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MIDTERM PERFORMANCE EVALUATION OF THE FISTULA CARE PLUS PROJECT:

Looking Back and Projecting Forward

February 2017

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Deborah A. Caro, Ph.D. (Cultural Practice, LLC) and Steven Arrowsmith, MD (Fistula Foundation)

Cover Photo by Erin Mielke. Nurses and patients at Maryam Abacha Women & Children Hospital in Sokoto, Nigeria.

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USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 214

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This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

ABSTRACT

The Fistula Care Plus (FC+) Project is a five-year global project supported by the USAID Offices of Population and Reproductive Health, and Maternal and Child Health and Nutrition. The project is designed to prevent, detect, and treat obstetric fistula. The purpose of this evaluation is to identify strengths and weaknesses of the project, as well opportunities for fistula programming beyond the life of the current project, including: 1) the extent FC+ has supported country ownership of fistula programming; 2) contributions FC+ has made to global leadership, advancing research and innovation, and transferring new technologies to the field; 3) the effects of management changes on the project; and 4) if FC+ is on track to achieve its objectives. The evaluation used a mixed method approach, including document and indicator data review, surveys of USAID Mission staff and nurses involved in post-operative fistula care, interviews with key stakeholders, and focus groups with post-operative fistula patients. The evaluation found that the project has contributed significantly to country ownership, particularly related to detection, treatment, and prevention. FC+ plays a key role in global leadership on the issues of safe surgery, with a concern both for apparent increases in iatrogenic fistula and to improve fistula and prolapse surgical outcomes. Despite early changes in personnel, there was a smooth transition, and the project stakeholders stated they were unaffected by these changes. Furthermore, the project is on track to meet its objectives, but it could begin to build upon its strong model to expand its focus on causes and treatment of incontinence in women more broadly.

ACKNOWLEDGMENTS

The Fistula Care Plus (FC+) Project enjoys widespread and enthusiastic support across a range of stakeholders. The Evaluation Team benefited from this goodwill, which was extended to us in conducting the midterm evaluation. We are grateful for all the help and support of our USAID team members, Laura McGough and Alanna White, as well as the valuable insights provided by Erin Mielke and Mary Ellen Stanton, Agreement Officer's Representatives (AORs) for the project. All four pushed us to dig deep into critical dimensions of the project. We are also extremely thankful to the EngenderHealth FC+ Global and Country Teams who made our site visits comprehensive and productive despite severe time constraints. We would also like to thank their USAID colleagues in Nigeria, Uganda, Democratic Republic of Congo (DRC), Bangladesh, Ethiopia, and Niger who either spoke to us in person or on the phone, or answered our survey. Particular thanks go to Dr. Lauri Romanzi, Project Director; Vandana Tripathi, Deputy Project Director; and Bethany Cole, Global Projects Manager, as well as the Country Project Managers in Nigeria, Uganda, DRC, and Bangladesh, Drs. Habib M. Sadauki, Rose Mukisa, Michel Mpunga, and Nazmul Huda PhD, Bangladesh Country Project Manager. In Nigeria, DRC, Uganda, and Bangladesh, the evaluators were supported by local consultants, Joshua Olatunji, Margot Bokanga, Hope Bamuheire, and Nasima Safa. They all made an enormous contribution to our knowledge and understanding of the project in their respective countries, particularly by helping us to communicate with the women affected by fistula and community health volunteers. We also want to thank the national and local officials from the ministries of health and local governments in Nigeria, Uganda, and the DRC, as well as the surgeons and nurses at the fistula hospitals we visited. They shared their hopes, successes, and challenges, and exhibited strong support and commitment to preventing fistula and responding to the needs of women and girls living with fistula, despite the challenging conditions they work in. We would like to thank Leah Ghoston of GH Pro for her guidance and support throughout the assignment. Finally, we thank the women we spoke to at hospitals in Nigeria, DRC, Uganda, and Bangladesh for their willingness to share their personal stories with us.

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ACRONYMS

ANC	Antenatal Care
AOR	Agreement Officer's Representative
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
BMMS	Bangladesh Maternal Mortality Survey
BSMMU	Bangabandhu Sheikh Mujib Medical University
CBO	Community-based Organization
CDOs	Community Development Organization
CEmOC	Comprehensive emergency obstetric care
CNRFO	Centre National de Reference pour des Fistules Obstétricales
COP	Communities of Practice
COSECSA	College of Surgeons of East, Central and Southern Africa
CSME	<i>Centre de Santé Mère/Enfant</i>
CYP	Couple Years of Protection
DHIS	District Health Information System
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EH	EngenderHealth
EmOC	Emergency obstetric care
EmOC	Emergency obstetric care
FC	Fistula Care
FC+	Fistula Care Plus Project
FGD	Focus Group Discussions
FIGO	International Federation of Gynecology and Obstetrics
FMOH	Federal Ministry of Health
FP	Family planning
GBV	Gender-based violence
GH	Global Health
GHPro	Global Health Program Cycle Improvement Project

HHOJ	Healing Hands of Joy
HIDN	Health, Infectious Disease, and Nutrition Office
HMIS	Health Management Information System
IGL	Imagerie des Grands Lacs
IHP	Integrated Health Services
ISOFS	International Society of Obstetric Fistula Surgeons
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health Division
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MSRK	Maternité Sans Risque de Kindu
MWAS	Ministries of Women's Affairs and Social Development
NGO	Non-governmental organization
NIPORT	National Institute of Population Research and Training
OF	Obstetric fistula
PNSR	National Reproductive Health Program / <i>Programme National de la Santé de la Reproduction</i>
POP	Pelvic Organ Prolapse
PROSANI	Projet de Santé Intégré
PY	Program Year
RCT	Randomized Control Trial
REF	Eradication of Fistula Network (<i>Réseau pour l'éradication de la fistule</i>)
SGBV	Sexual gender-based violence
TF	Traumatic fistula
UDS	Urodynamics
UNFPA	United Nations Population Fund

USAID	United States Agency for International Development
USG	U.S. Government
VRF	Vesicorectal Fistula
VVF	Vesicovaginal Fistula
WACS	West African College of Surgeons
WAHO	West African Health Organization
WDI	Women with fistula deemed incurable
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

This midterm performance evaluation occurred two and a half years into the five-year Fistula Care Plus (FC+) Project. The purpose of the evaluation was to identify strengths and weaknesses of the project, as well as opportunities for fistula programming beyond the life of the current project. The Scope of Work for the evaluation included four questions to guide data collection and analysis. Each of the questions also included a list of issues of particular interest to the Global Health Bureau and USAID Missions in the project's focus countries.

PROJECT BACKGROUND

The FC+ Project is a five-year global project (December 12, 2013 to December 11, 2018), with a \$ 74,490,086 ceiling, designed to prevent, detect, and treat obstetric fistula and other debilitating maternal morbidities (e.g., pelvic organ prolapse). To date, Core Funding is \$3,600,000 and Field Support is \$24,150,00 (through October 2016). Implemented by EngenderHealth (EH), it is designed to assist countries to strengthen policy and the enabling environment to institutionalize fistula prevention, treatment, and reintegration; strengthen maternal health and family planning (FP) services in the public and private sectors to support fistula prevention and treatment; enhance community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula; reduce transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support; and strengthen the evidence base for approaches to improve fistula care and scale up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment. The project also assists USAID/Washington to monitor fistula activities Agency-wide and report on this area of congressional interest.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

The team used a variety of methods, including Key Informant and group interviews, focus groups, and a survey for data collection in the United States, working with USAID in four countries: Bangladesh, Nigeria, Democratic Republic of Congo (DRC), and Uganda. The team was supported by a local evaluator who also assisted with planning in each country. The country visits to Nigeria, DRC, and Uganda were limited to five days in-country, which made extensive data collection very challenging, and site visits were limited to two hospitals each in Uganda and DRC, and three hospitals in Nigeria. Due to security concerns, the evaluation team was not able to travel to Bangladesh, but a local consultant was engaged to assist with data collection with visits to three hospitals.

The team relied on both in-person and virtual data collection, including document review, US-based interviews (of EH staff, USAID stakeholders, FC+ partner non-governmental organizations (NGOs), and prominent experts in the field of fistula), and site visits in Nigeria, DRC, and Uganda. In addition, two local researchers conducted Key Informant Interviews (KIIs) and Focus Groups Discussions (FGDs) with nurses and patients in Bangladesh. During site visits the evaluation team conducted KIIs and group interviews with approximately 150 individuals, including fistula surgeons; nurses; hospital administration staff; USAID Mission staff, FC+ Country Office Staff; local NGOs; national, regional, and local Ministry of Health (MOH) representatives; and community health workers. In Nigeria and DRC, the evaluators completed six FGDs with fistula clients, who were either waiting for or recovering from surgery. A short survey was sent to 11 USAID Missions; five people from four USAID Missions responded.

FINDINGS

Evaluation Question 1: To what extent has Fistula Care Plus supported country ownership of fistula programming (i.e., going beyond national vision statements to include technical and managerial capacity and allocation of domestic resources to address fistula)?

Country ownership is evident in Nigeria, Uganda, Niger, Togo, and Bangladesh, where FC+ provides strong policy support. Commitment is stronger in countries with funded policies than in those that have unfunded policies, which include Nigeria, Niger, and Uganda. In Nigeria and Uganda, where Fistula Care (FC) had a prominent role in developing the first five-year strategies, FC+ is now supporting the MOH in both countries to develop strategies for the next five years. Both countries have committed funding to fistula care. Bangladesh issued a policy but has not yet funded the policy. In DRC, FC+ continues to engage the government on the development of a national strategy, but the process has not yet produced a renewed strategy. In addition, FC+ has played a pivotal technical role in helping the Nigerian Federal MOH to develop and issue guidelines on the catheterization post-partum for obstructed and prolonged labor and post-operative for fistula patients based on the Randomized Control Trials (RCTs) conducted during the predecessor project. For FC+, the guidelines have been a major success in translating research into evidence-based policy.

Surgeons interviewed in Nigeria and DRC concurred that FC+ has been instrumental in creating networks that connect surgeons within and across countries, resulting in improved morale, sharing of best practices, and increased referral of patients. Surgeons also expressed appreciation for FC+'s emphasis on quality of care. The project is also working on developing standards of competence for fistula surgeons, but has not yet identified an organization to assume primary responsibility for credentialing fistula surgeons.

Detection efforts implemented under FC+ appear to be effective in identifying and recruiting women with fistula for surgery. The staff of health facilities visited during the evaluation stated that (1) they easily recruit the number of women with fistula for surgical camps and routine surgery, where offered, and (2) are seeing more women with fistula developed recently than women who have been living with fistula for many years.

These two findings indicate that women continue to develop fistula as a result of prolonged and obstructed labor, but appear to be getting care sooner after developing fistula than women did in the past. Secondly, the observations of the surgeons indicate that there is a sizable decrease in the backlog. One explanation, offered by surgeons and nurses, is that the remaining backlog is in more remote and hard-to-reach areas where women are isolated by geography or stigma, which impedes their access to information, transport, or care.

FC+ has greatly increased and focused its prevention efforts – which include training on the use of the partograph, FP integration in FC services, improved C-section skills, and messages to delay marriage and seek skilled care at delivery – over the course of the project, although there is variation across the five countries. The most notable gap in prevention programming are the lack of follow-through on training. In the case of both partograph and C-section training there is little post-training mentoring, supervision, or accountability, according to health professionals interviewed for the evaluation.

FC+ focuses on improving the enabling environment, particularly in reducing stigma and discrimination of girls and women living with fistula and post-repair. FC+ involvement in reintegration is focused on guiding operations research conducted by Terrewode, an FC+ resource partner.

Evaluation Question 2: What contributions has Fistula Care Plus made to global leadership, to advancing research and innovation, and to transferring new technologies to the field (emphasis on Objectives 3 & 5)?

FC+ has developed a portfolio of non-clinical operations research related to fistula prevention and reintegration. Population Council, an FC+ sub-awardee, conducted formative research on barriers to accessing care for fistula in Uganda and Nigeria.

Evaluation Question 3: There have been several management (staffing and structural) changes within the Fistula Care Plus team at EngenderHealth (EH) since the start of the project (all three key personnel have changed over time). How has this changed the technical direction and management of the program?

Despite considerable changes in staffing at the beginning of FC+ at both the global and country offices, these changes have ensured continuity of strong management and productivity of the project in focus countries and globally. USAID Missions, host country governments, and local partners all said that the transition between FC+ and the predecessor project was a smooth one and that the project is responsive to their needs and a strong partner.

Evaluation Question 4: What is the evaluation team's assessment regarding the project's future progress (is it on track to achieve its intended objectives)?

The project appears to be on track to meet its objectives. It has met or exceeded its planned targets for number of treatment sites supported, family planning, and number of participants reached through community-awareness building. The project has not fully met its planned benchmarks for repairs – it is a difficult benchmark to set as there is little reliable information on demand. The only way to determine demand is to see how many women respond to outreach.

Lessons learned include:

- Continuous respectful collaboration between FC+ and national and local governments in association with other global and national partners has increased political and financial commitments to public and private efforts to fistula prevention, detection, and treatment.
- Facility data does not support predictions of reaching the end of fistula cases anytime soon. New fistulae are appearing. The good news is that the backlog appears to have decreased based on surgeons' rough assessments that the number of women presenting for surgery with new fistula outnumber women who have been living with fistula for a long time.
- Training on the partograph has raised awareness among nurses and midwives about obstructed and prolonged labor. Partograph use lags behind awareness of its value.
- The slow adoption of results from the RCT on length of post-operative catheterization indicates that the trajectory from research to application in policy and practice requires focused advocacy to policy makers and practitioners, even when the evidence is clear and based on gold standard research.
- There is still a need for research on other clinical questions related to fistula treatment, and evaluation of prevention and reintegration approaches.

CONCLUSIONS

1. Country Ownership. FC+ has built on predecessor projects to continue strong support to strengthening country commitments to fistula care. The evidence for country ownership is particularly strong in Nigeria, Niger, and Uganda, which have committed funding in support of new policy initiatives. In DRC and Bangladesh, while the governments have expressed support through policy initiatives, the private sector has provided more funding support than the public sector. Communities of Practice of fistula surgeons have also contributed to greater country ownership by building a shared body of knowledge and cooperative relationships among health personnel.

2. Certification of Surgeons. Surgeons are leaving the field frequently because of the lack of any professional certification for fistula surgeons, which is recognized internationally and would allow them to grow professionally. For fistula surgeons that are non-specialists (i.e., Medical Officers, not Obstetrician/Gynecologists or Urologists) there is no clear professional advancement path; they are highly dependent on informal networks for improving their skills. There is a clear need for national or international bodies to certify fistula surgeons who are not specialists.

3. Networking of surgeons by FC+ contributes to their knowledge and skills development, and professional satisfaction. FC+'s efforts in organizing individual surgeons into a Community of Practice have been exemplary and very well received by individual surgeons. Giving surgeons an identity as a member of a professional community fosters sharing of new clinical ideas and insights, facilitates transfer of patients requiring special skills for repair, and encourages higher-level training via mentorship between community members.

4. When trained appropriately, FC+ has demonstrated that nurses are able to perform first level of screening for fistula. Detection and referral for initial fistula care can have negative impact when women without fistula respond to outreach efforts and present for care expecting treatment for a condition they do not have, often after significant travel. FC+ has greatly expanded the availability of screening at health centers, closer to where women live. Currently the dispersed screening sites rely on an interview instrument.

5. Use of the partograph along with the appropriate response, action, or referral is one of the most effective tools for preventing fistula. EngenderHealth has been an ardent promoter of the use of the partograph as a means of monitoring for obstructed and prolonged labor. Under FC+ they have continued to emphasize the importance of the use of the partograph and have supported training in most focus countries. While the use of the partograph is improving in some countries, such as Niger and Uganda, it is still not standard or effective practice for prevention of fistula in most counties.

6. Successful detection/outreach programs used a flexible, multi-modal approach. Likewise, the prevention message needs to reach women, men, healthcare providers, and government officials, and therefore a tailored approach is vital. Where FC+ has been successful in tailoring prevention messages to the different needs of women, men, and healthcare workers there appears to be a decrease in the gap between the number of women seeking care and the number requiring fistula surgery. In Nigeria, where FC+ has greatly diversified communication channels and honed its messages and decentralized its detection processes, the gap is only 11%, while in Bangladesh, where outreach communication channels are more limited, the gap is much wider (54%) (FC+ Semi-annual Report March 2015-March 2016).

7. FC+ has made relatively little use of its global resource partners, thereby foregoing opportunities for taking advantage of additional resources and expertise. Both Direct Relief

and the Fistula Foundation offer assistance in kind and financial resources that FC+ could leverage in support of the treatment sites the project currently supports financially and to purchase equipment. Greater use of those resources would free up resources for other types of investments, such as for research and improvements in quality of care. Dimagi, with their telecommunications capabilities, offers potential for digitizing collection of data for clinical research and M&E. The evaluation team identified a need to collect individual clinical data to assess the etiology and complexity of fistula being treated, types and numbers of complications, and average number of times a woman has been operated on.

8. There is still a critical need for a response to women's incontinence more broadly, especially as, according to published sources, somewhere between 29% to 54% of fistula clients suffer incontinence post-discharge after repair. Many women, especially those whose fistula is closed but continue to experience incontinence, would benefit from non-surgical interventions if the cause of their continued incontinence was properly diagnosed and other types of remedies were readily known and available in treatment centers.

9. FC+ has made a major advance in developing a gender equality and empowerment of women action plan for the project which includes training of staff, engagement of men as partners and agents of change, and developing activities that address gender power imbalances. The strategy, however, appears to lack one very important element – the empowerment of fistula clients as knowledgeable and active agents in decisions about their care and reintegration.

RECOMMENDATIONS FOR FC+

Key initiatives for future investment (Evaluation Question 4 continued)

There are several areas where FC+ has initiated activities that are important to continue for the duration of the current project and potentially expand or scale up in a future fistula program:

1. Communities of practice of surgeons. FC+ is supporting regional meetings that strengthen fistula surgery. There is potential to build on these efforts and to enhance them via more effective and diversified knowledge management practices, especially through electronic and social media.

2. Partograph training and mentoring skills for doctors. Knowledge and support from doctors in Uganda and Nigeria appeared to be an important criterion for determining the likelihood that nurses and midwives trained in the use of the partograph would actually use it for monitoring women for obstetric complications, especially for signs of obstructed and prolonged labor.

3. Task Shifting. The evaluation team identified fistula screenings by nurses and midwives (already practiced at Kitovu) as an appropriate area for task shifting as a means to start a transition away from the model multiplying the number of fistula center as a means of increasing women's access to care. The evaluation team proposes a more efficient and higher quality model that strengthens the capacity and increases availability of detection sites while decreasing the number of repair sites to a few strategically located and supported sites that provide quality of care by capable surgeons who have the opportunity to conduct a sufficient number of surgeries per year to be both current and competent.

4. Continued diversification of strategies for outreach and prevention. In the short term, FC+ will commit to the expansion of testing and validating differentiated reintegration interventions, which might be re-conceptualized as individualized social and economic support strategies, as a means of destigmatizing and de-victimizing women living with inoperable fistula or women living with the social and economic consequences of discrimination as a result of having a fistula disability.

5. The Evaluation Team views strengthening International Society of Obstetric Fistula Surgeons (ISOFS) capacity for credentialing fistula surgeons directly or in partnership with an academic or governmental body as one potential solution to the current conundrum of how to provide a career advancement pathway for fistula surgeons. In this capacity ISOFS would: (1) credential fistula surgeons, (2) validate best practices, and (3) partner with local professional organizations in more effective professional oversight and accountability.

As FC+ has concerns about whether ISOFS is the right organization to solve the credentialing problem, in the near term, it will explore potential alternative partnerships for this purpose, such as the West African College of Surgeons (WACS) and the College of Surgeons of East, Central and Southern Africa (COSECSA), which may be more prepared and sustainable country/regional partners.

6. The evaluation team strongly recommends FC+ and USAID to continue a wider focus on continence care. Incontinence after fistula repair is one of the great remaining challenges in fistula care. Although closing the fistula defect can be immensely challenging, fistula surgeons understand how to do it. The same is not true for incontinence. Injuries in untreated obstructed labor are widespread and uniquely patterned to disrupt normal bladder and sphincter function.

7. Make greater use of project partners like Dimagi, Fistula Foundation, and Direct Relief for innovative solutions to challenges. The evaluation team perceived that EngenderHealth's other FC+ Resource Partners were underutilized, especially when they were in a strategic position to address constraints and opportunities faced by the project.

8. Gender integration efforts should focus more directly on supporting fistula clients as active agents rather than as unfortunate victims. While efforts are being made to engage men as supportive partners and advocates, it is critical to design and implement actions that increase women's agency as advocates for and informed consumers of fistula services.

RECOMMENDATIONS FOR FUTURE PROGRAMMING

1. The evaluation team strongly urges FC+ and USAID to consider research with a focus on incontinence after repair. The problem of incontinence after repair has reached epidemic proportions and there is very little helpful clinical knowledge to guide therapy, and very few fistula surgeons with expertise in continence.

2. Test the impact of the integration of prevention, treatment, and reintegration practices at the level of a health referral network on preventing new occurrence and reducing backlog. This recommendation proposes that a follow-on project make a health network, rather than a fistula treatment center, the focus of the intervention. The rationale for the recommendation is that the focus on the whole network allows the project to address system constraints.

3. For treatment, each country should establish one or two multifunctional fistula centers per country or region in lieu of multiple centers all over the country with different capabilities to resolve women's fistula, depending on their level of complexity and types of treatment needed. The centrally located multifunctional center in each country or region should be staffed on a permanent basis with a cadre of highly skilled staff (e.g., urology, gynecology and general surgery in each place with availability to consult with plastic surgery), sophisticated diagnostic equipment, with the capacity to be able to treat any fistula case that might arrive – from simple cases to diversion surgery for cases deemed incurable. A robust system should be put into place to transport women to and from these centers with as much dignity and comfort as possible.

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of the evaluation was to provide the United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Health, Infectious Disease, and Nutrition Office (HIDN)/Maternal and Child Health Division (MCH) with an independent midterm performance evaluation of the Fistula Care Plus Project (FC+) to identify strengths and weaknesses of the project, as well as opportunities for fistula programming beyond the life of the current project.

A two-person external evaluation team (i.e., the core team), along with two USAID/Washington staff, undertook a midterm performance evaluation of the FC+ Project between June and September 2016. The core evaluation team was accompanied by three USAID staff who took part in visits to Nigeria. One core team member and one USAID staff person conducted field visits in the Democratic Republic of Congo (DRC) and Uganda. In Bangladesh, two local consultants conducted interviews with nurses and fistula clients. The evaluation team examined the project's progress towards achieving its planned results and lessons learned to-date. The team was asked to identify FC+ activities that may warrant continued future investment, as well as other fistula prevention, treatment, and reintegration interventions that are not part of FC+'s current portfolio but would likely contribute to improvements in the program.

EVALUATION QUESTIONS

This midterm performance evaluation occurred two and a half years into the five-year Fistula Care Plus Project. The evaluation was designed to identify strengths and weaknesses of the project, as well as opportunities for fistula programming beyond the life of the current project. The Scope of Work for the evaluation included four questions to guide data collection and analysis. Each of the questions also included a list of issues of particular interest to the Global Health Bureau and USAID Missions in the project's focus countries.

