IV, Annual Performance Report: EFY 2002 (2009/10)

Federal Democratic Republic of Ethiopia Ministry of Health (2010) Ethiopia's Fourth National Health Accounts (2007/2008), Addis Ababa.

Federal Democratic Republic of Ethiopia Ministry of Health. Roadmap for Accelerating the reduction of maternal and newborn mortality in Ethiopia 2012-2015

Federal Ministry of Health (2008) National Baseline Assessment for Emergency Obstetric and Newborn Care, Addis Abba, Ethiopia.

Federal Ministry of Health. National Reproductive Health Strategy 2006-2015; 2006

DFID. Reproductive Health Mapping Report, Ethiopia. May 2012.

FMOH HMIS for EFY2004

Campaign to End Fistula 2003;

Kelly J. and Kwast BE. 1993 Epidemiologic study of vesico-vaginal fistulas in Ethiopia. *International Urogynecology Journal*. October 1993, Volume 4, Issue 5, pp 278-281;

Melah G, Massa A, Yahaya U, Bukar M, Kizaya D, El-Nafaty A. Risk factors for obstetric fistulae in north-eastern Nigeria. *J Obstet Gynaecol*. 2007;27:819-23 ;

Muleta M, Fantahun M, Tafesse B et al. Obstetric fistula in rural Ethiopia. *East Afr Med J* 2007;84(11):525-33.

Cook RJ, Dickens BM, Syed S (2004). Obstetric fistula: the challenge to human rights. *Int J Gynaecol Obstet*. 87(1):72-7

Murphy M. Social consequences of vesico-vaginal fistula in Northern Nigeria. *J Biosocial Sci.* 1981;13:139-50.

Goh JT, Sloane KM, Krause HG, Browning A, Akhter S. Mental health screening in women with genital tract fistulae. *BJOG.* 2005;112(9):1328–30.

Muleta M, et al. Health and social problems encountered by treated and untreated obstetric fistula patients in rural Ethiopia. *JOGI Can.* 2008 Jan;30(1):44-50

Population Council/UNFPA . Ethiopia Young Adult Survey

World Bank. Preventing Fistula: Transport's role in empowering communities for health in Ethiopia. August 30-September 13, 2004.

Ethiopian Midwifery Association. The State of Ethiopia's Midwifery. 2012

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