- I. To what extent has Fistula Care Plus supported country ownership of fistula programming (i.e., going beyond national vision statements to include technical and managerial capacity and allocation of domestic resources to address fistula)?

Issues:

- Sustainable capacity for fistula prevention, detection, treatment, and reintegration built by Fistula Care Plus (emphasis on objectives 1&2)
- Consider clients' perspective on quality of care and any recommendations to enhance patient satisfaction
- Nigeria:
 - Refer to HIS data for survey of fistula repair centers across Nigeria and all fistula client data on repairs and outcomes
 - Observe surgical skills tracking tool for assessment of competency of surgeons
 - Confirm status of Federal Ministry of Health (FMOH) standards and guidelines (including for bladder catheterization), and status of Ibadan teaching hospital
- Bangladesh:

- Ways the project and USAID can improve advocacy for fistula prevention within the Ob-Gyn Society and the Government of Bangladesh
 - Ways the project can enhance quality assurance among service delivery implementing partners
 - Ways the project can enhance social and behavior change communication of early diagnosis and referral of cases
2. What contributions has FC+ made to global leadership, to advancing research and innovation, and to transferring new technologies to the field (emphasis on Objectives 3 & 5)?
 3. There have been several management (staffing and structural) changes within the FC+ team at EH [EngenderHealth] since the start of the project (all three key personnel have changed over time). How has this changed the technical direction and management of the program?

Issues:

- Project responsiveness to USAID Missions, USAID regional bureaus, host country governments, and other global stakeholders?
4. What is the evaluation team's assessment regarding the project's future progress (is it on track to achieve its intended objectives)?

Issues:

- Challenges and gaps identified
- Important technical lessons learned and best practices identified
- Key initiatives, activities, and approaches that warrant additional USAID investment in the future, beyond the end of the Fistula Care Plus project
- Other promising fistula program models and approaches, not addressed by Fistula Care Plus, which should be considered for future investment.

II. PROJECT BACKGROUND

The FC+ Project is a five-year global project (December 12, 2013 to December 11, 2018), with a \$ 74,490,086 ceiling, designed to prevent, detect, and treat obstetric fistula and other debilitating maternal morbidities (e.g., pelvic organ prolapse). To date, Core Funding is \$3,600,000 and Field Support is \$24,150,00 (through October 2016). Implemented by EngenderHealth (EH), it is designed to assist countries to strengthen policy and the enabling environment to institutionalize fistula prevention, treatment, and reintegration; strengthen maternal health and family planning (FP) services in the public and private sectors to support fistula prevention and treatment; enhance community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula; reduce transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support; and strengthen the evidence base for approaches to improve fistula care and scale up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment. The project also assists USAID/Washington to monitor fistula activities Agency-wide and report on this area of congressional interest.

The FC+ Project is both a continuation and an expansion of earlier iterations of USAID work on fistula under the ACQUIRE and Fistula Care (FC) Projects. The ACQUIRE project, funded by USAID and implemented by EngenderHealth, was the first mechanism for implementing fistula activities in Uganda and Bangladesh. Fistula Care was the first USAID dedicated global fistula program (2007–2013) with activities in 10 countries. FC+ is the follow-on project to FC, with a narrowing in the number of countries to six, and an expansion in scope to include attention to women with pelvic organ prolapse and women with fistula deemed incurable (i.e., where further surgical intervention will not close the fistula).

The “plus” in FC+ refers to the addition of attention to woman suffering from pelvic organ prolapse (POP) and expanded focus on public-private partnerships. The FC+ Team also includes a greater number and more diverse types of partners: Population Council, Terrewode, Dimagi, The Fistula Foundation, Direct Relief, and the Maternal Health Task Force. The evaluation did not address POP services as FC+ had not formally begun support to POP services at the time of the evaluation. The evaluation did however discuss with interviewees how they anticipated the introduction of POP services would affect the delivery of fistula services, both positively and negatively. In addition, several sites visited had already initiated the introduction of POP services independently in anticipation of FC+ future support. An additional dimension of the plus refers to research on women with fistula deemed incurable to identify their needs for reintegration and support, and the development of protocols for their long-term treatment and care.

FC+ addresses the goal of strengthening health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia by implementing the following five Objectives:

Table 1. Objectives and Indicators of Fistula Care Plus Project

Goal	Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia			
Goal-level Indicators	<ol style="list-style-type: none"> 1. Number of countries supported by Fistula Care Plus (FC+) 2. Number of sites supported by FC+ for fistula repair and prevention 3. Number of prevention-only sites supported by FC+ 			
Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors	Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula	Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support	Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment	Strengthened evidence base for approaches to improve fistula care and scaled up application of standard M&E indicators for prevention and treatment
Indicators				
<ul style="list-style-type: none"> • Number of countries receiving support from FC+ where governments or supported facilities have revised / adopted / initiated / implemented policies or guidelines for fistula prevention or treatment • Number of countries receiving support from FC+ where governments or supported facilities have addressed women with fistula deemed incurable (WDI), women with traumatic fistula (TF) and / pelvic organ prolapse (POP) in their fistula and / or broader reproductive / maternal health policies or guideline • Number of countries receiving support from FC+ in which governments have budget line item for fistula care 	<ul style="list-style-type: none"> • Number of community volunteers / educators trained in tools and approaches to raise awareness regarding fistula prevention and repair • Number of community awareness-raising activities / events conducted by program partners • Number of participants reached through community awareness-raising events / activities conducted by program partners. 	<ul style="list-style-type: none"> • Number and type of transportation initiatives introduced, enhanced, and/or tested • Number and type of communication technologies introduced, enhanced, and / or tested for improving communication with patients and / or providers. 	<ul style="list-style-type: none"> • Number of women requiring fistula repairs • Number of fistula repairs • Outcomes of fistula repair (percentage closed and dry) • Complications of fistula repair (percent of repairs with complications) • Number of health systems personnel trained, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider) • Number of supported facilities that have introduced treatment for POP • Number of POP treatment services provided 	<ul style="list-style-type: none"> • Number of evaluation or research studies completed • Percentage of supported sites reviewing fistula monitoring data bi-annually to improve fistula services.

Goal	Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia			
Goal-level Indicators	<ol style="list-style-type: none"> 1. Number of countries supported by Fistula Care Plus (FC+) 2. Number of sites supported by FC+ for fistula repair and prevention 3. Number of prevention-only sites supported by FC+ 			
Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
<ul style="list-style-type: none"> • Number of countries with fistula indicators included in the health management information system (HMIS) • Number of public / private partnerships established to address fistula prevention, repair, or reintegration by country. 			<ul style="list-style-type: none"> • Couple-years of protection in sites supported by FC+ • Number of FP counseling sessions provided to clients • Completion of partographs and management of labor according to protocol at sites receiving support for strengthening partograph use. 	

FC+ supports approximately 788 fistula prevention-only sites and 32 prevention and treatment sites in Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, Togo, and Uganda, (FC+ Semiannual Report March 2016).

Bangladesh: FC+ works with a combination of private, faith-based, and public sector hospitals in Bangladesh. Of the eight sites, two are prevention only sites. The principal government site is Bangabandhu Sheikh Mujib (BSMMU), a major research and teaching center, where FC+ expects to set up an on-site Fistula Prevention, Treatment and Training Center. FC+ works with Bangladesh Rural Advancement Committee (BRAC) to raise awareness in communities of the causes and ways to prevent fistula, and to identify and refer women living with fistula for care. In addition to supporting clinical, prevention, and reintegration services for fistula clients, FC+ has partnered with USAID/Bangladesh, other donors and the National Institute of Population Research and Training (NIPORT), to include questions on fistula and pelvic organ prolapse in hope of producing estimates of prevalence. In addition, the FC+ country office works closely with the Government of Bangladesh and other partners to update the national strategy to eliminate fistula. Currently, a major focus of the FC+ country staff is to engage professional organizations in improving the quality of obstetric care, especially in the private sector, as a significant number of fistula in Bangladesh are caused by unskilled doctors performing C-sections and hysterectomies.

Democratic Republic of Congo: The FC+ program in DRC works through subagreements with private faith-based hospitals to provide detection, treatment, and reintegration services. FC+ partners with St. Joseph's, Panzi, Health Africa, Imagerie des Grands Lacs (IGL), and Maternité Sans Risque de Kindu (MSRK). FC+ serves on a national working group aimed revising and updating the national fistula strategy. FC+ works with these hospitals to train doctors and nurses, improve quality of surgical care, improve emergency obstetric and neonatal care. The Project also supports the hospitals' outreach efforts to identify women in need of fistula services.

Niger and West Africa Region (Togo): In Niger and other West African Countries, FC+ works in collaboration with the Réseau de l'éradication de la fistule (REF) to support regional partners on prevention, treatment, outreach and detection, and reintegration. FC+ works with the REF to engage obstetric fistula providers in revisions to the National Obstetric Fistula Strategy, with the objective of using the strategy as a guide for the development and application of a regional strategy. The Project supports three prevention and treatment sites in Niger: Maradi Regional Hospital, Centre de Santé Mère/Enfant (CSME) in Tahoua, and the Centre National de Reference des Fistules Obstétricales (CNRFO) in Niamey, and four prevention-only sites. The FC+ Country Office supports an active community mobilization effort, which has increasingly integrated attention to gender inequality in its community activities. FC+ activities in Togo have focused on training surgeons and nurses, and conducting site assessments.

Nigeria: FC+ works in 11 of Nigeria's 36 states, including Bauchi, Cross River, Ebonyi, Jigawa, Kano, Katsina, Kebbi, Kwara, Oyo, Sokoto, and Zamfara, where FC+ supports training, clinical services, detection and screening, prevention, family planning, and reintegration. Two new sites have been added in Jos (Plateau State) and Zaria (Kaduna State). The project is also a member of the national fistula working group to develop the second five-year fistula strategy, as well as national technical guidelines for the implementation of conservative management (catheterization) of fistula, short duration of catheter use after fistula surgery, and algorithm and guidelines for management of survivors of sexual gender-based violence (SGBV). In addition, Nigeria is a focus country for digitization of health information related to fistula and for both formative and operations research on barriers to accessing fistula care. Currently, the Chair of ISOFS is held by a Nigerian fistula surgeon, who is also at the center of addressing long-term training and accreditation issues for fistula surgeons. FC+ is supporting efforts to develop a uro-gynecological training center at the University of Ibadan to improve and standardize fistula and prolapse surgical skills. The FC+ Country Team also works extensively with state and local government, particularly with State MOH on prevention, treatment (i.e., support to state and district hospitals), and reintegration (e.g. in conjunction with the Ministry of Women's Affairs and Social Development). POP activities are expected to begin in 2017. The Project supports local voluntary organizations to conduct outreach, awareness raising, and detection activities.

Uganda: The FC+ program in Uganda is similar to the program in other countries, although there has been a greater emphasis on FP integration, community health volunteers, and use of the partograph for prevention. Currently the Project is supporting treatment at Jinja, Kamuli, Hoima, and Kitovu Hospitals. The FC+ Country staff have supported the government on the development of the second five-year strategy, which is distinguished from its predecessor by having been allocated a budget. The Project has also been supportive of a national initiative for partograph use. The project has rolled out its use in lower-level health facilities that feed into the Kasese District Hospitals. FC+ plans to begin POP surgery in Jinja in 2017. FC+ Uganda supports several research efforts. It is collecting data on partograph use to analyze for scale up. Population Council conducted formative research on access barriers and is currently conducting operations research to test several interventions to overcome the barriers. Terrewode, another FC+ team member, is conducting operations research on options for women who are living with fistula that cannot be cured in-country with current skills and technology, and are therefore likely to have continue living with fistula.

III. EVALUATION METHODS & LIMITATIONS

The team used a variety of methods, including Key Informant and group interviews, focus groups, and a survey, for data collection in the United States, with USAID and four countries: Bangladesh, Nigeria, Democratic Republic of Congo, and Uganda. The team was supported by a local evaluator who also assisted with logistics in each country. The country visits to Nigeria, DRC, and Uganda were limited to five days in-country, which made it very challenging to do extensive data collection, and site visits were limited to two hospitals each in Uganda and DRC, and three hospitals in Nigeria. Due to security concerns, the evaluation team was not able to travel to Bangladesh, but a local consultant was engaged to assist with data collection with visits to three hospitals. The team relied on both in-person and virtual data collection. The types of data collection methods utilized by the team and the limitations encountered in the process of their application are discussed below.

1. **Document Review of quarterly, semiannual, and annual reports, and research reports from FC+**, as well as reports from other sources on fistula clinical concerns / evidence, barriers to accessing care; outreach, and reintegration; and policy documents (e.g., national and regional strategies, policies, and standards, and protocols). Initially, team members conducted a thorough review of project documents provided by USAID and FC+ to gain an understanding of the design and performance of the project according to monitoring data. The team conducted a descriptive analysis of monitoring and district health information system (DHIS) data.
2. **Key Informant and Group Interviews** were conducted with national and local Ministry of Health (MOH) officials, USAID program managers, surgeons, hospital administrators, and local officials in Nigeria, DRC, and Uganda. These discussions explored the status of local (community and district), regional (state/provincial), and national fistula programming and policies in the countries visited, including the successes achieved and the challenges that still need to be addressed. In addition, the team explored questions related to sustainability and quality of care with a major focus on the degree to which training and technical assistance by FC+ has increased the availability and quality of services for fistula patients. The team gathered a more limited amount of information on approaches to prevention and reintegration, which was a more prominent focus during the Uganda country visit than in DRC or Nigeria.
3. **Focus Group Discussions (FGD)** and less structured group discussion took place with fistula patients (two sites in each Nigeria and DRC, and four sites in Bangladesh). Because of the timing of trips and pooled efforts in Uganda, the evaluation team was not able to interview patients in that country. The evaluators met with and interviewed community groups in Uganda and Bangladesh. In Nigeria and Bangladesh, the team asked fistula clients about the services they had heard of and if they were able to access these services. Other topics explored included understanding women's pathways to labor and delivery that caused fistula, barriers to accessing maternal health services, post-repair messages, and the feasibility of women to act either independently or jointly with partners in response to messages. The evaluation team did not have the opportunity to interview partners of fistula clients to determine the degree to which partners and other family members are informed about fistula and involved in the care and reintegration of fistula patients. In Uganda, discussions with community health workers and religious leaders informed the evaluation team's understanding of what messages are transmitted at the community level, and to a lesser degree, the response.

4. **Survey of USAID staff:** The team conducted a survey of USAID staff supporting fistula activities in Missions. The purpose of the survey was to get input from Missions on the project's programmatic work, management, and leadership. There were also questions on USAID engagement with government and other stakeholders on fistula prevention, repair, and reintegration services; training of surgeons; models of delivery of services; and future plans for fistula programming and policy change. The survey went out to 11 countries, of which there were responses from five people in four USAID Missions: Democratic Republic of Congo, Ethiopia, Niger, and Uganda, despite multiple follow-up attempts by the Agreement Officer's Representative (AOR).¹ The evaluation team also interviewed USAID Mission Staff involved with FC+ in Bangladesh, Nigeria, Uganda, Democratic Republic of Congo, and Uganda.
5. **Survey of ward and outpatient nurses:** In Nigeria and Uganda, the evaluation team surveyed nurses at a total of two facilities, and conducted group interviews at four. In DRC, the evaluation team interviewed nurses at one hospital and in Bangladesh, the local team members interviewed nurses at three hospitals. The survey was designed as a lead-in into a group discussion with nurses about different dimensions of fistula care they are involved in pre-, during, and post-fistula surgery.
6. **Observational assessment:** While the team did not have time to conduct formal site assessments, team members carefully observed conditions of facility infrastructure, equipment, waste management, and interpersonal interactions among providers and patients on the wards and in FP counseling areas. In Nigeria and Uganda, the FC+ teams also had recently conducted site visits as input into quality improvement efforts.
7. **Interviews with surgeons:** The fistula surgeon on the evaluation team conducted both in-person and phone interviews with fistula surgeons in Nigeria, DRC, Niger, and Uganda to get information on their self-assessment of their skills, number of repairs completed per month, the proportion of fistula and prolapse surgeries conducted at the facility, and their opportunities for further training and certification. Information from these interviews have been analyzed in the context of information from the FC+ HMIS database and surgical tracking tool.

The evaluation team interviewed approximately 150 people in the United States and four FC+ focus countries. Table 2 lists interviews by type of interviewee and instrument. A more detailed list is included in Annex II.

¹ The low response rate is likely due to the timing of the evaluation, which took place during August, a time when many USAID Mission staff are on vacation or very busy with the end-of-fiscal year activities. Between the survey and in-person or phone interviews, the evaluation team had the opportunity to speak to USAID staff in all five FC+ countries.

Table 2. Summary of Interviews by Type of Interviewee

Interviewees	Number	Type of Instruments
USAID Staff in US	6	Key Informant and Group Interviews
USAID Staff in Missions	9	Key Informant and Group Interviews and survey sent out to 11 USAID Missions and received responses from 4 Missions
Global Partners	5	Key Informant Interviews
NGO Partners	5	Key Informant Interviews
Hospital Administrators	11	Key Informant Interviews
Village Health Workers	12	Focus Group Discussion
Government Officials	16	Key Informant and Group Interviews
Surgeons	17	Key Informant Interviews
Nurses	31	Key informant Interviews, Group Interviews, Surveys
Fistula Patients	41	Key Informant Interviews, Focus Group Discussions

Site and Sample Selection: Travel was limited to three of the five Fistula Care Plus countries: Nigeria, Democratic Republic of Congo, and Uganda. The team visited prevention, detection, and repair sites in Nigeria, and two sites each in Uganda and DRC. In each country, the team also conducted interviews with USAID staff involved with FC+, key actors in the Ministry of Health, other donors, and nongovernmental organizations (NGOs) collaborating with the project. In addition, local evaluators undertook data collection at three fistula repair centers and one detection center in Bangladesh. The countries were selected by USAID based on countries where local Mission staff had specific questions they wanted answered by the evaluation (Bangladesh, DRC, and Nigeria). Uganda was selected after the team could no longer visit Bangladesh because of security concerns.

Ethical Considerations & Human Subject Protection:

Informed Consent

For all FGD and key informant interviews an informed consent statement was read to all patient interviewees prior to their participation in interviews, and their oral consent was confirmed. The statement makes clear that they have the option to not participate. No personally identifying information was collected during the interviews.

Participant Confidentiality

The stakeholders interviewed for the study were informed of the purpose of the study as well as their right to confidentiality. No persons were required to participate in the evaluation nor subjected to any consequences if they decided not to participate. Names of clients and community participants in focus groups and interviews are not used or listed in the report to protect their privacy.

Limitations

Time allocated for field visits did not allow for visiting more than two to three fistula centers per country and spending two to four hours in each place in Nigeria, DRC, and Uganda. In Bangladesh, the

local researcher had a 15-day period to visit hospitals and covered more institutions and for longer periods of time. The timing of the visits also determined whether or not the evaluation team was able to interview fistula clients and surgeons at the time of the visit, as few hospitals do ongoing or routine repairs. If the evaluation visits didn't coincide with a camp or pooled effort there were no patients to interview and surgeons were away at camps in a different part of the country. The team was able to conduct the survey of nurses in two hospitals in Nigeria (in Kebbi and Sokoto) and one in Uganda (Hoima). The team compensated for this limitation by conducting follow-up phone calls with surgeons, but was not able to address the lack of access to fistula clients.

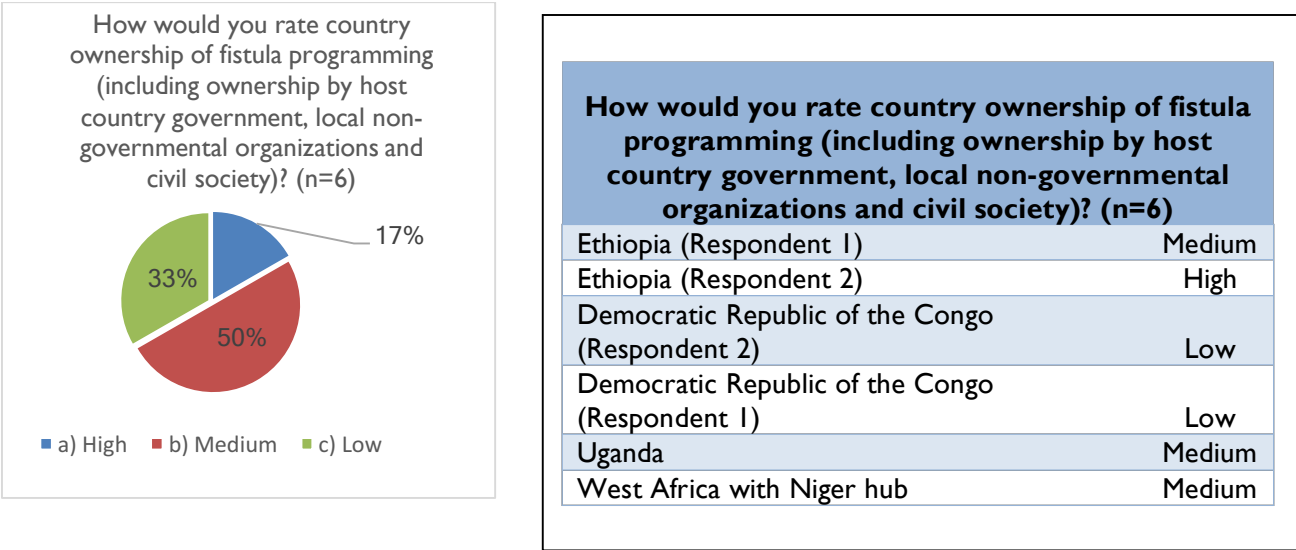
Similarly, because of time constraints for in-country visits, the evaluation team only interacted with two to three municipal or state government officials in each country. Focus groups with community health volunteers and health personnel was also limited to one site in Uganda. In Nigeria and DRC, time limitations and logistics did not allow for community visits. The evaluation team has drawn on project documents, published literature, and previous visits to fistula centers to fill in the gaps. In all instances, the team has tried to make explicit the source of the information in Section IV. Findings.

IV. FINDINGS

Question 1: To what extent has Fistula Care Plus supported country ownership of fistula programming (i.e., going beyond national vision statements to include technical and managerial capacity and allocation of domestic resources to address fistula)?

Country Ownership: Policies and Budgets

Figure 1. USAID Mission Rating of Country Commitment to Fistula Programming



The evaluation team asked USAID Missions to rate commitment of host countries to fistula programming. The responses were fairly consistent with what the evaluation team found during the country visits and review of documents for FC+ countries (i.e., DRC and Uganda).

The predecessor to FC+, the Fistula Care (FC) Project, supported the development of national fistula strategies in Nigeria (2011-2015), Uganda (2011-2015), Bangladesh (2013-2016), and Niger (2015-2019).² The four strategies covered treatment, prevention, and to a lesser extent reintegration. Both the Nigeria and Niger strategies include stipulations for budgetary allocations. The unique feature of the Nigeria strategy was that for the first time it established a stand-alone line item for fistula in the federal health budget. The strategy supports fistula treatment and prevention, including family planning with funding from federal and state budgets, with oversight by the Clinical Services and Reproductive Health Departments of the Federal Ministry of Health (FMOH) and State Departments of Health in eight states.³

Approximately 30% of core funding for FC+ comes from USAID’s Office of Population and Reproductive Health and is designated for FP, which is a critical element of the FC+ fistula prevention strategy. Five of the six FC+ countries, Bangladesh, DRC, Niger, Nigeria, and Uganda all have incorporated a strong statement on the preeminent place of FP in their national fistula prevention strategies. In Nigeria, EngenderHealth is playing a temporary role as primary USAID FP project in

² Niger and Bangladesh were not visited by the core evaluation team during the evaluation. In Bangladesh, two local researchers interviewed fistula clients, nurses, and staff of the FC+’s NGO partner for outreach, BRAC.

³ Funding from the States is provided in Kebbi, Sokoto, Zamfara, Kano Jigawa, Cross River, Ibadan, Kwara; three national centers supported by the FMOH, in Ebonyi, Bauchi, and Katshina; and a university hospital in Ibadan.

several states in the country, although the overlap with FC+ fistula treatment activities is in only one or two States. The USAID health officer who had oversight over MCH said that FC+ had greatly increased the emphasis on FP as part of fistula prevention compared to the predecessor project FC. Fistula treatment centers in the DRC also expressed a strong commitment to providing fistula patients with FP information and contraceptives, and even the Catholic Hospitals said that they refer patients who have an interest in FP to other facilities. The role of FP in FC+ prevention strategies in focus countries is discussed in the section on Sustainable Capacity for Fistula Prevention.

During interviews in both Kebbi and Sokoto States, the Nigerian State Health Commissioners expressed their commitment to treatment at Gesse VVF Center (Kebbi) and Mariam Abacha Hospital (Sokoto) and to prevention through investment in Antenatal Care (ANC) and Basic Emergency Obstetric Care (BEmOC) and referral to State hospitals when needed. In Kebbi State, the Commissioner said that health personnel and State MOH officials engage local religious, ethnic, and community leaders on delaying the age of marriage. In Sokoto, the Commissioner said that delaying the age of marriage is not culturally acceptable; therefore, they focus on delaying pregnancy in young women by promoting the use of FP. The Sokoto Commissioner also was featured prominently in national newspapers for his pledge to pay the bride wealth for any men who wanted to marry a fistula patient after her successful surgical repair.⁴

Niger's fistula strategy proposed a budget of approximately US\$5 million dollars per year for a five-year period from 2015 to 2020 (Wadworth nd). FC+ provided support for finalizing the 2016-2020 Niger national strategy on fistula elimination. The regional West Africa USAID Mission stated that there is less progress in non-FC+ countries in the region, such as Togo and Guinea, in developing and reaching tangible national goals on fistula.

Democratic Republic of Congo had a strategy in place from 2007-2009. The United Nations Population Fund (UNFPA) reported to the evaluation team that they are currently assisting in the development of a new strategy in DRC. The USAID Mission stated that, despite FC+'s and UNFPA's efforts and the new strategy, dependence on involvement of the national reproductive health program (*Programme National de la Santé de la Reproduction* or PNSR) has meant that there has been little progress. PNSR is overwhelmed by trying to attend to competing priorities and has limited capacity to coordinate all reproductive health activities in the country.

Currently, the FC+ Project, in partnership with UNFPA, is working with the ministries of health in Nigeria and Uganda to develop follow-on fistula strategies. Unlike the old strategy, the new strategy in Uganda will include designation of a budget. In Nigeria, in conjunction with the Federal MOH, FC+ is supporting a review of the strategy and its implementation as input into the development of the new strategy. In addition, with the help of FC+, Nigeria has just published new guidelines for catheterization during prolonged labor and for "conservative treatment," which involves catheterization for women with new fistula, within a period of up to six weeks postpartum.

FC+ has worked successfully with the government in Bangladesh to develop a Fistula Strategy. It is just being rolled out throughout the health system, but, as yet, has no clear means of funding for fistula treatment, prevention, and reintegration.

⁴ The launch of the policy was not without unintended ripples, as his initial offer of the bride wealth came with a candidate for marriage as well. The fistula client selected to receive the new husband decided to turn down the offer as she did not like the marriage prospect offered by the Commissioner.

Table 3. Services supported by Policies that Demonstrate Country Ownership in FC+ Countries

		Type of Service										
		Addresses:										
Country With FC+ support	Year	Integrated fistula into national policies	Secures budget line item	Family Planning	Reintegration	WDI	Iatrogenic	HMIS	Traumatic fistula	TA From FC/C+	Prevention	Community Engagement
Uganda	2010/11-2014/15	✓	No*	✓	✓	No	No	✓	No	✓	✓	T, R
Bangladesh	2013-2016	✓	No	✓	✓	✓-limited	✓	✓	No	✓	✓	P, T, R
DRC	2007-2009	✓	No	✓	✓	✓	No	No	✓	✓	✓	P, T, R
Niger	2015-2019	✓	✓	✓	✓	✓	No	✓	No	✓	✓	P
Nigeria	2011-2015	✓	No	✓	✓	No	No	✓	No	✓	✓	P, R

Key: FP= Family Planning; WDI= Women with Fistula Deemed Incurable; P=Prevention R=Reintegration; T=Treatment; TA= Technical Assistance.
 *This information is not available. This is not a current strategy but it is unclear if this is a future government priority.
 Table is excerpt from "National Strategies for Obstetric Fistula Prevention and Treatment". EngenderHealth, 2016.

In addition to the support provided by FC+, other USAID bilateral programs have also provided technical assistance for the development of national policies. For instance, the USAID Mission in Ethiopia reported progress on developing a national strategy to eliminate fistula by 2020 and the incorporation of fistula into the national health strategy.⁵

Sustainable Capacity for Treatment

The evaluation team defined sustainability for treatment based on the existence of an enabling environment (i.e., a national strategy), financial support for treatment, and a trained cadre of medical specialists, surgeons, and nurses, capable of responding to the needs of the majority of women with fistula.

Financing: As discussed in the last section, all countries except DRC have existing fistula strategies, although only the strategies in Nigeria and Niger are funded by national and state governments. The Nigerian Federal health budget provides funding of fistula surgery at three federal fistula centers (Ebonyi, Bauchi, and Katsina) and state funds support fistula repair at state centers in Kebbi, Kano, Sokoto, Zamfara, Jigawa, Kwara, and Cross River. In Oyo State, the Ibadan University Hospital is responsible for most fistula surgeries in the state. FC+ provides additional support with supplies and equipment.

In DRC, Uganda, and Bangladesh, the FC+ Project provides grants to public and private non-profit hospitals to cover fistula-related costs, including equipment and supplies, costs of feeding and caring for patients, and stipends for medical personnel participating in pooled surgical events away from their

⁵ Information provided via response to USAID Mission survey conducted as part of the FC+ evaluation.

home health facilities. In all countries, salaries are covered by the national, state / provincial or district governments for public services, and by the non-profit organizations, in the case of not-for-profit private hospitals (Bangladesh) or faith-based hospitals (DRC, Niger, and Uganda).

Country ownership in a Non-FC+ Country – Ethiopia

In early 2014, the Federal Ministry of Health established a dedicated Task Force to support the development and implementation of a national strategy to eliminate obstetric fistula (OF) by 2020. The ambitious strategy, launched in July 2014, with complementary pillars of prevention, identification, treatment, and rehabilitation/reintegration, is being implemented jointly by the government and development partners. In the two years since its launch, OF has been prioritized at all levels of the MOH and momentum for prevention, identification, and referral for treatment has grown. With significant technical and financial support provided by USAID-funded partners (Pathfinder Ethiopia, and John Snow Inc.), OF was included for the first time in the country's latest Health Strategy (2015), which offers a strong reporting and accountability framework. It was also included in this year's Demographic and Health Survey (DHS) and it is planned to include OF in the next revision of the HMIS in 2017.

Despite the similarity in FC+ grants to faith-based and private non-profit hospitals, interviews with surgeons revealed that the faith-based hospitals in DRC and Uganda were in a better position to weather cuts in external resources should they occur than the private hospitals in Bangladesh. Two surgeons working at faith-based facilities (St. Joseph in Kinshasa and HEAL Africa in eastern DRC) felt that they had an added layer – a buffer of support – through their connections to the Church, and that, if project support were to completely end from FC+, they could and would continue fistula repair at some level. In DRC, according to the USAID Mission, 70% of all healthcare delivered comes via faith-based facilities.

In Bangladesh, the healthcare system seems much more based upon the private sector (both for profit and non-profit), with private clinics, hospitals, and even medical schools forming the bedrock of the system. There are 58 private medical colleges in the country, and 30 run by the government.⁶ Within the FC+ project in Bangladesh, both of the Ad-din Hospitals, Kumudini Hospital, and MAMM's Institute, privately owned, and LAMB Hospital are faith-based. The only government supported hospital is Bangabandhu Sheikh Mujib Medical University (BSMMU), which is one of Bangladesh's most prominent medical research and teaching hospitals.

Communities of Practice (COP): To build technical capacity, FC+, like its predecessor FC, has provided training in different types of surgical skills, infections control, biosecurity and waste management, and counseling. In FC+, however, surgeons in Nigeria and DRC also remarked on the value of project efforts to network surgeons and in national and international COPs. Surgeons interviewed for the evaluation stated that their participation in COPs had improved skills, morale, sharing of best practice, and increased their comfort with referring clients to other surgeons when needed. Two surgeons commented that participation in a COP was “the best thing” about FC+.

⁶ . List of medical colleges in Bangladesh – Wikipedia [cited 2016 Sep 14]. Available from: https://en.wikipedia.org/wiki/List_of_medical_colleges_in_Bangladesh

Standards for competence and currency⁷ in fistula repair were a recurrent issue: A common complaint voiced in the interviews by fistula surgeons who are non-specialists was that there are no clear standards of practice or career path for them. One Nigerian doctor explained that it is impossible to recruit a doctor for fistula repair as fistula is not promoted as a specialty and therefore medical officers who work as fistula surgeons cannot be promoted in the system, no matter how many years of experience they have. The doctor interviewed stated that he trained two surgeons and two nurses, and only one nurse is still at the facility. His own training to take on more complex cases is limited by the lack of a training program that leads to certification. In spite of the hopes of fistula surgeons and funders, there are still no universally recognized standards for competence in fistula surgery. Neither the International Society of Obstetric Fistula Surgeons (ISOFS) nor the International Federation of Gynecology and Obstetrics (FIGO) have maintained such standards. Although FIGO has developed a competency-based training curriculum, they do not certify competence for individual surgeons. The certificate states merely that the six-week course was completed.⁸

Specialty certification is seen by national surgeons as a *sine qua non* for professional advancement. In Africa and Southwest Asia, the goal of medical training is to reach “Consultant” status, and then, with time, to become a “Senior Consultant.” Job security, compensation, and professional standing are based on this system. For those surgeons who have completed specialty training (Residency or Fellowship) in gynecology or some other surgical discipline, there is a clear path for professional advancement within their basic specialty. But for a significant number of doctors (such as those at project sites in Birnin Kebbi and Sokoto, Nigeria), the surgeons began as medical school graduates, then certified as Medical Officers, and were trained on-the-job in fistula surgery with little potential for advancement. They find themselves in perpetual limbo as they are not eligible for advancement because there is no official way to certify as fistula surgeons through an academic institution, national or international profession association, or by the government. A quite experienced doctor who rated himself as only advanced and not expert, stated that especially in parts of northern Nigeria, the biggest challenge is “recognition of the certificate for the labor in academic career.” He continued to state that “doctors are not at all likely to stay as this [Bauchi] is a difficult place to begin with and there is no hope for advancement with the lack of certification.”

This issue was at the forefront of the evaluation team’s discussions with surgeons at all the sites and is a serious threat to keeping trained surgeons on staff at fistula centers, especially outside of large urban centers. During interviews, these surgeons characterized their jobs as professional dead-ends, where they are perpetually treated and compensated as junior physicians. One of them, formerly on the Birnin Kebbi staff, has done more than 5,000 repairs in his long career, but is still considered junior to those with any specialty certification.

The lack of certification affects the sustainability of treatment capacity and prevents the provision of routine services appropriate for all women with fistula, as the routine services are limited to treating fistula that appear to be uncomplicated at diagnosis, forcing other women to wait until there is room in a camp. Lack of certification also affects the quality of care.

⁷ Currency refers to how often a surgeon must perform fistula repair to maintain skills.

⁸ Illustrator Template—FIGO_Global_Competency-Based_Fistula_Surgery_Training_Manual_0.pdf [Internet]. [cited 2016 Sep 13]. Available from: http://www.figo.org/sites/default/files/uploads/wg-publications/fistula/FIGO_Global_Competency-Based_Fistula_Surgery_Training_Manual_0.pdf

“Very little training is done at camps, as the visiting surgeons view camps as an opportunity to reduce case backlog, and not as a training event. One surgeon even tells the younger doctors not to ask questions, as he finds this distracting as he operates.” (Fistula surgeon in northern Nigeria).

Quality of Care and Professional Standards: Supportive supervision of and accountability for fistula surgeons is an emerging issue now that there is a worldwide recognition of a crisis in the growing incidence of iatrogenic fistula (Raassen, Ngongo, Mahendeka 2014). FC+ is in the process of developing a database in Uganda to collect clinical data on individuals as a pilot, to better track quality of care. This is motivated in part by anecdotal reports by surgeons interviewed in all four countries visited of an increase in the number and proportion of iatrogenic fistula and failed repairs, especially but not exclusively in Bangladesh, where the C-section and hysterectomy rates are high. Other countries also report an increase in the proportion of iatrogenic fistula, and a non-related but worrisome trend of women with incurable fistula after multiple repair attempts continuing to seek and find surgeons to perform additional surgeries even when there is little chance of a positive outcome. Surgeons interviewed all agreed that the proportion of iatrogenic fistula is rapidly increasing among the patients presenting for care. There were varied estimates of the prevalence of iatrogenic fistula. One doctor in Nigeria estimated it to be as high as 40%, while another estimated it was only 1%. Most estimated a prevalence at 5-20% of new cases in Nigeria. They also all acknowledged that most women with fistula of over one year’s duration generally have endured multiple failed attempts at repair. FC+ monitors 29 sites across the five countries, where during the first half of year 2015-2016, an average of 16.6% of fistula cases were identified as iatrogenic. Notably higher percentages of fistula cases in Bangladesh (33.3%) and DRC (20.2 %) were identified as iatrogenic (FC+ Semi-Annual Report May 2016: 35).

Clinical quality of care has been a primary focus of the FC+ Director in response to increases in iatrogenic fistula and women subjected to multiple unsuccessful surgeries. Three surgeons independently mentioned in their interviews that they felt that the Project Director had brought new attention and energy to the area of quality of clinical care, and that they could see positive impact on the outcomes in their work.

In general, the evaluation team found the state of overall professional standards to be relatively low. Nurses interviewed for the evaluation spoke of the lack of a regular presence of some surgeons on the ward to manage post-operative issues. At only one of the hospitals visited (a faith-based hospital in Uganda) did the nurses say that surgeons make daily rounds during the two-week post-surgery period. Doctors did not make daily rounds, and nurses sat in a corner of the ward observing patients from afar. In one hospital in Nigeria, the surgeon said that the nurses did not even check on patients periodically during the day; instead, both doctors and nurses practiced what he called “autopilot post-op care.” Doctors saw their patients once post-operatively and by the second post-op day, nurses handed out bottles of medicine to the fistula patients with oral instructions on when to take their medications during the day and night. This general lack of accountability for patient care was confirmed by nurses’ responses to the survey question, “Are there consequences for a job poorly done?” In both Nigeria and Bangladesh, the majority of nurses stated that there are no consequences for them for poor performance, even though they said they are supervised.

In most facilities visited, a review of clinical record-keeping demonstrated that this practice was inadequate. Doctors are not routinely involved in obtaining informed consent for surgery, deferring to the nurses for this task. All of the surgeons surveyed saw issues like informed consent for surgery (considered a surgeon’s responsibility in Western medicine) as something for nurses to do. At an earlier

visit to one of the hospitals, one evaluator was told that the head of nursing was not a nurse and that her duties consisted of timekeeping.

Surgeons were open and forthcoming in discussions of success rates (defined as a closed fistula with no residual incontinence at discharge). The entire community is aware that there are still no universally agreed upon descriptors of success in fistula repair. Universally in surgeon interviews, the issue of incontinence after fistula repair was listed as the most common and the most vexing of challenges to a dry patient at discharge after repair.⁹

Prolapse Treatment: There has been a good deal of confusion about the roll-out of support for treatment of prolapse by FC+. Most partners understand the plus in FC+ refers to offering services for prolapse. In some facilities in some countries, prolapse surgery is already offered to women who would benefit from it, even though the actual roll-out by the project has not yet occurred. Most providers interviewed were not clear how prolapse would be integrated or developed in parallel to fistula services.

a) Sustainable Capacity for Detection

All of the providers interviewed stated that with the detection measures they had in place, patient recruitment generated a consistent flow of clients for scheduled pooled efforts and routine care, where offered. Review of quarterly reports showed that some sites had a relatively slow period at the beginning of the project (that was attributed to the delays in the transition from FC to FC+). But at the midpoint of the project, planned detection numbers of fistula repairs are being met, although planned repairs lag slightly behind expectations for completion.

In some cases, detection was being done by partner NGOs or community-based organizations (CBOs) (such as in Kebbi and Sokoto states in Nigeria, where small CBOs were partnered with ward-level state government [the ward is the smallest administrative division in Nigeria's governmental structure]). In Bangladesh, FC+ partner BRAC plays an important role in identifying women for fistula surgery and providing adequate knowledge and social support to ensure women get the services they need once identified, such as transport and reassurance that the surgery is free of cost, including food during their hospitalization. In others, such as Panzi in the DRC, the hospital is home base for outreach in the catchment area. In Uganda, community health workers do much of the outreach and local midwives and doctors do an initial screening in some places.

Sites with faith-based affiliations, like St. Joseph's in Kinshasa, had the advantage of a ready-made detection network through the community-based health services of the Catholic Church.

Communication networks have improved and been diversified in FC+. While FC relied heavily on mass media, FC+ has combined mass media with other more local outreach activities. FC+ has been able to build on and successfully broaden on pilot initiatives in FC, such as work with religious and indigenous leaders to deliver key messages to their congregants and constituents, and more effective outreach via local NGOs and community health workers. A major change has been greater education of community-based healthcare providers. Many of the fistula clients interviewed in Nigeria said that they had been

⁹ Surgeons define success by a woman's fistula being closed and without any incontinence. Many women who are initially dry at discharge develop residual incontinence after leaving the hospital, even when the fistula remains closed. Although women return for checkups at three to six months, once her repair is registered as closed and dry at discharge, the record is not corrected. Therefore, the rates of "success" at discharge do not accurately reflect longer term outcomes.

referred by their local healthcare center. Where they exist and are willing, former fistula clients are also active as fistula champions and provide “testimonies” about their experience of successful treatment.

Although women with fistula still experience a great deal of stigma and discrimination, their isolation seems to have decreased slightly, resulting in earlier detection and treatment. All the providers interviewed reported that, in contrast to perhaps a decade ago, the majority of fistula cases were “new,” meaning that the time between initial injury and presentation for treatment was, on average in the opinion of the surgeons, one year or less. In interviews, providers attributed earlier detection to greater awareness about fistula on the part of other healthcare providers, who are more likely to refer women after delivery, and to a greater awareness among the population that fistula can be surgically repaired.

Interestingly, providers also ubiquitously reported that they had very little patient backlog. It might take two weeks for an individual woman to receive her repair, but generally, this time was spent in programmed preoperative activities, including screening, assessing, and enhancing fitness for anesthesia and surgery, and teaching patients about their upcoming treatment and hospitalization. Delays now appear to be due to availability of more experienced surgeons to treat complicated fistula and occasional disproportionate demand for a particular pooled effort or camp, but almost all women in those circumstances are rescheduled within a month or two.

USAID Mission staff were less sanguine on reporting elimination of backlog. In Uganda, for instance, they said that they believe there is still a big backlog of cases, with new cases occurring all the time. They pointed out that in FC+ intervention areas of the country FC+ support has greatly contributed to the reduction in backlog. In other areas, however, there is a backlog. There are currently two centers that offer routine care, of which one, Hoima, only offers routine services when its surgeon is not participating in camps elsewhere. Consequently, the model is not yet sustainable at the national level. In Nigeria, the MOH prioritized getting accurate numbers of prevalence and incidence. They wanted to conduct a national/household level survey, but ran out of money after conducting the survey in one State because of the size of the sample necessary to detect fistula cases. In Bangladesh, the Mission was successful in getting questions on fistula included in the Bangladesh 2016 Maternal Mortality Survey (BMMS), with the expectation of generating more accurate estimates for prevalence of fistula and pelvic organ prolapse.

b) Sustainable Capacity for Fistula Prevention

Attention to prevention varied from country to country, with the highest level and broadest approach to prevention evident in Uganda, and the least evident in Bangladesh. Prevention interventions include strengthening capacity and quality of service delivery for family planning to prevent unintended pregnancy, use of partograph and cesarean section to identify and respond to prolonged obstructed labor, and elective cesarean section for delivery of babies post-fistula repair, and other safe surgeries (such as hysterectomy) to prevent iatrogenic fistula.

Family planning continues to be an important prevention strategy supported by FC+.

Table 4. Family Planning Counseling and CYPs Supported by FC+

	FY13/14 Actual	FY14/15 Actual	FY15/16 Planned	FY15/16 To Date (5/2016)
Number of family planning counseling sessions provided	38,373	149,610	204, 532	182,030
Number of CYP provided	40,039	107,986	153,261	103,052

As indicated in Table 4, both counseling sessions and Couple Years of Protection (CYPs) supported by FC+ have increased each year of the project. Because of an increase in the uptake of long-acting methods, CYPs have surpassed the number projected for FY2015-FY2016 even before the end of the year. The number of planned counseling sessions for FY2015-FY2016 also appears to be on track to meet or surpass the number of planned sessions. The evaluation team met with family planning counselors in Nigeria and Uganda. In Nigeria, the team found some concerns about quality in both sites. In one site there appeared to be lack of attention to basic cleanliness and sanitation. At another site, the counselor expressed views that ran contrary to supporting clients in making an informed choice of method. In Uganda, the team interviewed one FP counselor at the hospital's FP clinic and spoke to fistula ward nurses about FP. The counselor demonstrated her knowledge of different methods and answered questions knowledgeably in line with standard protocols. The nurses on the ward in Sokoto Nigeria and Hoima, Uganda expressed their satisfaction in being able to communicate information about FP on the fistula ward through group sessions with clients, but rely on the FP counselors at the FP clinic to provide detailed information about FP methods to women. One issue that FC+ has not overcome, especially in northern Nigeria, is how to convince hospitals to allow women to leave with a method of their choice at discharge following fistula repair. Almost all hospitals require women to wait for getting their chosen method when they return for a follow-up visit three to six months after discharge. The rationale is that women do not return to live with their husbands until after they have spent six months healing at the home of another close relative, usually at their parents' homes. While this may be a norm, it is not based on evidence that demonstrates that all women are isolated from their partners for six months.

In Uganda, the FC+ Team has supported extensive training on the use of the **partograph** for nurses and midwives. Most nurses and doctors interviewed stated there were many excuses given by trained personnel for why they did not use the partograph. When interviewed about why midwives who have been trained don't use the partograph, local health authorities replied that they lack fully developed skills, perceive it to take too much time away from paying attention to the woman in labor, and because they are not held accountable for its use. In a visit to Buraru, the evaluation team members spoke with a midwife who is a committed user of the partograph. She showed us fully completed partographs for the last month and used it during two births that occurred the day of the team's visit. The doctor at this level 3 health center, staffed by a doctor, nurse, and midwife, was also extremely supportive of the midwife's use of the partograph and both he and the midwife said it was essential for guiding their decisions about when to refer women to level 4 health centers where C-sections can be performed.

Elective **C-Sections** are recommended for safe delivery for women who decided to become pregnant after undergoing fistula surgery. To help women avoid risking a subsequent fistula in their delivery, many fistula centers are encouraging fistula clients to return to the centers where they underwent fistula repair surgery to have an elective C-section. A safe C-section is one of the elements of preventive care supported by FC+.¹⁰ Fistula centers and hospitals in both Nigeria and Uganda offer free elective C-section operations to all former fistula clients. The evaluation team saw evidence of women returning

¹⁰ "To assess the quality of labor monitoring and management of prolonged/obstructed labor, FC+ conducts partograph reviews annually at facilities that receive FC+ support for labor and delivery care. When possible, reviews are also conducted at facilities where FC+ plans to provide such support during the life of the project, even if the support is not currently being provided. Such support may include training, supervision or other inputs related to emergency obstetric care (EmOC), Basic Emergency Obstetric Care (BEmOC), partograph/labor monitoring, and C-section. Support may also include provision of supplies, equipment and/or expendables, through a formal agreement, for labor and delivery services as well as improving infrastructure and/or systems (i.e. data capture, supervision, monitoring) (FC+ May 2016: 31)."

for C-sections at Mariam Abacha Hospital in Sokoto, Gesse Fistula Center in Kebbi, Nigeria and at Kitovu Hospital in Makasa, Uganda. These hospitals also provided free transportation and food for women while waiting for their scheduled C-sections. The Gesse Fistula Center in Kebbi, Nigeria, offered elective C-sections to former fistula clients even though they do not offer routine delivery services, as the facility is a free-standing fistula center, which, by definition, is established for fistula repair only. One potential concern is that as a result of not having maternal and neonatal care, they lack the basic infrastructure and training on emergency newborn care. Newborn complications must be referred to the District hospital.

Nevertheless, both Gesse Fistula Center in Kebbi, Nigeria, and Kitovu Hospital in Masaka, Uganda had a very positive response from former fistula surgical clients who returned to have their babies at the hospitals where they had been repaired. Both centers reimbursed women for transport when they returned and gave them a “newborn package,” with supplies for the mother and newborn. Nurses and doctors indicated that women return because of their trust of the staff where they had their fistula surgery.

Although the programs are relatively new and face challenges, several countries (some states in Nigeria, Niger, Uganda) are trying to offer free C-sections to all women. The lack of a fee for the operation, however, does not address other financial constraints, such as the cost of transport, consumables, and other associated costs for the woman and the person who accompanies her to the facility, who may also have opportunity costs from forgoing days of work, and costs for child care for older children. It is not clear how widely it is known that C-sections are free for all women and whether increased knowledge of the free service will have an impact on making the decision to go to the hospital.

The evaluation team saw evidence of strong collaborative relationships among FC+ offices, fistula sites, federal, state, and local governments, and local champions, such as clergy, local NGOs (Nigeria) and Village Health Workers (Uganda) that are important for increasing the effectiveness and sustainability of prevention efforts. For instance, in Sokoto and Kebbi States, the State Ministries of Health had launched aggressive community outreach programs to encourage use of antenatal care (ANC), FP, and delivery by a skilled provider. The two states are investing federal funds they have received in basic emergency obstetric care (BEmOC) centers and to strengthen comprehensive emergency obstetric care (CEmOC) services. While the team was in Nigeria, there was at least one article on “fistula prevention” efforts in Sokoto by the State Ministry of Health in a major newspaper each day.

FC+ has begun to focus on **safe surgery**, in particular by offering capacity-building in obstetric surgery, such as C-sections, and hysterectomies, to address increasing rates of iatrogenic fistula; this is across all countries, but especially in Bangladesh, where levels are estimated as high – causing 30% of all fistula – due to a very high rate of C-sections and hysterectomies.

Nurses and administrators at the health facilities visited by the evaluation team confirmed that fistula clients are educated about FP during the time on the ward. Most also have the opportunity to go for individual counseling before they are discharged. However, in Nigeria, women do not have the option to take a method with them at discharge. The nurses say that at discharge, all women go to stay with their natal families away from their partners. Messaging to patients on family planning seemed to occur at nearly all sites at the patient’s three-month, follow-up visit after repair.

Most providers felt that there were no viable pathways in their geographic areas for referral from a lower level of emergency obstetric service to a higher one. Often women or families are simply given a referral letter and the well wishes of the referring doctor, without other active participation on the part of the referring facility. In Nigeria, there were new state-government initiatives to increase the number

of ambulances, but the logistic channels to get the ambulance to the patient, and the patient quickly to the operating room, do not seem to be adequately addressed by state governments.

Information is lacking to adequately assess if referral systems, and more generally, access to CEmOC, are adequate. While reporting of deaths is in place in some form at all sites on a yearly basis, none of the providers interviewed were aware of any formal reporting to government for “near miss” events in obstetrics, especially formation of fistula. As fistula can be seen as a marker of failure of provision of CEmOC, reporting and evaluation of these events is central to developing and improving CEmOC.

c) Sustainable Capacity for Reintegration

While FC funded a number of local organizations to provide reintegration services for women post-surgery, FC+ focuses on improving the enabling environment, particularly in reducing stigma and discrimination of girls and women living with fistula and post-repair. The mandate of FC+ on reintegration is:

“For reintegration, FC+ will assist facilities, NGOs, and MOHs to link with (i) poverty eradication, literacy, and numeracy programs and with (ii) community development organizations (CDOs) to support education, skills, and microfinance opportunities for women, and consider establishing networks for WDI and women with TF for more intensive social and economic support. FC+ will also facilitate engagement with private-sector entities to support access to prevention, treatment, or reintegration, as appropriate in each setting (FC+ Cooperative Agreement 2013:20).”

There is little indication of a strategic approach to reintegration by FC+. The Project’s involvement in reintegration is focused principally on guiding operations research conducted by Terrewode, an FC+ resource partner. The research in Uganda will test screening tools and individualized rights-based reintegration strategies for women living with incurable fistula. Although focused on women with incurable fistula, the Terrewode research has the potential to test screening tools that will generate information upon which to design evidence-based reintegration programming that better serves the needs of women with the least options for returning to a social and economic support system.

In Uganda currently, women who go to the government hospital in Hoima have little support or counseling to help them with economic or psychosocial support once they leave the hospital. At the Catholic Church-run Kitovu Hospital in Masaka, fistula patients receive support in the form of handicraft classes and in-kind gifts from donors that support the hospital. It is not evident whether these services meet the different needs of women, although they said that they enjoyed having something to do while healing.

In Nigeria, reintegration of women who have undergone fistula treatment is the governmental responsibility of the Federal and State Ministries of Women’s Affairs and Social Development (MWAS). In Kebbi State, the Permanent Secretary of MWAS informed the evaluation team that there are no decrees or policies at the state level to mandate or support reintegration services. She said her staff do what they can to provide minimal social services to women with fistula while they wait for surgery, such as learning skills to make them financially self-reliant or some minimal counseling to re-establish their self-esteem. The Kebbi State Commissioner of Health stated that the two ministries (MOH and MWAS) share responsibility for management of fistula, but that they lack a partner comparable to FC+ for rehabilitation. The Kebbi State Secretary of Women’s Affairs indicated that they provide some minimal services related to training on income-generation skills. She said many women who have lived with fistula for many years are in need of psychosocial support but her Ministry has very little funding for

providing such support. For the most part there is little differentiation of services so that all women receive the same types of services regardless of their need. It is unclear how useful the skills are for earning a living. In Sokoto State, the Commissioner of Health offered to pay the bride wealth payment for any man who agreed to marry a woman who had successfully undergone fistula repair. As of the time of the interview, only one man had sought the payment. The fistula client he wanted to marry rejected his offer of marriage, saying that she was not interested in marrying him and thought she could find a better partner.

In the DRC, the Panzi Foundation reported having the most developed reintegration services, which are primarily supported by private funds raised by the Panzi Foundation. Reintegration programming at the hospital pre-dated the FC+ program. Panzi's Foundation has been financed through long-term and committed relationships with outside funders. The Panzi Foundation provides survivors with 12 months of training that includes literacy and numeracy, job skills training, micro-grants, and loans to support the women in launching micro-enterprises, and outreach to rural communities to help women transition back into communities post-repair.

In Bangladesh, there was no evidence of reintegration services in the hospitals visited by the local researcher who interviewed patients and nurses at five non-profit private hospitals.

The only real evidence of employment for women supported by reintegration services that the team could verify was for a few women in both Nigeria and Uganda who were hired by the hospitals when they had no home to return to and their fistula was deemed inoperable.¹¹

Quality of Care from the Clients' Perspective

During the course of the fieldwork for the evaluation, the team asked fistula patients about the quality of care. Virtually all women interviewed said they were extremely grateful to have access to surgery, but their satisfaction – whether recently operated on or about to be discharged – hinged on the outcome of their surgery. Their answers about their ability to ask questions and get satisfactory answers was influenced by the context of being interviewed in the hospital and their subordinate structural position in their communities and in the hospital, where they are perceived as victims rather than active agents in their care. Most women living with fistula have experienced considerable trauma and social marginalization before making their way to the hospital, and many live in societies with highly unequal gender relations. As a result, all said that they were able to ask questions, even though the questions, according to the women and confirmed by the nurses, mostly concern whether or not the surgery will heal their fistula. In line with the findings of a recent study of early marriage among fistula patients in Sokoto, Nigeria (Claghan, Gambo, and Fellin 2015), women interviewed for the evaluation rarely demand much more of their physicians than to know whether they will be healed. In response to the question: “What questions did you want to ask during the screening,” they said:

“I didn't have any questions at all, just wanted to be healed.” (Woman at St Joseph's Hospital in DRC)

“Can I ever recover from fistula? And the doctor answered that by God's willing, I can recover and that I shouldn't worry about food or a fee.” (Woman in Kebbi, Nigeria)

¹¹ At the time of writing the evaluation report, the evaluation team was told that the Uganda MOH now has a minimum standard of care for reintegration in its new policy. The new policy was not available while the team was in Uganda to review the standards.

But when asked if there were any questions the nurses were unable to answer, she said “*Why is it that patients live with fistula for ten years or more?*” She said she received the following answer: “*We have faith in God. But the patient has had a series of repairs and says she has fears.*”

Others said they did not ask questions because their knowledge is limited; therefore, asking questions was not necessary.

All the women said that they were allowed to bring their partner to counseling, but few actually had their partners present during consultations and exams. Interviews of women in the facilities immediately post-repair indicate they are satisfied, but strongly tied to outcomes of their surgery. No routine formal assessment of patient satisfaction is ongoing at any of the FC+ sites during hospitalization, at discharge, or during follow-up visits at three or six months.

After surgery, many women experience the hospital as a place of acceptance and freedom, especially after having experienced stigma and discrimination while living with fistula in their communities. Their satisfaction seems linked to this freedom from stigma, receiving free food, and camaraderie with other patients, but ultimately satisfaction appears to be tied directly to results of the surgery, in particular for women who have had previous unsuccessful repairs. Overall, in DRC, Nigeria, and Bangladesh, women say their experience in the hospital is a positive one.

Question 2: What contributions has Fistula Care Plus made to global leadership, to advancing research and innovation, and to transferring new technologies to the field (emphasis on Objectives 3 & 5)?

a) Quality of Care and Safe Surgery

The previous section on treatment discussed two aspects of care that have a direct impact on quality of care, the lack of standards for competency and currency (i.e., having conducted a sufficient number of surgeries within a period of time to maintain skills) in fistula repair, and the increase in the proportion of iatrogenic fistula.

FC+ has implemented a policy to track “sentinel events,” such that the hospital leadership, FC+ country staff, and even FC+ New York staff are notified within 24 hours of any serious complication or patient death. This process is driven out of New York rather than established as routine local practice. In the instance of a recent death in Nigeria, the FC+ Director immediately flew to investigate (i.e., to conduct an audit). While this action led to a useful inquiry, it did not produce local or national actions to institute a sentinel event process that isn’t driven from New York.

b) Research

The type of randomized control trial (RCT) research conducted under FC has not been replicated or planned under FC+, according to the AOR and Project Director, because of a preference for more localized clinical and operations research. FC played an important leadership role in conducting the RCT on duration of catheterization following simple fistula repair and created expectations for follow-on leadership for additional fistula-related research of the same rigor and caliber. In personal communications with FC’s RCT partners at the World Health Organization (WHO), they told the evaluation team that they had not seen a multi-center clinical trial with such clean, quality data. Since study design had begun with much skepticism about doing clinical research in the very resource-challenged areas where FC+ centers function, they were happy that the precedent that research was “do-able” had been set through the hard work of FC staff. The data made a clear statement that should

eventually lead to reduced hospital stays for fistula patients and reduced cost per case. FC+ has requested that WHO conduct an expedited desk review of the RCT to put out the guidelines this year. FC+ will conduct a survey on the RCT to assess adoption of its recommendations. Nevertheless, they understand that clinical research is time- and resource-intensive, and most likely not possible with current funding levels of FC+. As an alternative to conducting multi-country clinical RCTs, FC+ will support more local level clinical research.

FC+ has developed a portfolio of non-clinical operations research related to fistula prevention and reintegration. Population Council, an FC+ sub-awardee, conducted formative research on barriers to accessing care for fistula in Uganda and Nigeria. As a result of the formative research, they identified transport, communications, and financial barriers as critical obstacles to seeking care. Operations are currently underway to test “whether a comprehensive information, screening, and referral intervention can reduce transportation, communications, and financial barriers to accessing preventive care, detection, and treatment. Specific objectives are:

- To develop and deploy a mobile phone-based screening service that women can access to learn about fistula and become aware of their fistula status.
- To develop and validate an index that scores the severity of a respondent’s barriers to accessing fistula treatment.
- To increase provider ability to diagnose fistula and to promote efficient referral to fistula repair centers.
- To develop a transportation voucher system to reduce barriers to reaching fistula repair centers.¹²

It is too early in the research to assess its value, but the research promises to provide insights into potential interventions to address critical obstacles to fistula prevention and detection. In addition, Terrewode, an FC+ resource partner, has designed research to test individualized approaches to social and economic reintegration of women living with fistula deemed incurable in Uganda. The hypothesis is that to be successful, reintegration strategies must be tailored to the diverse but specific needs of different women post-operatively, or when surgical intervention, under existing surgical knowledge and skills, is not a viable response for women who have already undergone multiple surgeries without being able to close the fistula and remedy incontinence. One approach does not fit all. The research protocol was reviewed and approved by the Institutional Review Board at Makerere University in Uganda. As of mid-September, Terrewode was still waiting for approval from the President’s Office.

Question 3: There have been several management (staffing and structural) changes within the FC+ team at EH since the start of the project (all three key personnel have changed over time). How has this changed the technical direction and management of the program? Issue: Project responsiveness to USAID Missions, USAID regional bureaus, host country governments and other global stakeholders?

This question asks the evaluation team to both assess change in the technical and management direction of the project, as well as to gauge the responsiveness of the project to its stakeholders. This section first examines perceptions related to changes in direction and leadership, and secondly, assesses the responsiveness of project to USAID and local and national governments.

¹² From Protocol for Reducing barriers to care seeking for fistula repair in Uganda. Submitted to the Institutional Review Boards at Population Council and Makerere University June 2016.

Impact of Changes in Management and Staffing on Partners

There were major leadership and staffing changes in both the global office in New York and in some of the country teams in the transition from FC to FC+. Changes in leadership – the Director and Deputy Director – signified changes in focus and energy in some dimensions of the project at the same time they provided remarkably smooth continuity in others. The staff in FC+ Country Offices visited during the evaluation stated that the transition from FC to FC+ had been by and large without significant disruption, continuing support for treatment, detection, and prevention, while enhancing leadership for quality of care and data for decision-making through strengthened M&E and operations research. In Nigeria, although the Country Director changed, the deputy remained the same. Other key members of the staff also remained in place.

At the country level, all teams experienced some turnover of staff. Several governments experienced this as a gap in support from USAID to EngenderHealth at the beginning of FC+ which caused a delay of several months. In some countries, the delay resulted in dismissal of staff, delay in making subawards, and a decrease in fistula repairs. Once the funds were available, the country programs were able to reinstate activities and the project quickly ramped up to provide strong support.

Implementing organizations and staff at both public and nonprofit hospitals and fistula centers, with few exceptions, said they had experienced no adverse consequences from the transition in local or global leadership. To the contrary, most surgeons interviewed for the evaluation voiced their appreciation for greater focus on data, safety, and quality of care promoted by the FC+ Director through the community of practice. One surgeon in DRC said that he thinks FC+ is an improvement over FC as there is a clearer delineation of specific goals. He greatly appreciates the community of practice. Three other doctors interviewed in the DRC also commented on the value of the COP.

There are several new initiatives in M&E led by the FC+ Deputy Director that promise to contribute to increased knowledge about the population of women seeking care for fistula, prolapse, and other forms of incontinence. These include development of an electronic platform in Uganda to upload patients' electronic records, with clinical data on the type of fistula, date of onset, and number of years living with fistula.

Host Country Governments: In Nigeria and Uganda, national, state, and district health ministers and commissioners extolled the strong support they had received and continue to receive from FC+ on a variety of issues, including the development of national strategies, celebration of national fistula day, prevention activities, equipment and supplies for treatment, and serving on national fistula coordinating bodies. National stakeholders said that they didn't experience any major changes between FC and FC+.

Global Stakeholders: Interviews with global stakeholders revealed a perception of more of a contrast between FC and FC+ than was noted at the country level. Global stakeholders stated that they heard less about FC+ than they had about FC. They said they were less aware of FC+ activities. The gist of their observations was that FC had a higher international profile on the global stage than FC+. Overall, global partners viewed the addition of prolapse to the project's objectives as a positive development as long as there is capacity within health facilities and it doesn't adversely affect fistula services. Some former FC partners do not feel part of FC+'s global community in the same way they did under FC.

Responsiveness to USAID Missions: Feedback from USAID Missions was very positive about FC+. The Missions all attested to having a collaborative and responsive relationship with the project, especially from the Country Offices. Many call on FC+ for guidance on programming beyond fistula care, such as

maternal and newborn health (MNH) and FP. There is considerable variation in how countries fund and implement fistula activities. The table below, drawn from the Mission Survey undertaken by the evaluation team, illustrates the variation:

Table 5. How is fistula programming currently funded in your country? Select all that apply (n=6)¹³

USAID Mission	USAID field support to FC+	USAID Bilateral project(s)	USAID field support to another project	Other donor funded activities	Other	If you selected USAID Bilateral project(s), USAID field support to another project, Other donor funded activities, and/or other, please list the project(s) or explain.
Uganda (Respondent=1)	X			X		Other support for fistula programming in Uganda is supported through UNFPA, AMREF, and World Vision these support fistula prevention and repair services.
Democratic Republic of the Congo (Respondent =1)	X	X				Integrated Health Program implemented by MSH (PROSANI through E2A), UNFPA program; USAID bilateral project: Integrated Health Services (IHP through E2A); USAID field support through FC+
Ethiopia (Respondents=2)		X	X	X	X	We use the Evidence 2 Action mechanism to work on fistula identification, referral, prevention, and reintegration. In FY 2017, this is being rolled into a bilateral RMNCAH mechanism also implemented by Pathfinder.
Ethiopia (Second respondent)			X	X	X	<ul style="list-style-type: none"> • E2A: Mission funding to field support for prevention, identification, referral, re-integration, coordination UNFPA funding for Treatment and Rehabilitation / Reintegration support provided by WAHA at three university hospitals. • Hamlin Fistula Hospital Ethiopia funding for treatment, raised through private donations collected by Hamlin entities in at least nine countries • Healing Hands of Joy supported by private donations raised in the US.
West Africa with Niger hub (Respondent = 1)	X			X		

¹³ Responses were received from Ethiopia, DRC, Uganda, and the West Africa Regional Office.

Additionally, Mission staff in Nigeria, Uganda, Bangladesh, and DRC provided information through group and individual interviews with staff engaged with the FC+ Project.

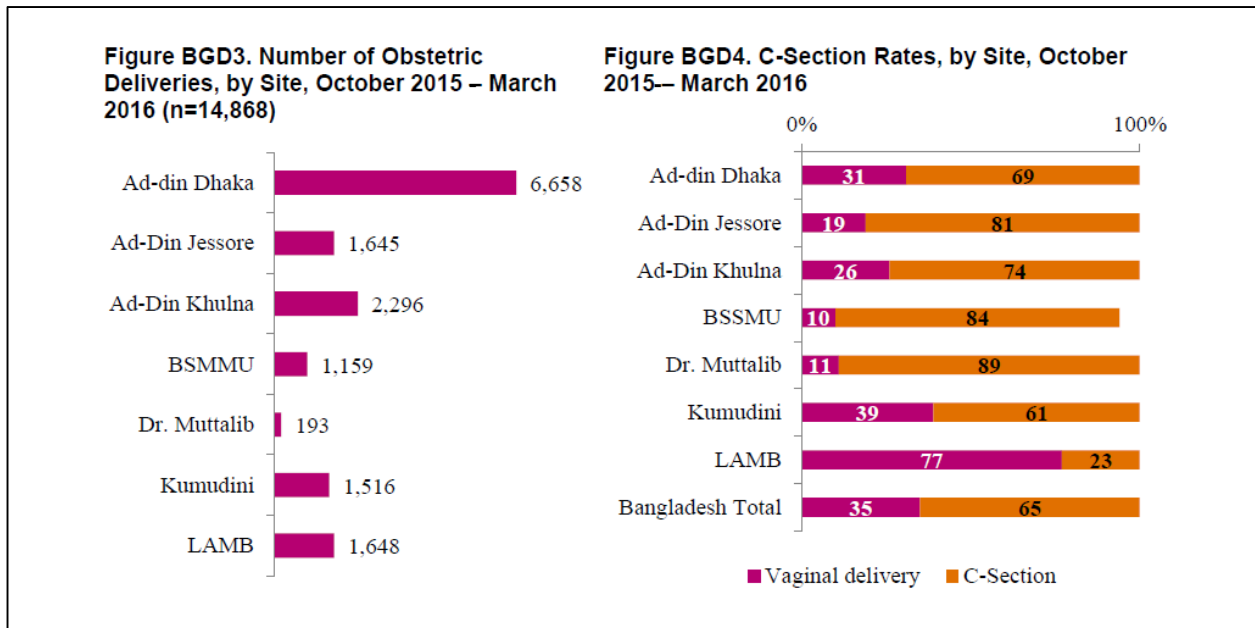
- **Nigeria:** The Mission said that FC+ works more on prevention, prolapse, and men's and community engagement than FC. They are also satisfied with FC+ expanded support to fistula repair centers throughout the country, particularly to new centers, with supplies, equipment, and training. The Mission appreciated FC+ technical guidance on advising against investing in a national prevalence census and the suggestion to identify more cost-effective approaches to assess prevalence.
- **Uganda:** The Mission has also been pleased with the type and level of support received from FC+. The Mission is moving towards integration of health programs and wants FC+ to be part of the integrated approach to maternal, newborn and child health (MNCH) under their new RHITES projects. They see system improvements in the Health System as critical to improvements in the delivery of fistula services. The new program will coordinate much more closely with Sweden, UNICEF, UNFPA, and DFID. They are interested in having FC+ be more integrated across the districts supported by the four donors.
- **DRC:** The Mission FC+ point of contact said he has a good working relationship with FC+. He stated that FC+ does not require much attention and they do their job with limited assistance, which is helpful to free up the Mission from having to hyper-focus on them. He also said FC+ has very dedicated partners who go above and beyond in their work, with very little compensation.
- **Bangladesh:** USAID/Bangladesh praised FC+ for having significantly improved outreach and detection in comparison to FC. They attributed the improvements to the collaboration with FC+ partner BRAC. FC+ also has provided good support to the hospitals providing fistula repairs. Of greatest concern is the both the rising rate of C-sections and the rise in iatrogenic fistula from C-sections and hysterectomies. Except at Lamb Hospital, C-section rates at FC+-supported hospitals are between 61% and 89%. This compares to 24% in Uganda, 32% in DRC, and 50% in Niger at FC+ facilities. Surgeons estimate the rate of iatrogenic fistula to be around

USAID/ DRC Assessment of Achievement of FC+ Objectives in the Country

In response to the Mission Survey, USAID/DRC responded that Objective 1 and 2 (See Table 1 of this report for Project Objectives) have not been achieved at this point in the project. Limited advances in Objective 1 are due to lack of active involvement of the National Reproductive Health Program (PNRS), which has been a challenge given the competing priorities faced by the Ministry of Health and the relative limited capacity of the PNRS to coordinate all reproductive health activities in the country. Objective 2 was partially accomplished. The Mission stated that the communication component was weak and did not allow widespread "community understanding and practices to present fistula, improve access to fistula treatment, reduce stigma, and support re-integration of women and girls with fistula." Except for the organization of World Fistula Day, the project did not have enough activities under this objective. There have been missed opportunities, such as the use of fistula champions to raise awareness, the media coverage of the annual reports, and the use of mobile technology. Objectives 3 and 4 have been well covered despite the Mission's assessment of very limited implementation of the family planning program. Nevertheless, the Mission stated that the most successful aspects of the project have been financial support to allow fistula surgery to patients and organized outreach through fistula repair campaigns in hard-to-reach locations and capacity strengthening of a new cohort of fistula surgeons. (Response to Survey sent by Evaluation Team)

33%.¹⁴ FC+ is working with other partners to improve quality of care but the Mission says there is room for improvement. They wanted FC+ to engage the National Association of Obstetricians and Gynecologists to increase quality and accountability. The Mission recognizes that FC+ does not have infinite resources and therefore prevention efforts in Bangladesh are limited. They said that there are other mechanisms that could take on prevention within the context of broader MNH programming. Currently, most MNCH projects don't take fistula into account. The Mission wants to increase FC+'s relationship and collaboration with these programs. There is also a need to engage private Ob/Gyns who perform many elective C-sections. Another area that needs strengthening is the response for women who have fistula deemed incurable.

Figure 2. C-Section Rate at FC+ Assisted Hospitals in Bangladesh¹⁵



- Niger:** The USAID Mission in Niger was not interviewed by the evaluation team but did respond to survey. In their survey responses, the Mission wrote that at country level, FC+ has supported a number of successful activities to train fistula surgeons, train community volunteers on behavior change communication (BCC), detection, and referral; support prevention and repair sites; promote the integration of FP into fistula care; and support the finalization of the 2016-2020 Niger national strategy on fistula elimination. This contrasts to significantly less progress at regional level, in West Africa more broadly. Despite experience-sharing and exchange with Togo and Guinea, the USAID Regional Mission has not made significant progress in reaching tangible West African regional goals (e.g., close engagement and collaboration with the regional body West African Health Organization (WAHO), regional exchange, experience sharing, standardization of tools, or regional strategy development for a fistula free generation in West Africa.¹⁶

¹⁴ Estimate from FC+ Semi-Annual Report March 2015-March 2016, p. 35.

¹⁵ From FC+ Semi-Annual Report March 2015 to March 2016, p. 55

¹⁶ EH, as a subawardee on the Health Service Delivery [confirm this with EngenderHealth] Project recently reinitiated fistula programming in Guinea, but this is independent of FC+. Under the FC Project, Guinea was a focus country, but has not had dedicated fistula programming since the end of FC in 2013.

Question 4: What is the evaluation team’s assessment regarding the project’s future progress (is it on track to achieve its intended objectives)?

The evaluation team reached the conclusion that FC+ is on track to meet the majority of its targets toward achieving its objectives, even though delayed start-up of the project has put them behind on some targets related to number of repairs, trainings (for healthcare providers and communities), and number of FP counseling sessions, CYP. The findings related to the project’s objectives have been discussed in the preceding sections of the report. Below is a brief review of quantitative measurements of achievements against objectives and targets. The evaluation team found that in general, the project is on track to meet, and in some areas, supersede, quantitative measures of its objectives.

Table 6. Select Benchmarks and Achievements of FC+¹⁷

	FY13/14 Actual	FY14/15 Actual	FY15/16 Planned	FY15/16 to-date
Number of countries supported by FC+	5	6	6	6
Number of sites supported by FC+ for fistula repair and prevention	25	31	35	32
Number of prevention only sites supported by FC+	16	749	790	788
Number of participants in community volunteer/educator training in tools and approaches to raise awareness regarding fistula prevention and repair	114	776	607	141
Number of community awareness-raising activities/events conducted by program partners	12	1,990	1,895	2,693
Number of participants reached through community awareness-raising events/activities conducted by partners: in-person and via mass media.	10,745	274,087 (in person) 140,000 (mass media)	306,750 (in person) (in person) 1,550,000 (mass media)	257,288 (in person) NA (mass media)
Number of fistula repairs	873	2,876	4,121	1,519
Number of participants in health systems personnel training, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex, and cadre of provider)	161	1,065	1,395	548
Number of family planning counseling sessions provided	38,373	149,610	204,532	182,030
Number of CYP provided	40,039	107,986	153,261	103,052

The sub questions related to Question 4 of the evaluation are treated in the conclusion and recommendations section of the report, where the report addresses the challenges and gaps identified in the course of the evaluation; important technical lessons learned and best practices; key initiatives, activities, and approaches that warrant additional USAID investment in the future, beyond the end of the Fistula Care Plus project; and other promising fistula program models and approaches, not addressed by Fistula Care Plus, which should be considered for future investment.

¹⁷ Table from FC+ Semi-Annual Report October 2015 to March 2016, p.22

V. CONCLUSIONS

I. COUNTRY OWNERSHIP

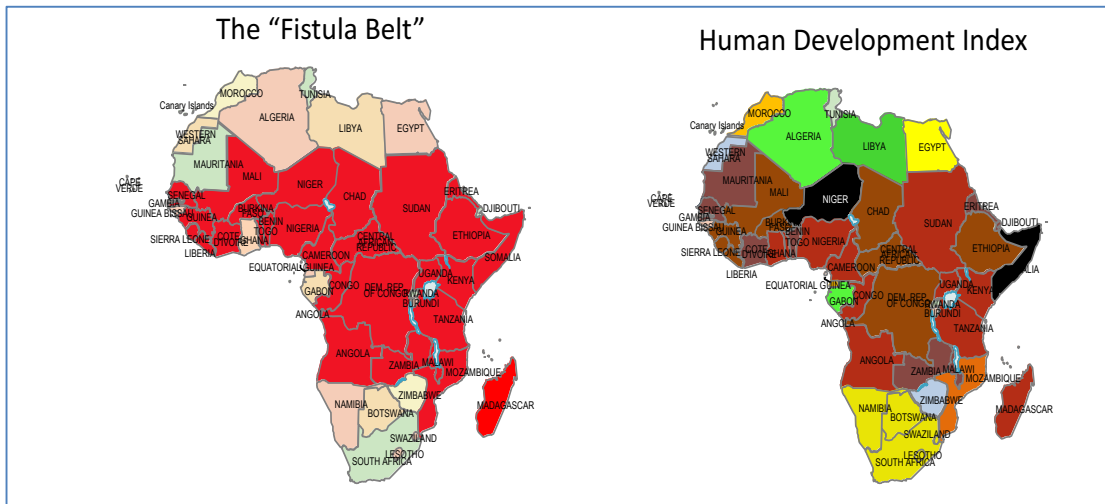
FC+ has built on predecessor projects to continue strong support to strengthening country commitments to fistula care. The evidence for country ownership is particularly strong in Nigeria, Niger, and Uganda, countries that have committed funding in support of new policy initiatives. In DRC and Bangladesh, while the governments have expressed support through policy initiatives, the private sector has provided more funding support than the public sector. The COP of fistula surgeons has also contributed to greater country ownership by building a shared body of knowledge and cooperative relationships among health personnel. Additionally, local governments in several countries have begun to commit resources and include preventative messages as part of their health outreach programs. Research supported by FC+ is also contributing to country ownership as it is testing solutions and international evidence at the local level which is more readily acceptable to governments than externally generated evidence.

FC+ is to be commended for a steady, consistent, and intentional effort to involve ministries of health and other governmental bodies in the work of both the FC and FC+ projects. This effort seems to have led to widespread buy-in in terms of national strategy and policy and in national funding for fistula care. Other fistula efforts could and should learn from this example and see that eventually this effort bears fruit on a scale that an NGO alone could never achieve.

1. EH's first efforts at networking and building a community of practice have been successful.
2. The issue of the lack of a certification pathway for fistula surgeons is one that affects all fistula programming everywhere. In discussion with EH New York and country-level staff, we know that everyone is aware of this challenge and the potential for a devastating loss of trained personnel.
3. FC+ has made a good start in a range of efforts to combat the issue of iatrogenic fistula and poor quality fistula repair. The FC+ Project Director has been a tireless advocate and active convener in this area, especially in conjunction with the WHO safe surgery initiative and the G4 Alliance.

A Disease of Poverty

Figure 3. Tracking of Fistula Incidence with the Human Development Index



Countries with significant fistula issues and activity (red) – vs UN HDI (2009 data), (darker areas have lower HDI)

Fistula is unique among public health-scale issues in that both the prevention (ultimately emergency cesarean section and FP) and the treatment (fistula repair) are surgical, and therefore dependent upon functional healthcare institutions in the very countries where the healthcare delivery systems are closest to utter collapse. And so, rather than looking for evidence that quality fistula care can sustainably be provided for free into perpetuity, we used other proxies for proof that there was local/national ownership of the issue and effort of some kind towards diminishing need for outside input of resources.

a) Sustainable Capacity for Treatment

When discussing sustainability in the context of fistula, it is important to highlight that fistula programming is inherently unsustainable in the classic sense of achieving financial self-sufficiency, either through government funding or by fee for service. Fistula is truly a marker for profound poverty. It affects the poorest women in the world's poorest countries. The bottom 15% of the countries listed in the United Nation's Human Development Index essentially map out the countries that also have the highest supposed incidence of fistula. Nevertheless, there are clear signs in all countries where FC+ has intervened of increased political and economic support for fistula treatment.

FC+ has provided encouragement and support to the Nigerian government's treatment efforts, resulting in increasing commitment to and ownership and direction of fistula care in the country. There is similar but more incipient commitment and ownership at the state and local level.

In Uganda, there are positive signs of the government increasing its financial and political commitment to fistula, particularly with the promised allocation of a budget in support of a new five-year strategy.

In Bangladesh, FC+ was successful in integrating protocols on fistula into the maternal health guidelines, but the overall commitment of the government and the professional community in Bangladesh appears to be less than observable in Nigeria and Uganda.

USAID/DRC's recognition of FC+ commitment to improving treatment in the country is notable and speaks to the renewal of the high level of project support after an unfortunate hiatus caused by a delay in startup of FC+.

Country ownership and commitment has a direct effect on a country's capacity to weather fluctuations in funding levels from donors. The impact of the delay in release of USAID funds at the beginning of FC+ was felt more acutely in DRC than Nigeria, for instance, because of the lack of government investment in fistula treatment, which in DRC is financed through the project and donations raised by faith-based hospitals. The evaluation team was not able to assess the effectiveness of the support to government services financed by the USAID Mission through the Management Sciences for Health (MSH) PROSANI (Projet de Santé Intégré) project (and continued as PROSANI Plus by MSH as a partner on the Evidence to Action project).

Increased financial sustainability at the national level appears to be more likely in government-supported and faith-based facilities than in private non-profits with more limited potential for raising funds for fistula care, especially when they depend on fee-for-service for their financial sustainability. Unless there are ways to cross-finance fistula services, it is doubtful these hospitals in Bangladesh will be able to even partially finance fistula surgery and client support during recovery. As the pathway for fistula care, a system based on private institutions seems more vulnerable and less sustainable – the death or financial misfortune of a single individual could bring down a fistula center in this model.

The enthusiasm of fistula surgeons for networking was an unexpected outcome and is a good indicator of sustainability as engaged surgeons are more likely to get professional satisfaction when their work under challenging circumstances is supported by learning and feedback from their peers.

The evaluation also identified a number of issues that warrant further attention by FC+ in the last two years of the project. These issues are discussed below.

Certification: The issue of certification hides a tremendous challenge to sustainability of fistula programs across the five FC+ nations. Nearly all of the medical officer/surgeons interviewed hinted that they were so discouraged by their lack of ability to move forward that they were not at all sure how long they could remain in their position as a fistula surgeon. This issue has been repeatedly brought to the leadership of FIGO, which refuses to take on the liability of vouching for surgeon skill, and to ISOFS, which to date has been unable to take any definitive action. FC+ leadership, along with the reviewers, is aware of this situation, and it in no way points to any deficiency in project design or implementation. However, this situation is a threat to sustainability of service delivery. The FIGO Fistula Team is under new leadership and perhaps there is an opening for a change of stance of this crucially important organization.

Surgical Skills Currency: Less commonly addressed is the issue of “currency” of fistula repair skills – how often a surgeon must perform fistula repair to maintain skills. By comparison, an airline pilot, no matter how many certificates of proficiency he or she might acquire, must document at least three take-offs and landings per month to carry passengers. There has been to date only one published standard in the 2006 “WHO Manual,” where the editors state: *“It is generally agreed that a specialist surgeon and trainer should have performed at least 300 fistula repairs before starting to train others and have an ongoing case load of more than 150 fistula repairs per year.”* (Lewis and de Bernis 2006) For instance, the number of fistula repairs in Bangladesh call into question the currency of surgeons in the country. If one follows WHO guidelines on the need to perform a minimum of 150 cases per year to maintain an expert-level in fistula surgical skills, the reported number of 300 repairs per year in Bangladesh suffices to keep only two surgeons current in surgical skills.

The issue of increasing rates of failed repairs and in iatrogenic fistula have been alarming to the entire fistula community. Certification is one arm of an overall approach to competency. There must be documentation that an individual surgeon has had a sound background in training in repair, clear standards for this training, and sufficient practice through a minimum number of 150 surgeries to remain current in fistula surgical skills. To date, no single professional or academic body has taken on the responsibility to generate and implement these standards. While the project is very focused on improving quality of care through increased and improved training, and the development of a training center for uro-gynecology, it has not addressed the issue of currency. Discussions of sustainability of fistula services focus on increasing capacity through surgeon training and increased number of facilities is the only way to approach the level of need. There are clear indications from speaking to surgeons and hospital administrators that there is no immediate need for more centers as not a single FC+ site reported a significant backlog of cases, and none reported a waiting time of over two weeks for repair. The evaluation team concludes that it is worth asking if there may be too many facilities in some areas, to the detriment of surgeons being able to treat a sufficient number of cases to remain skillful in this difficult branch of reconstructive surgery.

Increased recognition of failed surgery and the need for a better response: There is broad and increasing consensus among active fistula surgeons that women with failed surgery are making up an ever-growing proportion of overall surgical cases. Scientific data to support this contention are lacking, and for now, this “evidence” must be considered anecdotal. Are surgeons pushed through training curricula too rapidly in an effort to increase capacity for care? Are surgeons practicing in locations with too few clients for surgeons to maintain, much less improve them? For now, these questions are left to conjecture.

Increased Incidence of Iatrogenic Fistula: There is better evidence that more women are presenting for care of injuries not from obstetric origin, but from surgical error. In this category of fistula, the most common etiology is injury during cesarean section, and to a lesser extent from hysterectomies. The project has placed increased focus on quality of care, which is particularly important for addressing another issue raised by the findings of the evaluation. Based on surgeons’ perceptions, the evaluation team found indications of an increase in presentation of fistula from surgical error. In this category of fistula, the most common etiology is injury during cesarean section and hysterectomy. This new observation highlights the need to pivot to re-examine surgical training, accountability for outcomes among individual surgeons, and even government policies about who can perform Cesarean sections and hysterectomies.

In most developing countries, medical school is followed by a period of obligatory national service, where the new doctor is posted, usually to some remote site, often with no professional support and often as the only healthcare provider available to large catchment areas of local citizens. So, these medical graduates are often called upon to do C-sections with no training, under horrible conditions, and with no assistance. As the examination of outcomes for individual surgeons is simply not a part of the professional surgical culture in most countries with poorly resourced health systems, iatrogenic fistula and multiple failed repairs issue are manifestations of problems in the health system. FC+ cannot take these larger problems on unilaterally. FC+ is making a major contribution, however, through its focus on safe surgery. The FC+ Project Director has been one of the pioneers in the new international safe-surgery effort, and EH is a member of the G4 Alliance,¹⁸ a new organization trying to address safety

¹⁸ The G4 Alliance [Internet]. [cited 2016 Sep 13]. Available from: <http://www.theg4alliance.org/>

issue across the spectrum of surgery in the developing world. She is introducing new “Quality Assurance Trackers” with tools to streamline clinical M& E in supported sites, and is supporting new WHO efforts to encourage the use of surgical checklists to improve quality of care.

FC+ has implemented a policy to track “sentinel events” such that the hospital leadership, EH Country Staff, and even EH New York staff are notified within 24 hours of any serious complication or patient death. Certainly, the current level of professional standards is a contributor to the issue of failed repair and iatrogenic fistula.

The Right to Respectful Care: FC+ can do more to engage surgeons and nurses in modeling respectful care to women and protecting their rights to accurate information, autonomy in decision-making, and dignity. While many surgeons are very attuned to the best interests of women with fistula, there are indications that there is little real engagement of women as active participants in decisions about their care, particularly when they have been subjected to multiple surgeries. Sustainable care is successful care. Word of failures travels remarkably fast in the community of women living with fistula. For instance, implementation of diversion surgery for incurable fistula has ground nearly to a halt in Niger because one woman had a terrible outcome from a diversion done by visiting surgeons who left immediately after her operation. All of the women with fistula seem to have heard of this case, and to date almost none have been willing to even discuss diversion. **While this was not surgery supported by the project**, such incidents are of concern because they have the potential to limit options that may help some women, if done well.

b) Sustainable Capacity for Detection

There has been quite a bit of discussion recently in the fistula community that numbers of new clients are decreasing and that we have begun to see the end of fistula as a large-scale health issue. At least in the five countries of FC+, we found no evidence to support this premise.

It seems that multi-faceted approaches to detection have become standard operating procedure. The team did not encounter anyone who felt that the burden of designing and maintaining detection programs was too expensive or too strenuous to be practical. Each site seems to have found its own way.

Example of Task Shifting in Ethiopia for Community Detection of Fistula linked w/ Polio Campaign

According to USAID/Ethiopia, Pathfinder and John Snow International have supported accelerated identification and referral efforts by mobilizing communities and the media to do so and by training mid-level health workers for community level diagnosis. They have also technically and financially supported the federal and regional health bureaus to systematically identify and follow-up women suspected as having obstetric fistula, identified during annual house-to-house Polio Campaigns, in the last two years. In addition to supporting accelerated identification and referral, they have partnered with a sub-grantee – Healing Hands of Joy (HHOJ) – to support rehabilitation and reintegration of treated women (response to the survey sent by the FC+ evaluation team).

To date there has not been a systematic comparison of different screening modalities., although the FC+ staff indicated that they were not confident that remote screening apart from fistula repair centers was as reliable as on-site screening.

c) Sustainable Capacity for Prevention

The continued flow of new fistula clients in search of care, especially an increased proportion with more recent fistula, rather than women who have lived with fistula for years, indicates that there is a critical need for prevention. Activities aimed at the prevention of fistula are diverse and are present in nearly all fistula centers in FC+ in the form of FP counseling and services to prevent unintended pregnancy, to delay pregnancy for a year post-repair, and to deliver at a facility where an elective cesarean section can be performed, and within the wider communities in which the project supports prevention activities, such as FP, birth preparedness planning, and use of the partograph. FP is a major component of the FC+ prevention strategy. Integration of FP into fistula services has been a central approach to preventing recurrence of fistula in women after repair. Currently, post-repair women receive educational talks about FP from the fistula ward nurses. If they are interested in receiving individual counseling, they attend FP clinics within the hospitals where they are recovering from fistula surgery. Although FP was available in all the facilities visited by the evaluation team, except those run by the Catholic church, the evaluation team concluded that there were some issues that require attention from FC+. In Nigeria, the team found several examples of poor quality of care and counseling skills. In both Uganda and Nigeria, the team found that constant turnover of fistula ward nurses contributed to a lack of current knowledge on FP because new personnel had not been trained, and trained personnel had moved on to other responsibilities. There is also a perception among surgeons that FP is a topic that nurses – not surgeons – should discuss with clients. Except for the hospital in Kebbi, where the surgeon organized groups of men companions of fistula clients, there is still insufficient attention paid to engaging men in discussions of FP. In Nigeria, in particular, healthcare providers continue to delay women's access to contraceptives until they return for their three- or six-month checkup, based on the belief that all women live apart from their partners for six months post-surgery.

Awareness of FP can provide the education necessary to prevent fistula, especially in young women who should delay pregnancy until their bodies mature, and older women who can prevent pregnancies that are unintended, too close, too frequent, and unwanted. In Uganda, community health volunteers include FP as part of their fistula prevention messages. The evaluation team was not able to verify if a variety of FP methods were available and accessible in community health posts on an ongoing basis. In both Nigeria and Uganda there was a strong preference for injectables, but it was not clear if that was based on fully informed choice, or because it was more available than other methods, or if it reflect provider bias.

Another FC+ prevention strategy is to recommend that fistula clients who get pregnant after surgery attend a health facility equipped to perform a C-section, and if convenient, return to the hospitals where their fistula surgery was performed as those facilities have staff familiar with the needs of fistula clients. While this is an effective strategy to encourage women to return to a facility where they felt well taken care of, not all fistula facilities are equally equipped to address all obstetric and neonatal emergencies, should they arise. In Kebbi, Nigeria, and Kitovu, Uganda, the fistula hospitals encourage women to return to the hospital for their C-section. At Kitovu, they are set up to perform C-sections and to administer both obstetric and neonatal emergency care. However, in Kebbi, the hospital is neither equipped to transfuse women should they need it nor to deal with neonatal emergencies. If a woman or her baby experience an emergency, they have to be transported to the regional hospital. Although women like to return to a facility where they have had their fistula repaired, it is not recommended to perform C-sections at dedicated fistula centers because of the lack of equipment and personnel to perform neonatal resuscitation if the baby is born in distress, and the lack of on-site blood banking could be an issue if a woman has a post-partum hemorrhage. This is not a problem at fistula centers that are

located or co-located with full service hospitals, such as Maryam Abacha in Sokoto, Farida Hospital in Zamfara in Nigeria, and Hoima and Kitovu Hospitals in Uganda.

A third prevention strategy is to promote use of the partograph to monitor for prolonged and obstructed labor. Although the Ugandan health center visited by the evaluation team had made encouraging progress in the implementation and ownership of the use of the partograph, there was little evidence of its consistent and correct use elsewhere in FC+-supported countries. Despite wide dissemination of messages to seek care by a skilled provider for labor and delivery care, many women in FC+-supported countries continue to arrive at health services after days in labor. In addition to not reaching care in time, several fistula patients interviewed, including those with recent cases, told stories of further delays once they reached the hospital (third delay), where they were left to wait for as much as 24 hours after arrival. Their stories indicate a need for FC+ to collaborate with other MCH programs to develop more effective messages for healthcare personnel about the importance of developing intake protocols that quickly identify women who have been in labor longer than 24 hours and to perform C-sections immediately. One positive finding is that once women experience obstetric fistula, they are being referred more quickly to fistula surgical services, and thus do not have to live with the condition for years and years before receiving surgery.

The apparent increase in iatrogenic fistula requires a new approach to fistula prevention. FC+ has taken a significant step in that direction by focusing on safe surgery and quality of care. As mentioned earlier, the FC+ Project Director has been very involved in the issue professionally for many years and has used her connections as a global advocate and practitioner to focus attention on surgical quality of care in the context of fistula, and maternal morbidities more broadly.

A functioning referral system is vital to the prevention of fistula from obstructed labor, to ensure their timely access to C-sections. Currently, access to C-sections and hysterectomies as lifesaving and morbidity-averting interventions introduces a new level of complexity for fistula prevention, where timeliness is not sufficient. The message to seek such care is a simple one, as long as a woman can count on not being subjected to unanticipated harm in the process. In the face of increasing awareness and identification of the risk of iatrogenic fistula, it is necessary to ensure that in addition to women having access to timely emergency care, doctors must have sufficient training, equipment, infrastructure, competency, and accountability for performing C-sections and hysterectomies, regardless of whether the procedures are under emergency or elective conditions.

d) Sustainable Capacity for Reintegration

Nigeria's approach of working through the Ministry of Women's Affairs to implement reintegration interventions seemed to cause confusion and lack of consistency from one site to the next.

There is a need to have some means of selecting clients for assistance. Previous efforts to address fistula clients' needs with a common approach have not been based on evidence of what works or on an assessment of what they need. Most women with incurable fistula need maximal support as their prospects for integration into their communities free of discrimination appear to be limited. Clearly, women with short-duration of having lived with fistula, minor injuries, and strong family support can often succeed at home with no reintegration assistance. It has been reported in international meetings – but to our knowledge not published – that the cost of reintegration services can easily exceed that of the entire hospitalization for repair. Terrewode argues that not all women require the same types of reintegration interventions post-repair, despite the fact that most approaches, including those supported

by FC+ and its partners, are commonly one-size-fits-all approaches. This should not discourage FC+ from finding means to provide help to women who need it, but it should motivate the project to take a more systematic approach to learning who needs help and who does not. An important complement of supporting women's agency in their care and reintegration is to work with communities on challenging discrimination against women with fistula. Successful approaches developed in response to stigma and discrimination in the context of HIV and gender-based violence (GBV) may offer some viable models that can be adapted to address stigma and discrimination in the context of fistula.

Terrewode argues that both needs and responses are diverse and must be tailored to the individual. They are testing a much-needed set of screening tools, which have the potential to yield information on needs and effectiveness of responses appropriate to the needs. In addition, there is a clear need to engage women as active agents in the process of reintegration rather than treating them as passive recipients of donor-driven handouts. In line with Terrewode's approach, it may be time to reconsider the use of the term "reintegration" and use more neutral terms such as socio-economic support, capacity building, empowerment, or livelihood strategies to better describe the range of options that different women may require either separately or in combination.

e) Quality of Care from the Patients' Perspective

Having an idea of patient satisfaction is important in the design of our programs for patients. While patient satisfaction surveys may be seen as a foreign, Western concept in some countries, an interview with former fistula clients after leaving the hospital may yield more useful results. The evaluation team did not find any evidence of the project having undertaken routine client satisfaction surveys, and especially not several months after surgery, even though there is increasing evidence that many former clients deal with residual incontinence months or years after surgery. Given that phone contact is used to provide women with transport to fistula centers prior to repair, phone surveys may be a way to follow up with patients on satisfaction with their surgery and their treatment while they were hospitalized.

In most contexts women who have developed fistula do not have much say over decisions that affect their lives, and their experience during and after receiving care does not allow them much agency over their care either. Their experience, with little opportunity to make autonomous decisions about their healthcare, makes it difficult to get honest answers about quality of care while they are still in the facility.

The best time to assess quality would likely not be at the time of discharge, when clients might still be afraid that a frank opinion could alter their ongoing care, but later, when the patient has fully recovered to a new baseline state. Follow-up via mobile phone interviews may produce more honest information on satisfaction and quality from the user's perspective. FC+ is already using voice surveys for the barriers survey and could use the same technology to conduct client satisfaction surveys or interviews.

2. GLOBAL LEADERSHIP

As one of the final activities in the information-gathering portion of the review, the evaluation team finally met with the New York-based staff of FC+. They clarified some of the issues discussed above.

The evaluators learned that the main reason that there has been no follow-on multi-country RCT to the Catheter RCT has been the lack of funding. Dissemination on the results of the research has not been as robust as expected. FC+ understands that many countries view international research as insufficient for

policy change, and require that similar research be conducted locally before issuing a change in protocols and guidelines.

The FC+ Director is a clinician who has been very focused on the quality of clinical services for the project, while the previous Director had different professional and interpersonal skills and agenda. The evaluation team views this as indicative of a different leadership style and focus – putting greater emphasis on prevention and quality of care, and more localized clinical research – which may lead to more expedient uptake of the RCT-recommended protocols, along with other evidence-based practices.

The value of the Catheter RCT, as a Fistula Care-generated innovation, will not be fully realized unless surgeons internalize the benefits of modified catheter management principles. The project, as promised by the Director, can do a better job of disseminating the results and their importance in terms of shortening hospitalization times and associated risks and costs. Progress is evident, nonetheless, in the development of WHO guidelines and the issuance of catheter guidelines in Nigeria.

Given the value of using mobile telecommunications for health, the evaluation team was initially surprised that FC+ had not made any use of its partner Dimagi. The team learned that FC+ had chosen to work with a different cell-based technology partner (VOTO) as a research partner because of their voice messaging capabilities, which are more practical when working with populations with low literacy level. Nevertheless, the evaluation team views Dimagi as a resource partner that has important potential for innovating and improving reporting of health information, especially clinical records information that could improve knowledge on types of fistula, levels of complication, and outcomes.

Under the leadership of the FC+ Director, the project has contributed to elevating the issue of safe surgery in the context of fistula, in connections with the G4 Alliance and ISOFS. This is particularly important in face of a perceived rise in the incidence of iatrogenic fistula.

3. EFFECTS OF CHANGES IN PROJECT MANAGEMENT AND STAFF

Although there were significant changes in management and staffing of the project on the core New York team between the end of FC and the beginning of FC+, the transition has been without major disruption of activities in the implementation countries. Delays in start-up of the new project created some gaps in funding and the loss of some staff in country offices, but overall had little effect in program implementation. The interruption in funding at the beginning of FC+ had little visible influence on treatment, which continued uninterrupted in all but DRC.

FC+ has developed a portfolio of social science research focused on implementation science and operations research to generate evidence on effective prevention and reintegration approaches. The expansion of the focus of FC+ to include prolapse and, more recently on incontinence more broadly, is accompanied by an emphasis on safe surgical practices, which contributes positively to prioritizing quality of care and accountability for surgical outcomes.

FC+ has made relatively little use of its global resource partners, thereby foregoing opportunities for taking advantage of additional resources and expertise. Both Direct Relief and the Fistula Foundation offer in-kind and financial resources that FC+ could leverage in support of the treatment sites the project currently supports financially and with equipment. Greater use of those resources would free up resources for other types of investments, such as for research and improvements in quality of care. Dimagi, with their telecommunications capabilities, offers potential for digitizing collection of data for clinical research and M&E. The evaluation team identified a need to collect individual clinical data to be

able to assess the etiology and complexity of fistula being treated, types and numbers of complications, and average number of times a woman has been operated on, to name a few. While both Population Counsel and Terrewode are playing an active role on the project, there are ways to use their expertise more broadly. For instance, currently Terrewode is about to launch a study of the effectiveness of different reintegration strategies for women with fistula deemed incurable in Uganda. FC+ has the opportunity to conduct parallel studies in other countries.

Similarly, a heightened focus on M&E and data for decision-making in the project has helped to identify areas for improvement in indicators and greater disaggregation of data useful for identifying geographical locations where women are more likely to develop fistula, changes in the average number of years that women who access surgical services are living with fistula before repair, changes in the relative proportions of types and causes of fistula, and average age of occurrence of fistula.

4. PROSPECTS FOR MEETING PROJECT OBJECTIVES

Overall, the project seems to be on track to meet its objectives. Aside from some confusion among stakeholders about when the project will begin the integration of support for prolapse by the project, there are not major problems related to project implementation. The section on lessons learned and the recommendations speak explicitly to Question 4 which asked the evaluators to make recommendations for both the near term (the next 2 ½ years) and the more distant future (for a potential follow-on project).

Lessons Learned

There are already important lessons learned from project actions during the first two and a half years of operation, including:

- Networking efforts have improved morale and communication among surgeons.
- The surge in iatrogenic fistula cases changes the face of fistula prevention from a focus exclusively on emergency obstetric services to require a new emphasis on monitoring of basic pelvic surgical outcomes and provide better training and systems of accountability for surgeons/gynecologists.
- Training and mentoring on partograph, where instituted, has resulted in improved referral practices.
- Facility data does not support prediction of reaching the end of fistula cases anytime soon – new fistula cases are still appearing, and in some countries, such as Uganda, Niger, and DRC, the USAID Mission believes that there is still a significant backlog that has not yet been addressed.
- One of the greatest challenges to sustainable care is maintenance of a stable cadre of competent surgeons. The voices of the surgeons themselves have been singing the same song: that until fistula care is a recognized surgical discipline, they will remain in a professional “dead-end” preventing professional advancement and job-security.
- FC+ support, in partnership with UNFPA and others, has contributed significantly to increasing ownership and leadership by national, state/provincial, and district governments of fistula programming.
- Although many stakeholders had hoped the FC-supported RCT study team could go on to other clinical questions with further randomized prospective trials under FC+, it is unlikely to happen without substantial increases in funding.

A Look Toward the Future

The idea of literally millions of women with fistula waiting for care goes against the most recent epidemiologic estimates of fistula prevalence and incidence. None of the surgeons we interviewed reported significant patient backlogs, but all seemed to report a steady level of new cases presenting for care.

There are increasing indications that many fistula clients go home to face the possibility of loss of continence over time. According to published sources, somewhere between 29% to 54% of fistula clients suffer incontinence post-discharge after repair.¹⁹ A recent study from Kenya found that among women who returned for follow-up only 54% were dry (McFadden, Taleski, Bocking, Spitze, Mabeya 2011). In some places 45% are incontinent at the time of discharge (Drew, Wilkinson, Nundwe, Moyo, Mataya, Mwale M, Tang 2016). We are simply not providing women with the relief that they have hoped for. We have gone from not thinking about rehabilitation and social reintegration to thinking everyone needed access to these interventions, to thinking maybe only a subset do. In the area of prevention, the focus has been in improving access to emergency obstetric care (EmOC), to now when we are quickly building evidence that a significant portion of fistulas are complications of pelvic surgery.

The problem of incontinence post-repair: Incontinence after fistula repair is one of the great remaining challenges in fistula care – although closing the fistula defect can be immensely challenging, we understand how to do it. The same is not true for incontinence. Injuries in untreated obstructed labor are widespread and uniquely patterned to disrupt normal bladder and sphincter function (Barone, Widmer, Arrowsmith, Ruminjo, Seuc, Landry, et al 2015). The modern means of assessing bladder function and incontinence is a spectrum of studies known collectively as urodynamics (UDS). Machines for UDS cost tens of thousands of dollars – and there are the consumables (specialized catheters, pressure sensors, etc.) – and so very limited study has been done of how bladders behave as basic function returns after fistula repair (Arrowsmith et al 1996). There are many types of incontinence, and the nature of fistula injuries make women after fistula repair at risk for all of them. Bladder capacity and urethral muscle is lost or the nerve supply to either or both is lost, or the ability of the bladder to fill at low pressure is lost, or the ability of the woman to sense bladder fullness or send a command to void is lost. For decades, women who were wet after successful closure of a fistula were labelled as having “stress incontinence,” one type of this condition. But it turns out that very few fistula patients have this type alone, and surgical interventions over the years have failed at an alarming rate.

The problem of incontinence after repair has reached epidemic proportions and we have very little helpful clinical knowledge to guide therapy. We have very few fistula surgeons with expertise in continence. This is something that the reviewers know that the FC+ leadership has seen and taken to heart. FC+ has already begun to support efforts to train their surgeons in continence care, and the reviewers applaud this effort and advocate for its expansion. If there is to be any clinical research as a part of FC+ or the follow-on project, the reviewers recommend that it be based on the issue of incontinence after repair. Many women, especially those whose fistula is closed but continue to experience incontinence, would benefit from non-surgical interventions if the cause of their continued

¹⁹ I. Browning, Andrew 2004 “Prevention of residual urinary incontinence following successful repair of obstetric vesico-vaginal fistula using a fibro-muscular sling.” BJOG: an International Journal of Obstetrics and Gynaecology. Vol. 111, pp. 357–361.
2. Turan, Janet Molzan; Khaliah Johnson; Mary Lake Polan 2007 “Experiences of women seeking medical care for obstetric fistula in Eritrea: Implications for prevention, treatment, and social reintegration,” Journal of Global Health, An International Journal for Research, Policy and Practice, Volume 2, - Issue 1

incontinence was properly diagnosed and other types of remedies were readily known and available in treatment centers.

A different paradigm: Fistula Care Plus is programming that has been put into place at a time of much greater knowledge about fistula treatment than USAID's early efforts during the ACQUIRE project. Our point was that there are too many centers where only simple surgeries can be done without a camp approach. We believe that the levels of care model may not be appropriate for fistula. To date, the means of addressing the unmet need of fistula has been to establish multiple centers in each country, within reasonable distance, in regions with what are assumed to be areas of high prevalence. Some of the centers are stand-alone, but most are not and are instead associated with health facilities, private or public. Doctors have been trained, and investments have been made in centers, in awareness, and prevention. Perhaps at this point, then, it would be fair to ask if the things that were envisioned as the best way forward in the early days of a response to fistula really are best.

A pyramidal system was envisioned where junior surgeons in district or lower facilities could identify and treat simple cases, leaving the more difficult ones for more experienced surgeons and centers with a broader range of services.

There is evidence that the first attempt at surgery for women with fistula has proven to be the "golden moment" when hopes for success are greatest, and that dryness occurs with ever-diminishing frequency with each subsequent attempt at repair. This argues for having the best surgeon try first. In practical terms, most surgeons would agree that their ability to assess fistula during the screening process can be very limited – that it is easy to find that a fistula that seemed terrible in clinic was not so bad in surgery, but that the opposite is often true, that simple-appearing fistula can end up being quite complex. Once again, this argues against having less experienced surgeons give it the first shot, as the woman's one chance of having her difficult fistula repaired could be squandered.

There seems to have been a trend for fistula cases to become more difficult to repair as more and more failures cycle through centers across a region. The worse the cases get the more clinical skill and training that is required, and the skills needed often jump the boundaries between disciplines in pelvic surgery. To be a completely prepared fistula surgeon, skills in gynecology, urology, general surgery, and plastic surgery all must in place. This has proven to be a tremendous training challenge as the current FIGO system has helped to give many new doctors an initial exposure to fistula surgery, but very few move up the ladder towards more and more difficult fistula repairs. It can be extremely difficult to persuade people who attain these skills to live in the rural areas where we want them to work. A doctor with the skill sets to be a great fistula surgeon has all of the options to be successful in a private practice in a capital city. But often we expect them to live in a village with no electricity, no good educational options for children, no career opportunities for spouses, and perhaps compromised safety and security.

VI. RECOMMENDATIONS

Key initiatives for future investment (Question 4 continued as Recommendations)

There are several areas where FC+ has initiated activities that are important to continue for the duration of the current project and potentially expand or scale up in a future fistula program. These initiatives include:

1. Communities of practice of surgeons: FC+ is supporting regional meetings that strengthen fistula surgery. There is potential to build on these efforts and to enhance them via more effective and diversified knowledge management practices by the project, especially through electronic and social media.

2. Partograph training and mentoring skills for doctors: Knowledge and support from doctors in Uganda and Nigeria appeared to be an important criterion for determining the likelihood that nurses and midwives trained in the use of the partograph would actually use it for monitoring women for obstetric complications, especially for signs of obstructed and prolonged labor. FC agreed that strengthening partograph training and improving use of partograph data is a priority for the remainder of the project. The evaluation team would emphasize that in addition to training, engagement of doctors in providing supervision and mentoring are important activities for getting to habitual partograph use. The evaluation team concurs with FC+ that this is most likely to occur within a more comprehensive prevention strategy that integrates strengthening EmOC (e.g., C-section safety), improvement in community comprehension of prolonged/obstructed labor, birth preparedness planning, and strengthened referral systems.

In the future, a follow-on project might consider expanding the research to focus on evaluating a comprehensive prevention strategy up and down an entire referral network from community health posts to sub-district BEmOC clinics to district CEmOC district hospitals to a regional referral hospital in comparison to a matched non-intervention referral network to assess the impact on decreasing the number of women in danger of obstructed or prolonged labor beyond 24 hours without EMOC. It is important to incorporate fistula as a notifiable event in national HMIS and as a trigger for conducting maternal audits to improve accountability by midwives and doctors as a critical element of accountable prevention strategies.

3. Task Shifting: The evaluation team identified fistula screenings by nurses and midwives (already practiced at Kitovu) as an appropriate area for task shifting as a means to start a transition away from the model multiplying the number of fistula center as a means of increasing women's access to care. The evaluation team proposes a more efficient and higher quality model that strengthens the capacity and increases availability of detection sites while decreasing the number of repair sites to a few strategically located and supported sites that provide quality of care by capable surgeons who have the opportunity to conduct a sufficient number of surgeries per year to be both current and competent.

Well-trained nurses and midwives can provide detection and referral of women suffering from incontinence to the appropriate facility and type of care. More specialized examination for level of complication can be done at the specialized centers. Task shifting can increase nurses' and midwives' involvement in conservative treatment, during prolonged labor, catheterization for women with newly developed fistula within six weeks of delivery, and post-operative.

FC+ is not ready to commit to more decentralized screening because of past findings of poor care and misdirection of women with fistula at lower-level facilities in both Nigeria and Uganda.²⁰ As stated above, the evaluation team views decentralized screening as part of a larger strategy to consolidate and centralize fistula surgical services in more specialized facilities both capable of treating different levels of complication and referring women with inoperable fistula for appropriate social services.

4. Continued diversification of strategies for outreach and prevention: In the short term, FC+ will commit to the expansion of testing and validating differentiated reintegration interventions, which might be re-conceptualized as individualized social and economic support strategies, as a means of destigmatizing and de-victimizing women living with inoperable fistula or women living with the social and economic consequences of discrimination as a result of having a fistula disability. Changing language is an important first step in viewing women post-surgery or without surgery as agents of their future lives and endeavors.

To do this well requires partners outside the health system; it would also potentially require sub-awards and other funding mechanisms as well as additional staff to coordinate. Alternatively, it may be a function better carried out by a different type of organization than one skilled at training health workers to provide quality fistula treatment and prevention services. Preparing a paper documenting the research findings on appropriate and empowering responses to women’s needs, successes, challenges might be more feasible, setting up scope for future project/follow-on.

5. The Evaluation Team views strengthening ISOFS capacity for credentialing fistula surgeons directly or in partnership with an academic or governmental body as one potential solution to the current conundrum of how to provide a career advancement pathway for fistula surgeons. In this capacity ISOFS would: credential fistula surgeons, validate best practices, and partner with local professional organizations in more effective professional oversight and accountability.

As FC+ has concerns about whether ISOFS is the right organization to solve the credentialing problem, in the near term, it will explore potential alternative partnerships for this purpose, such as the West African College of Surgeons (WACS) and the College of Surgeons of East, Central and Southern Africa (COSECSA), which may be more prepared and sustainable country/regional partners. In the longer term, some combination of graduated pre-service training, residency, and fellowship program in conjunction with a process to credential surgeons who have been practicing for years without formal credentials is most likely to address the issue. The answer could also come via partnerships with African/Asian universities who could offer post-graduate fellowship training in “Female Pelvic Medicine” (as proposed at the University of Ibadan in Nigeria). The reviewers have seen that FC+ is trying to use its influence as a powerful force in fistula care to push along this concept of certification even during the remaining duration of the project.

6. The evaluation team strongly urges FC+ and USAID to continue a wider focus on continence care. Incontinence after fistula repair is one of the great remaining challenges in fistula care. Although closing the fistula defect can be immensely challenging, fistula surgeons understand how

²⁰ Pop Council formative research has shown that when screening is done at primary healthcare centers, staff often misdiagnose and recommend inappropriate treatment of fistula. This recommendation speaks to decentralized screening at district and regional centers, with the move toward centralized referral for more skilled diagnostic evaluation and treatment at a full-service fistula surgical center. See Recommendation 3 under future planning for a fuller description of the proposed model of care.

to do it. The same is not true for incontinence. Injuries in untreated obstructed labor are widespread and uniquely patterned to disrupt normal bladder and sphincter function.

Effort has been made to address this issue in the current project. FC+ has just sponsored a short-course seminar on voiding pathophysiology, including hands-on training to use new diagnostic technology to elucidate the pathophysiology of complex post-fistula lower urinary tract dysfunction. They are vocal supporters of a new Fellowship of Female Pelvic Medicine at the University of Ibadan in Nigeria, which would include residency-level training in the treatment of incontinence after fistula repair. They have engaged corporate partner Laborie (www.laborie.com) at ISOFS 2016 and in Project Years (PY) 4 and 5 to support this crucial teaching and training in FC+ sites in a model of public/private partnership to address this issue.

7. Make greater use of project partners like Dimagi, Fistula Foundation, and Direct Relief for innovative solutions to challenges. The evaluation team perceived that EngenderHealth's other FC+ Resource Partners were underutilized, especially when they were in a strategic position to address constraints and opportunities faced by the project, such as mobile data collection (Dimagi), leveraging additional resources for fistula surgery to FC+ nonprofit subawardees and procurement of U.S. Government restricted pharmaceuticals (Fistula Foundation), and provision of surgical equipment and supplies to free up project resources for other activities (Direct Relief).

While FC+ found another mobile partner with voice messaging capabilities to be more in line with their needs reaching clients and for conducting research on transport, they recognize that Dimagi's cell technology offers a useful platform for clinical and M&E remote data reporting capacities in PYs 4 and 5. A clinician-focused collaboration with Dimagi or another mHealth partner might make sense for a sustainability-focused follow-up on project.

In the time remaining in FC+, Direct Relief registration of sites has occurred in full in Uganda, in part in DRC, and in part in Nigeria, all in PY3. The Bangladesh MOH no longer permits charitable donations of medical goods. Niger engagement of Direct Relief registration will take place in PY4. Documentation of Direct Relief progress will emerge in the Annual Report and carry forward into PY4 reporting. FC+'s goal is 100% registration and delivery of goods to all eligible sites by end of PY4.

For future M&E and research efforts, the evaluators propose the development of a centralized database of patient records on an electronic platform. In the near term, FC+ is in the process of developing a digitized fistula patient register in Uganda and Nigeria in PY4 of the current project.

8. Integration by focusing on fistula clients as active agents rather than as unfortunate victims. While efforts are being made to engage men as supportive partners and advocates, it is critical to design and implement actions that increase women's agency as advocates for and informed consumers of fistula services. They would also benefit from activities and resources that increase their skills as negotiators and decision-makers in their families, communities, and health services. There is a need to expand clients' comprehension of full and informed choice and how to exercise their rights to evidence-based information and practices underlying their care options. Educating fistula surgeons and nurses, as well as doctors and nurses providing obstetric care and family planning, on the elements of respectful, rights-based, and empowering care, and holding them accountable for delivery of such care is critical to positive treatment and prevention outcomes.

In the short term, FC+ will begin to examine its prevention, treatment, and "reintegration" activities from a gender equality and empowered client perspective, and begin to make strategic changes in the

organization and delivery of treatment, prevention, and psychosocial and economic support interventions.

Recommendations for Future Programming

1. The evaluation team strongly urges FC+ and USAID to consider research with a focus on incontinence after repair. The problem of incontinence after repair has reached epidemic proportions and there is very little helpful clinical knowledge to guide therapy, and very few fistula surgeons with expertise in continence. This is something that the reviewers know that the FC+ leadership has seen and taken to heart. But if there is to be any clinical research as a part of FC+, the reviewers recommend that it be based on the issue of incontinence after repair. FC+ has already begun to support efforts to train their surgeons in continence care, and the reviewers applaud this effort and advocate for its expansion.

2. Test the impact of the integration of prevention, treatment, and reintegration practices at the level of a health referral network on preventing new occurrence and reducing backlog. This recommendation proposes that a follow-on project make a health network, rather than a fistula treatment center, the focus of the intervention. The rationale for the recommendation is that the focus on the whole network allows the project to address system constraints. While FC and FC+ have worked at different levels of the health system with different types of activities, to-date, there has not been a focus on a geographically integrated approach that would allow USAID to test the complex of interventions at the level of a health referral network and a full range of contraceptive methods, from the community to a regional referral hospital with the capability for fistula and prolapse treatment, quality ANC, skilled birth attendance, use of the partograph, EmOC, referral, and transport, community and household members awareness and engagement in birth preparedness, and support strategies that respond to women's diversified needs post-repair or when they have fistula deemed incurable.

3. For treatment, each country should establish one or two multifunctional fistula centers per country or region in lieu of multiple centers all over the country with different capabilities to resolve women's fistula, depending on their level of complexity and types of treatment needed. The centrally located multifunctional center in each country or region should be staffed on a permanent basis with a cadre of highly skilled staff (e.g., urology, gynecology and general surgery in each place with availability to consult with plastic surgery), sophisticated diagnostic equipment, with the capacity to be able to treat any fistula case that might arrive – from simple cases to diversion surgery for cases deemed incurable. A robust system should be put into place to transport women to and from these centers with dignity and as much comfort as possible. It is feasible for centers like this to function at high levels of productivity with relatively few surgeons. Women would get their best shot at receiving resolution, repeat repair rates would drop, and success would increase. It is estimated that it would be far less costly to transport clients to a central repair facility than to try to build and operate more and more new centers with only partial capacity, or to continue to operate rotating camps, that are not resulting, in many places, in increasing skills of surgeons, or consistently providing the necessary post-operative and long term follow-up care needed by fistula patients. The centralized multifunctional center would be supported by regional (provincial, state, or district) level screening facilities capable of accurately diagnosing fistula, pelvic organ prolapse, and other causes of severe incontinence.



Photo by Deborah Caro. Kitovu Hospital, Masaka, Uganda.

ANNEX I. SCOPE OF WORK

Assignment #: **212** [assigned by GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 2-8-2016

Last update: 5-20-2016

Refer to the USAID [How-To Note: Developing an Evaluation SOW](#) and the [SOW Good Practice Examples](#) when developing your SOW.

I. TITLE: **MID-TERM EVALUATION OF THE FISTULA CARE PLUS PROJECT**

II. Requester / Client

USAID/Washington

Office/Division: GH / HIDN

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

3.1.1 HIV

3.1.4 PIOET

3.1.7 FP/RH

3.1.2 TB

3.1.5 Other public health threats

3.1.8 WSSH

3.1.3 Malaria

3.1.6 MCH

3.1.9 Nutrition

3.2.0 Other (specify):

IV. Cost Estimate: \$XXXXXXXX (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period

Expected Start Date (on or about): June 6, 2016

Anticipated End Date (on or about): October 21, 2016

VI. Location(s) of Assignment: (Indicate where work will be performed)

Washington, DC; DRC; Nigeria; and Bangladesh

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

VIII. BACKGROUND

Project being evaluated:

Project Title:	Fistula Care Plus
Award Number:	OAA-A-14-00013
Award Dates:	December 12, 2013 and will end on December 11, 2018
Project Funding:	\$74.49 million ceiling
Implementing Organization(s):	EngenderHealth (prime) with The Population Council, Dimagi, TERREWODE, Direct Relief, The Fistula Foundation, and the Maternal Health Task Force
Project AOR:	Erin Mielke

Background of project/program/intervention:

An obstetric fistula is a hole between the vagina and rectum or bladder that is caused by prolonged obstructed labor, leaving a woman incontinent of urine or feces or both. In developing countries, obstetric fistula typically results from prolonged, obstructed labor. In December 2013, GH/HIDN/MCH awarded the Fistula Care Plus Project, a 5-year worldwide Cooperative Agreement to EngenderHealth as the prime implementing partner. The Population Council is a core partner, and other implementing partners are: Dimagi, TERREWODE, Direct Relief, The Fistula Foundation, and the Maternal Health Task Force. The Fistula Care Plus Project is designed to allow USAID Missions and Bureaus to easily access high quality, specialized technical assistance and support for their activities involving fistula prevention, treatment and reintegration; and monitoring, evaluation and research. Building on the results and lessons of the prior Fistula Care Project, this new project increased emphasis on country ownership and public-private partnerships, and also addresses pelvic organ prolapse in selected settings.

In terms of funding and management, the project has a ceiling of \$74.49 million. Fistula Care Plus's core funding and field support are each split between the MCH account and FP/RH funds. The USAID management team includes the AOR and Program Assistant in PRH, and the Alternate AOR within HIDN. The project is housed in the HIDN Office, and receives majority MCH funding (70%), but it also receives about 30% FP/RH funding and has historically been co-managed between the HIDN and

PRH Offices. The primary audience for this evaluation is USAID, for ongoing and future program planning.

Description of activity/project/program

Fistula Care Plus is designed to assist countries to strengthen policy and the enabling environment to institutionalize fistula prevention, treatment and reintegration; strengthen maternal health and family planning services in the public and private sectors to support fistula prevention and treatment; enhance community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula; reduce transportation, communications and financial barriers to accessing preventive care, detection, treatment and reintegration support; and strengthen the evidence base for approaches to improve fistula care, and scale-up application of standard monitoring and evaluation indicators for prevention and treatment. The project also assists USAID/Washington to monitor fistula activities Agency-wide and report on this area of congressional interest.

Fistula Care Plus addresses the goal of strengthening health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia by implementing the following five Objectives:

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

The Project’s two scale-up strategies are the Levels of Care Framework, and the ExpandNet approach to scaling up interventions.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Fistula Care Plus works in Bangladesh, Democratic Republic of the Congo (DRC), Niger, Nigeria, and Uganda

IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this activity is to provide the United States Agency for International Development’s (USAID) Bureau for Global Health (GH)/Health, Infectious Disease and Nutrition Office (HIDN)/Maternal and Child Health Division (MCH) with an independent mid-term performance evaluation of the Fistula Care Plus Project. Fistula Care Plus is a five-year global project that began on

December 12, 2013 and will end on December 11, 2018. As the project is half way through implementation, HIDN/MCH is commissioning this mid-term evaluation to examine the project's progress towards achieving planned results and lessons learned to date. The evaluation team will identify Fistula Care Plus activities that may warrant continued future investment, as well as other fistula prevention, treatment and reintegration interventions not a part of Fistula Care Plus's current portfolio that would likely contribute to improvement of the program.

B. Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

In order of importance, USAID fistula program managers and Fistula Care Plus project staff are the intended audience.

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

The findings will be used to improve the current project in its remaining years, and will also be used to inform the future design of USAID's global fistula program.

D. Evaluation Questions & Matrix:

- a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**
- b) List the recommended methods that will be used to collect data to be used to answer each question.
- c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

All questions listed below should result in a list of actionable recommendations for Fistula Care Plus and USAID, including recommendations:

- To enhance achievement of technical results before the end of project
- For how to modify activities or approaches that are not achieving the expected results, or if they should be discontinued
- To enhance management of the project

	Evaluation/Analytic Question	Research Methods	Application or Data Use
I	<p>To what extent has Fistula Care Plus supported country ownership of fistula programming (going beyond national vision statements to include technical and managerial capacity and allocation of domestic resources to address fistula)?</p> <p><u>Issues to consider:</u></p> <ol style="list-style-type: none"> a) Sustainable capacity for fistula prevention, detection, treatment & reintegration built by Fistula Care Plus (emphasis on Objectives 1, 2 & 4) b) Consider clients' perspective on quality of care and any recommendations to enhance patient satisfaction c) Nigeria: 	<p>Main data sources: key informant interviews (including fistula clients, Ministry of Health officials and healthcare providers), project documents, field visits including service delivery record reviews</p>	

	<ul style="list-style-type: none"> – Refer to HMIS data for survey of fistula repair centers across Nigeria and all fistula client data on repairs and outcomes – see surgical skills tracking tool for assessment of competency of surgeons – confirm status of FMOH standards and guidelines (including for bladder catheterization), and status of Ibadan teaching hospital <p>d) Bangladesh:</p> <ul style="list-style-type: none"> – Ways the project and USAID can improve advocacy for fistula prevention within the Ob-Gyn Society of Bangladesh and the Gov’t of Bangladesh – Ways the project can enhance quality assurance among service delivery implementing partners – Ways the project can enhance social and behavior change communication for early diagnosis and referral of cases 		
2	What contributions has Fistula Care Plus made to global leadership, to advancing research and innovation, and to transferring new technologies to the field (emphasis on Objectives 3 & 5)?	Main data sources: key informant interviews, field visits, project documents	
3	There have been several management (staffing and structural) changes within the Fistula Care Plus team at EngenderHealth since the start of the project (all three key personnel have changed over time). How has this changed the technical direction and management of the program? <u>Issues to consider:</u> a) Project responsiveness to USAID Missions, USAID regional bureaus, host country governments and other global stakeholders?	Main data sources: mission surveys, field visits, key informant interviews	
4	What is the evaluation team’s assessment regarding the project’s future progress (is it on track to achieve its intended objectives)? <u>Issues to consider:</u> a) Challenges and gaps identified b) Important technical lessons learned and best practices identified c) Key initiatives, activities and approaches that warrant additional USAID investment in the future, beyond the end of the Fistula Care Plus project d) Other promising fistula program models and approaches, not addressed by Fistula Care Plus, which should be considered for future investment	Main data sources: Performance Management Plan and work plans, key informant interviews, field visits, mission surveys.	

Methods:

General Comments related to Methods:
Once the evaluation team has developed the data collection tools (questionnaires, interview guides, etc.) based on the agreed upon evaluation questions and approaches, they will present them to

HIDN/MCH, PRH/SDI and GH Pro Technical Advisor for review and approval prior to their application in order to verify their appropriateness. **All tools should include an informed consent statement.** These tools will be used in all data collections situations, especially during country field visits, in order to ensure consistency and comparability of data.

Field Visits: The evaluation team is expected to travel together to three countries, selected based on the large scale and variety within their fistula programming and for representation of both Asia and Africa field programs: Bangladesh, DRC and Nigeria. The full team will travel together to the first country then split to two groups to visit the other two countries. USAID staff will accompany the team on the field visits, so that a minimum of two people will visit each country. The evaluation team is expected to interview project staff, USAID Mission Health Office staff, other implementing organizations, and Fistula Care Plus partners (including local NGOs, public sector representatives etc.) and beneficiaries in these three countries, and review a sample of service delivery records in health facilities. Points of contact for each country will be identified by USAID and Fistula Care Plus staff. The three missions have been notified of the planned evaluations.

■ **Document and Data Review** (*list of documents and data recommended for review*)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. HIDN/MCH and PRH/SDI and/or Fistula Care Plus will provide the evaluation team with a package of briefing materials related to the Fistula Care Plus evaluation. This documentation will include:

- Fistula Care Plus award document (including program description), annual reports, work plans, Performance Management Plan, financial reviews and reports, and management reviews which are developed and reviewed as part of the continuous monitoring of the project
- Fistula Care Plus technical, advocacy and research program documents

These will include, but not be limited to:

- 1) Fistula Care Plus Associate Cooperative Agreement
- 2) Fistula Care Plus work plans Years 1-3
- 3) Fistula Care Plus Quarterly and Annual Reports
- 4) Fistula Care Plus Performance Management Plan
- 5) Fistula Care Plus Management Reviews and Memos
- 6) Technical Briefs
- 7) Research Reports
- 8) Financial Reviews and Reports
- 9) Other Fistula Care Plus Project Documents
- 10) Fistula Care Plus advocacy materials
- 11) USAID Evaluation Policy
- 12) <http://www.fistulacare.org/pages/index.php>

The team also is expected to review Fistula Care Plus’s website, which includes a database of project sites, indicators and activities (see <http://www.fistulacare.org/pages/index.php>).

Secondary analysis of existing data (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis

■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

The evaluation team will conduct qualitative, in-depth interviews with key stakeholders and partners (a preliminary list of stakeholders and partners is attached in Annex 3, but the evaluation team should add to this list as necessary). Whenever possible, the evaluation team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. Fistula Care Plus and USAID staff will give advance notice to several key informants, and then the evaluation team will follow-up to schedule the interviews in coordination with Fistula Care Plus and USAID staff.

Key informants (see Annex 2) should include, but not be limited to:

- Fistula Care Plus project staff
- Fistula Care Plus's partner staff at Population Council, TERREWODE, Dimagi, Direct Relief, Fistula Foundation and the Maternal Health Task Force
- USAID/Washington (HIDN/MCH and PRH/SDI) Fistula Care Plus project management staff, and Legislative and Public Affairs staff
- USAID Missions, in countries in which Fistula Care Plus works or collects data
- Fistula Care Plus in-country partners, including public sector and NGO/FBO entities (e.g., BRAC, Heal Africa, government facilities in Nigeria, etc.)
- Beneficiaries (fistula repair clients, fistula advocates)
- Experts with a variety of perspectives on fistula programs, including those from UNFPA's Campaign to End Fistula, WHO's Special Program of Research, Development and Research Training in Human Reproduction, Centers for Disease Control and Prevention, and international professional associations, such as FIGO and the International Society for Obstetric Fistula Surgeons

■ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

Can be with groups of fistula clients (ex: on post-operative wards in fistula repair sites) or with groups of fistula advocates or community ambassadors who help identify and refer women to repair centers for treatment

■ **Group Interviews** (*list categories of groups, and purpose of inquiry*)

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly.

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

Fistula repair clients will be interviewed, where available, in fistula treatment facilities.

■ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

Fistula repair sites will be assessed – to see how the pre-operative, surgical and post-operative care is provided, including counseling. Issues to observe include adequate equipment and infrastructure to perform surgery with anesthesia, infection prevention procedures, and adequate staffing for pre- and post-operative care.

Cost Analysis (*list costing factors of interest, and type of costing assessment, if known*)

■ **Survey** (*describe content of the survey and target responders, and purpose of inquiry*)

The evaluation team should design and implement web-based survey (i.e., Survey Monkey) of USAID regional and country Missions that have bought into or worked with Fistula Care Plus regarding their level of satisfaction and experiences with the project.

The evaluation team should also design and implement a web-based survey to poll outside organizations that have partnered with Fistula Care Plus (such as UNFPA, WHO, and FIGO) regarding their level of satisfaction and experiences with the project.

Both survey questionnaires will be reviewed and approved by HIDN/MCH and PRH/SDI before the surveys are implemented.

■ Observations *(list types of sites or activities to be observed, and purpose of inquiry)*

Field Visits: During country visits the Evaluation Team may decide to visit fistula care and prevention sites to conduct semi-structured observations.

Data Abstraction *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

--

Case Study *(describe the case, and issue of interest to be explored)*

--

Verbal Autopsy *(list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)*

--

Rapid Appraisal Methods *(ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)*

--

Other *(list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)*

--

If impact evaluation –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual

Case	Counterfactual

X. HUMAN SUBJECT PROTECTION

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation,

if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

As the team reviews the documents available and interview lists and develops the data collection tools, they will ensure that they will in fact have the data they need to adequately respond to the evaluation questions. Once all data is collected, several days will be spent on carefully compiling, reviewing and identifying key findings prior to making a presentation of preliminary findings to USAID.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, country specific data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include Fistula Care Plus proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines

- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. This briefing may be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **In-brief with Fistula Care Plus** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.

Evaluation Workplan: The evaluation team shall prepare a workplan, including milestones and deliverables with due dates clearly established during the Team Planning meeting, to be provided to USAID for approval. This plan will include, but not be limited to, the following items:

- Key evaluation questions
- Evaluation protocols, including methods, and for each method:
 - data collection procedures
 - sample
 - limitations
- Data collection tools
- Timeline for key activities, including product due dates
- Schedule of interviews, both internal and external
- Schedule of informal and final debriefing presentations to USAID and Fistula Care Plus
- Schedule of field visits

This work plan (including questionnaires, etc.) will be approved prior to initiation of key informant interviews and site visits.

Fieldwork, Site Visits and Data Collection – The evaluation team will visit Bangladesh, DRC and Nigeria for data collection. Selection of sites for in-country site visits will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field. USAID staff will join the evaluation team for these country visits and assist with data collection.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
<input checked="" type="checkbox"/> Launch briefing	June 15, 2016
<input checked="" type="checkbox"/> In-brief with USAID/HIDN	June 21, 2016
<input checked="" type="checkbox"/> Workplan with timeline	June 29, 2016
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	June 30, 2016
<input checked="" type="checkbox"/> In-brief with Fistula Care Plus	June 24, 2016
<input checked="" type="checkbox"/> Routine briefings	Bi-monthly
<input checked="" type="checkbox"/> Out-brief with USAID/HIDN with Power Point presentation	September 1, 2016
<input checked="" type="checkbox"/> Findings review workshop with stakeholders with Power Point presentation	September 2, 2016
<input checked="" type="checkbox"/> Draft report	Submit to GH Pro: September 7, 2016 GH Pro submits to USAID: September 9, 2016
<input checked="" type="checkbox"/> Final report	Submit to GH Pro: September 30, 2016 GH Pro submits to USAID: October 5 2016
<input checked="" type="checkbox"/> Raw data	October 5, 2016
<input checked="" type="checkbox"/> Report Posted to the DEC	October 21, 2016
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytcs must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

GH Pro will recruit three external team members. Between them, the team members should have substantial and demonstrated knowledge of fistula treatment and prevention issues as well as international public health in the fields of maternal health, family planning and reproductive health. At least one of the evaluation team members should be an evaluation expert. Additionally, at least one of the evaluation team members should be fluent in French.

In addition to the two team members recruited by GH Pro, two staff members from USAID's PRH and HIDN Offices will act as full team members (full time during team planning meetings and country visits) to facilitate introductions with key informants, provide briefings about the project, participate in field visits and contribute knowledge of USAID policies and procedures and of maternal health, FP and RH. USAID staff will not be responsible for report writing but will coordinate their own travel plans, country clearances, other logistics, and expenses will be provided separately by the HIDN and PRH Offices.

Edit as needed to the Team Lead's position description.

Key Staff 1 Title: Team Lead & Evaluation Specialist:

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations. As an evaluation specialist, the Team Lead will also provide quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- Minimum of 10 years of experience in public health, which including experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods and tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management; Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- 7-10 years' experience in MH services, including expertise in several of the following areas:
 - Fistula care
 - Clinical service delivery, including counseling
 - Capacity building of health workers and institutions
 - Community-based activities (e.g., behavior change communications and social support)
 - Quality improvement
- Experience implementing and leading USAID evaluations and projects/programs
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Familiarity with USAID
- Familiarity with USAID and PEPFAR policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans
- Fluent in spoken and written English
- Fluent in French is desirable
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 2 Title: Maternal Health Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in maternal health (MH), as well as FP/RH, with a focus on clinical services and quality of care. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 10 years of experience in international public health in the fields of maternal health, family planning and reproductive health; USAID project implementation experience preferred
- 7-10 years' experience in MH services, including expertise in several of the following areas:
 - Fistula care
 - Clinical service delivery, including counseling
 - Capacity building of health workers and institutions

- Community-based activities (e.g., behavior change communications and social support)
- Quality improvement
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- An advanced degree in Public Health or other relevant course of study.
- Demonstrated skill in written and oral communication.
- Demonstrated knowledge of USAID policies and procedures.
- Ability to work effectively in, and communicate with, a diverse set of professionals.
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Fluent in spoken and written English
- Fluent in French is desirable
- Experience in conducting USAID evaluations of health programs/activities
- Demonstrated knowledge of USAID policies and procedures, including familiarity with USAID M&E policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Program Assistant /Logistics Coordinator (DC based) to work part time with the Evaluation Team to arrange interviews, meetings and logistics, and other support duties as needed by the Evaluation Team.

Local Logistics/Program Assistant (1 per country visited) will support the Evaluation Team for country site visits. The Logistics/Program Assistant support the Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations, including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments, including assisting booking interviews. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

- Yes – If yes, specify who: two staff members from USAID’s PRH and HIDN Offices will act as full team members (full time during team planning meetings and country visits)
- Significant Involvement anticipated – If yes, specify who:.
- No

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

DC, Bangladesh, DRC and Nigeria.

XV. LOGISTICS

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- USAID Facility Access
- Electronic County Clearance (ECC) (International travelers only) for Bangladesh and DRC
- GH Pro workspace
- Travel -other than posting (specify): GH Pro will arrange travel to all work locations (DC, Bangladesh, DRC and Nigeria)
- Other (specify):

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
 - Develop SOW.
 - Peer Review SOW
 - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide

additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- a. The report **must not exceed 30-40 pages** (excluding executive summary, table of contents, acronym list and annexes).
- b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

PROPOSED OUTLINE FOR EVALUATION REPORT

TABLE OF CONTENTS
ACKNOWLEDGEMENTS
ACRONYMS AND ABBREVIATIONS
EXECUTIVE SUMMARY
INTRODUCTION
Purpose
 Background
Methodology
FINDINGS organized by Evaluation Questions
Program
Technical
Management
CONCLUSIONS
LESSONS LEARNED
PRIORITIZED RECOMMENDATIONS
FUTURE DIRECTIONS
ANNEXES:

- Evaluation Scope of Work
- Evaluation Methods and Limitations
- Data Collection Instruments
- Sources of Information
 - List of Persons Interviews
 - Bibliography of Documents Reviewed
 - Databases
 - etc]

Disclosure of Any Conflicts of Interest
Statement of Differences (if applicable)

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

XIX. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Erin Mielke	Mary Ellen Stanton	Alanna White
Title:	Fistula Care Plus Management Team (AOR)	Fistula Care Plus Management Team (Alt AOR)	Program Analyst
USAID Office:	Population and Reproductive Health Office (PRH)/Service	Health, Infectious Disease and Nutrition (HIDN)/Maternal and	Population and Reproductive Health Office (PRH)/Service

	Delivery Improvement Division (SDI)	Child Health Division (MCH)	Delivery Improvement Division (SDI)
Email:	emielke@usaid.gov	mstanton@usaid.gov	awhite@usaid.gov
Telephone:	571-551-7034	571-551-7389	571-551-7068
Cell Phone:	571-243-7867		

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2
Name:	Amani Selim	
Title:	Evaluation Technical Adviser	
USAID Office:	Office of Population & Reproductive Health	
Email:	aselim@usaid.gov	
Telephone:	571-551-7528	
Cell Phone:		

XX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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XXI. LIST OF ADDITIONAL DOCUMENTS/ANNEXES

Annex 1: Brief Description of Fistula Care *Plus* project

Annex 2: Key Stakeholders, Partners & USAID Contacts

ANNEX I: BRIEF DESCRIPTION OF THE FISTULA CARE PLUS PROJECT

Fistula Care Plus aims to strengthen health system capacity for fistula prevention, detection, treatment and reintegration in Sub-Saharan Africa and South Asia. Building on the learning and accomplishments of the global Fistula Care Project (2007-2013), the new project will increase emphasis on country ownership and public-private partnerships to enhance the sustainability of country programs and in selected settings will also address pelvic organ prolapse.

Services Provided

Strengthen the enabling environment to institutionalize fistula prevention, treatment and reintegration in the public and private sectors;

Enhance community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula;

Reduce transportation, communications and financial barriers to accessing preventive care, detection, treatment and reintegration support; and

Strengthen the evidence base for approaches to improve fistula care, and scale-up application of standard monitoring and evaluation indicators for prevention and treatment.

Fistula Care Plus Implementing Partners

Fistula Care Plus is implemented by EngenderHealth (prime) with core partner Population Council and other partners Dimagi, TERREWODE, Direct Relief, the Fistula Foundation and the Maternal Health Task Force.

Fistula Care Plus Project Framework

Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia				
<i>Obj. 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors</i>	<i>Obj. 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula</i>	<i>Obj. 3: Reduced transportation, communication, and financial barriers to accessing preventive care, detection, treatment, and reintegration support</i>	<i>Obj. 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment</i>	<i>Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment</i>
1.1 Establish sustainability plans: from policy to implementation	2.1 Create awareness and reduce stigma about OF	3.1 Reduce transportation barriers for prevention and treatment of OF	4.1 Strengthen facility-level capacity to prevent fistula	5.1 Increase standardization in terminology, classification, and indicators
1.2 Improve data available on OF to facilitate planning	2.2 Establish partnerships to facilitate achievable, holistic goals for reintegration to meet the needs of women with fistula	3.2 Improve communication in support of fistula prevention, treatment, and reintegration	4.2 Increase capacity for treatment	5.2 Strengthen monitoring and evaluation/research (ME&R) systems and use of data
1.3 Advocate for a fistula-free generation		3.3 Reduce financial barriers to fistula prevention, treatment, and reintegration	4.3 Integrate family planning (FP) services to respond to client needs	5.3 Use research findings to improve practice
			4.4 Support and establish treatment/care programs for WDI and POP	5.4 Contribute to the evidence for improved programming and care
Scale-up strategy 1: Implement the levels of care framework				
Scale-up strategy 2: Use ExpandNet approach to scale up interventions				

Levels of Care and ExpandNet approaches to Scale Up: FCP will apply two approaches. The first proposes a national, triaged approach to OF and POP service delivery. To scale up services to address OF, WDI, TF, and POP, FCP will apply the Levels of Care (LOC) Framework developed under FC. The LOC framework applies a systems approach to the continuum of care: prevention, treatment, and reintegration. As described in the objectives, prevention must be integrated at all levels of the health system and at the community level. Ultimately, strengthened prevention will be the solution to OF and POP. At the prevention level (*Level 1*), in addition to creating awareness at both the community and facility levels, services to ensure planned pregnancies, safe births, good postpartum care, and treatment by catheterization and fitting of ring pessaries to address POP (see Objective 4) will be provided. Treatment for adjunct conditions will also be provided at some facilities, prior to referral. Cases requiring surgical treatment would be identified and referred. Treatment (*Level 2*) must be provided at a facility, or during outreach, with the requisite equipment, supplies, drugs, and skilled surgical team.

ExpandNet: Nine steps for developing a scaling- strategy (WHO 2010)

- Plan to increase the scalability of the innovation.
- Increase the user organization's capacity to implement.
- Assess the environment and planning.
- Increase the resource team's capacity to support scale-up.
- Choose between vertical or horizontal scale-up.
- Consider the role of diversification.
- Address spontaneous scale-up.
- Finalize the scale-up strategy.
- Implement.

Maintaining and improving surgical skills requires a reasonable caseload. Treatment requires long hospital stays (approximately three weeks) with quality pre-, intra-, and postoperative care. Treatment centers should be located to ensure that women from all parts of the country have access to care, with transportation support. For the most complex cases, advanced surgical skills may only be available in a few specialist centers in a country (*Level 3*). At these centers, care for WDI and for women with advanced stages of POP can be provided, and training can be supported. Follow-up and reintegration can be provided through linkages at all levels. This strategy will be incorporated into all country work plans to determine how it will best fit with the health infrastructure in that country. The second scale-up approach is for evidence-based interventions to improve service access or quality. FCP will apply the ExpandNet approach: addressing the requirements of the innovation itself, the resource or knowledge team, and the user organization. The unique service environment in a country or institution, and the scale-up strategy to be employed, are taken into account. FCP will follow the nine steps for scaling up. (See box.) Implicit in this strategy is that the “knowledge owners” of the innovation will be employed in its replication and scale-up within their own country and to other countries. Two examples in this proposal include community screening strategies in Nigeria to better estimate the need for services and reintegration strategies in Uganda. Nigerian and Ugandan institutions and staff will support South-to-South transfer of knowledge, with support from the global and country staff. At both global and country levels, partners will be prepared to assess and rapidly incorporate new learning/research as it is shared and adapt practices as appropriate. (Objective 5 includes a “research-to-practice” component.)

ANNEX 2: KEY STAKEHOLDERS, PARTNERS & USAID CONTACTS

The evaluation team should add to this preliminary list of stakeholders and partners as necessary.

USAID/Washington

Health, Infectious Disease and Nutrition (HIDN)/Maternal and Child Health Division (MCH) Fistula Care Plus Management Team

Mary Ellen Stanton (Alt AOR)

Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) Fistula Care Plus Management Team

Erin Mielke (AOR)

Alanna White (Program Analyst)

HIDN Front Office

Elizabeth Fox (Director)

Kelly Saldana

PRH Front Office

Ellen Starbird (Director)

Aly Cameron (Deputy Director)

HIDN/NUT

Neal Brandes (MCH Research)

Esther Lwanga (MCH Research)

Africa Bureau

Sylvia Alford

Population Health and Nutrition and Foreign Service Nationals and Foreign Service Officers in the Missions

Bangladesh: Ferdousi Begum, Marietou Satin

DRC: Thibaut Mukaba (FP/RH Mgmt Specialist)

Ethiopia: Josh Karnes (FSO)

USAID West Africa: Mbayi Kangudie

Mali: Dr Madina BA SANGARE (Senior Reproductive Health Advisor)

Nigeria: Nancy Lowenthal (HPN), Gertrude Odezugo (FSN)

Uganda: James Tanu Duworko

Fistula Care Plus

Lauri Romanzi, Project Director

Vandana Tripathi, Deputy Project Director

Karen Levin, Sr. M&E Associate

Bethany Cole, Sr. Global Projects Manager

Joseph Osei, Finance Manager

Karen Beattie (fistula consultant and former FC+ Project Director)

Fistula Care Plus Field Staff

Kenya: Isaac Achwal Senior Medical Associate

Nigeria: Habib Sadauki, Former Country Project Manager

Uganda: Rose Mukisa, Country Project Manager

Bangladesh: SK Nazmul Huda, Country Project Manager
DRC: Michel Mpunga, Country Project Manager

Fistula Care Plus Consultants

Dr. Steve Arrowsmith (Trainer and research advisor)
Dr. Serigne. Magueye, Senegal (Trainer)
Dr. Tom Raassen (Trainer)

Fistula Care Plus Partners

Population Council: Charlotte Warren, Senior Associate, Ben Bellows, Associate
Dimagi, Neal Lesh, Chief Strategy Officer
TERREWODE: Alice Emasu, Founder and Executive Director
Direct Relief, Ben Williams Director of International Programs
Fistula Foundation, Kate Grant, CEO
Maternal Health Task Force: Mary Nell Wegner, Executive Director

Other Fistula Research Advisory Partners

Maggie Bangser, Founder/ Former CEO of Women's Dignity Project, Tanzania

Ellen Brazier, Research Staff Member Institute for Implementation Science in Population Health

Sheena Currie, Sr Maternal Health Adviser at Jhpiego

Celia Pett, Independent RH Consultant, EngenderHealth

Kate Ramsey, Former Technical Specialist, Obstetric Fistula Co-ordinator, Campaign to End Fistula
United Nations Population Fund

Other Development Partners

WHO

Metin Gulmezoglu, Coordinator, Maternal and Perinatal Health and Preventing Unsafe Abortion Team
Ozge Tuncalp, Department of Reproductive Health and Research

UNFPA

Erin Anastasi Current Technical Specialist, Obstetric Fistula Co-ordinator, Campaign to End Fistula
United Nations Population Fund

ISOFS

Dr. Oladosu Ojengbede, President

FIGO

H. Rushwan, **Chief Executive Officer - Professor**

Gillian Slinger, Fistula Training Initiative Project Manager

WAHA International

Dr. Sinan Khaddaji, Secretary general, Women and Health Alliance

Facility-based Healthcare providers, managers, and fistula clients (Facilities are to be determined in coordination with the respective Missions and Fistula Care Plus)

ANNEX II. EVALUATION METHODS AND LIMITATIONS

Type of Instrument	Participants	Number of Participants	Location
Key Informant Interviews	USAID/GH Staff	6	
	USAID Mission Staff	9	Nigeria (3), Bangladesh (2); Uganda (3); DRC (1)
	Fistula Care Plus Staff	26	USA (3); Nigeria (15); DRC (3); Uganda (5); Bangladesh (7)
	Global Partners and FC+ Resource Partners <ul style="list-style-type: none"> MHTF Women's Dignity UNFPA Dimagi 	5	USA (3) Uganda (2)
	National Government and Local Government Officials	16	Uganda (3) Nigeria (13)
	NGO Staff <ul style="list-style-type: none"> Rural Youth Initiative and Kebbi Youth Vanguard Terrewode BRAC 	5	Nigeria (2) Uganda (2) Bangladesh (2)
	Surgeons	17	Nigeria (8) DRC (9)
	Hospital Administrators	11	Uganda (3) Nigeria (5) DRC (3) Bangladesh ()
	Nurses, Midwives, and doctors (non-surgeons)	9	Nigeria (1) DRC (1) Uganda (3) Uganda 4
	Nurses and Doctors	11	Bangladesh: BSMMU (7) MAMS (2) ADDIN Jessore (2)
	Fistula Patients	3	St. Joseph's Hospital, Kinshasa, DRC
	Fistula Patients	7	Ad deen Medical College & Hospital, Dhaka, Bangladesh (2)

Type of Instrument	Participants	Number of Participants	Location
			BSMMU Dhaka, Bangladesh (4) MAMMS (4) ADDIN Jessore (3)
Group Interview or Focus Group Discussions	Fistula Patients 3 Groups	21	Maryam Abacha Hospital Sokoto, Sokoto State, Nigeria
	Fistula Patients 2 Groups	10	Gesse Fistula Center, Birnin Kebbi, Kebbi State, Nigeria
	Nurses 1 Group	4	Gesse Fistula Center Birnin Kebbi, Kebbi State, Nigeria
	Nurses	7	Hoima Regional Referral Hospital, Hoima Uganda
	Nurses	2	Kitovu Hospital, Maska, Uganda
	Village Health Workers	12	Bararu, Uganda

Additionally, the evaluation team also employed observational techniques in fistula repair centers and other parts of hospitals and health centers where fistula repair and prevention activities are housed.

LIMITATIONS

Despite repeated outreach by the FC+ AOR, the survey of USAID Missions produced very few responses, probably because of the time of year. Timing coincided with both summer vacation and the end of the fiscal year.

The evaluation team was not allowed to travel to Bangladesh. The consultants produced useful information on fistula patients but very little from other stakeholders. This made the information harder to compare with data from the other countries visited. Overall, the time in the three countries visited was too short, preventing the team from exploring various topics in depth. The project is too complex and varied across different countries to comprehensively assess all the interventions in a five-day visit. We highly recommend more extended fieldwork in subsequent evaluations.

In Nigeria, restrictions on USAID staff travel made coordination between them and the core evaluation team interesting. It is a tribute to all involved that we were able to weather the challenges with a sense of humor and a lot of creativity.

It would have been useful to spend more time with the project staff at the beginning of the evaluation. It would have provided additional context for our field visits. We were able to compensate by spending a very useful debrief session to fill in holes and correct misconceptions.

ANNEX III. PERSONS INTERVIEWED

KEY INFORMANT INTERVIEWS

NO.	NAME	TITLE	ORGANIZATION	COUNTRY
UNITED STATES				
1.	Erin Mielke	Reproductive Health Senior Technical Advisor	USAID	USA
2.	Mary Ellen Stanton	Senior Maternal Health Adviser	USAID	USA
3.	Alanna White	Program Analyst	USAID	USA
4.	Laura McGough	Maternal and Child Health Technical Advisor	USAID	USA
5.	Elizabeth Fox	Deputy Coordinator Child and Maternal Survival, Director Office of Health, Infectious Diseases, and Nutrition	USAID	USA
6.	Ellen Starbird	Director, Office of Population and Reproductive Health Bureau for Global Health	USAID	USA
7.	Lauri Romanzi	Project Director	FC+ (Global Office)	USA
8.	Vandana Tripathi	Deputy Director	FC+ (Global Office)	USA
9.	Bethany Cole	Global Projects Manager	FC+ (Global Office)	USA
10.	Neal Lesh	Chief Strategy Officer	Dimagi	USA
11.	Mary Nell Wegner	Executive Director	Maternal Health Task Force	USA
12.	Maggie Bangser	Founder/Former CEO of Women's Dignity Project, Tanzania	Bangser Consulting, formerly Director of Women's Dignity	USA
BANGLADESH				
13.	Dr. SK Nazmul Huda	Country Project Manager	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
14.	Dr. Farhana Akhter	Senior Program Officer	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
15.	Ms. Hena Baroi	Program Officer (M&E)	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
16.	Mr. Nitta Nondow Biswas	Program Officer (Community Engagement)	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
17.	Dr. Isart Jahan	Program Officer (Field activities)	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
18.	Md. Ashifur Rahman	Asst. Admin & Finance Officer	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
19.	Dr. Tariqul Islam	Director	Ad-din Women's Medical College Hospital	Bangladesh
20.	Dr. Nahid Yasmin	Director-Hospital	Ad-din Hospital, Dhaka	Bangladesh
21.	Dr. Md. Golam Mortuza Shikder	Director-Hospital	Ad-din Hospital, Khulna	Bangladesh

NO.	NAME	TITLE	ORGANIZATION	COUNTRY
22.	Dr. Sayada Farjana Yasmin	Assistant Professor	Ad-din Akij Medical College Hospital, Khulna	Bangladesh
23.	Ms. Lonia Rahman	Fistula Nurse	Ad-din Hospital, Dhaka	Bangladesh
24.	Ms. Arpita Biswas	Senior Staff Nurse	Ad-din Hospital, Khulna	Bangladesh
25.	Mr. Kyle Scott	Executive Director	LAMB Hospital, Parbatipur, Dinajpur	Bangladesh
26.	Dr. Antje Oosterkamp	Medical Director	LAMB Hospital, Parbatipur, Dinajpur	Bangladesh
27.	Dr. Bea Ambauen	Fistula Surgeon	LAMB Hospital, Parbatipur, Dinajpur	Bangladesh
28.	Ms. Bulbuli Mollik	Nursing Director	LAMB Hospital, Parbatipur, Dinajpur	Bangladesh
29.	Dr. Dulal Chandra Podder	Director & Fistula Surgeon	Kumudini Hospital, Mirzapur, Tangail	Bangladesh
30.	Dr. Bilkis Begum	Assistant Professor & Fistula Surgeon	Kumudini Hospital, Mirzapur, Tangail	Bangladesh
31.	Ms. Shefali Rani Sakar	Vice Principle	Kumudini Nursing Institute, Mirzapur, Tangail	Bangladesh
32.	Prof. Saleha Begum Chowdhury	Advisor	University Fistula Center, Bangabandhu Sheikh Mujib Medical University (BSMMU)	Bangladesh
33.	Dr. Farhana Alam Foara	Program Officer	University Fistula Center, BSMMU	Bangladesh
34.	Prof. Sayeba Akhter	CEO, Fistula Surgeon	MAMM'S Institute of Fistula & Women's Health, Dhaka	Bangladesh
35.	Prof. Dr. Khalilur Rahman	Anesthesiologist & Consultant	Dr. Muttalib Community Hospital, Dhaka	Bangladesh
36.	Prof. Dr. Anowara Begum	Fistula Surgeon	Dr. Muttalib Community Hospital, Dhaka	Bangladesh
37.	Dr. Lucky Ghose	Senior Medical Officer-HNPP	BRAC	Bangladesh
38.	Mr. Hasnain Sabin Nayak	Country Director	HOPE Foundation for Women and Children of Bangladesh, Cox's Bazar	Bangladesh
39.	Dr. SK Nazmul Huda	Country Project Manager	Fistula Care Plus Project, EngenderHealth Bangladesh	Bangladesh
DEMOCRATIC REPUBLIC OF CONGO				
40.	Dr. Justin Paluku	Fistula Surgeon, Obstetrician - Gynecologist, & Hospital Director	Heal Africa, Goma	
41.	Dr. Barthelemy Aksanti	Project Manager	Heal Africa, Goma	DRC
42.	Dr. Tina Amisi Notia	Fistula Surgeon & Project Manager	Hopital General de Reference de Panzi, Bukavu	DRC
43.	Dr. Dolorès Nembunzu	Fistula Surgeon, Hospital Director & Project Director	Hopital St. Joseph, Kinshasa	DRC
44.	Prof. Ahuka Ona Longombe	Fistula Surgeon & Medical Director	Imagerie des Grandsa Lacs (IGL), Beni	DRC
45.	Dr. Gisele Kilomba	Fistula Surgeon	Imagerie des Grandsa Lacs (IGL), Beni	DRC

NO.	NAME	TITLE	ORGANIZATION	COUNTRY
46.	Aime-Noel Muisha Kaneno	General Director	Imagerie des Grandsa Lacs (IGL), Beni	DRC
47.	Prof. Jean Pascal Manga Okenge	Fistula Surgeon & Project Director	Maternite Sans Risque de Kindu (MSRK), Kindu	DRC
48.	Dr. Aime Manga Lomane	Fistula Surgeon & Obstetrician Gynecologist, Hospital Director	Maternite Sans Risque de Kindu (MSRK), Kindu	DRC
49.	Dr. Xavier Tshibangu Wa Tshibangu	Fistula Surgeon & Obstetric Gynecology Assistant	Maternite Sans Risque de Kindu (MSRK), Kindu	DRC
NIGERIA				
50.	Dr. Habib Sadauki	Country Project Manager	Fistula Care Plus	Nigeria
51.	Dr. Adamu Isah	Deputy Country Project Manager	Fistula Care Plus	Nigeria
52.	Stanley Obinna	Finance and Operations Manager	Fistula Care Plus	Nigeria
53.	Eberechukwu Diokpo	Project Officer	Fistula Care Plus	Nigeria
54.	Emmanuel Ogbe	Administrative and Logistics Officer	Fistula Care Plus	Nigeria
55.	Suleiman Zakaria	Clinical Associate, Abuja	Fistula Care Plus	Nigeria
56.	Amodu Abiodun	Clinical Associate, Sokoto	Fistula Care Plus	Nigeria
57.	Ibrahim Haruna	Program Assistant	Fistula Care Plus	Nigeria
58.	Solomon Ameh	Project Accountant	Fistula Care Plus	Nigeria
59.	Samuel Ubeke	Finance and Administrative Officer	Fistula Care Plus	Nigeria
60.	Olajumoke Adekogba	Reproductive Health/Family Planning Advisor, Abuja	Fistula Care Plus	Nigeria
61.	Ademola Afolabi	Logistics Officer	Fistula Care Plus	Nigeria
62.	Amina Bala	Community Mobilization Officer	Fistula Care Plus	Nigeria
UGANDA				
63.	Dr. Amandua Jacinto	Assistant Commissioner-RH	Ministry of Health	Uganda
64.	Dr. Francis Mugume	Surgeon	Ministry of Health	Uganda
65.	Dr. Peter Mukasa	Fistula focal person	Ministry of Health/ UNFPA	Uganda
66.	Molly Tumusiime	Program Associate Community Engagement	EngenderHealth	Uganda
67.	Dr. Paul Muwanguzi	Senior Clinical Associate	EngenderHealth	Uganda
68.	Hassan Kanakulya	Program Associate M&E	EngenderHealth	Uganda
69.	Kakembo Samuel	Project M&E Officer	EngenderHealth	Uganda
70.	Lucy Asaba	Program Associate Medical	EngenderHealth	Uganda
71.	Dr. Rose Mukisa	Country Manager	EngenderHealth	Uganda

NO.	NAME	TITLE	ORGANIZATION	COUNTRY
72.	Agnes Were	Program Officer- Community Engagement	EngenderHealth	Uganda
73.	Dr. Joseph Ruyonga	Assistant District Health Officer	Hoima	Uganda
74.	Annet Mutagaywa	District Health Officer	Hoima	Uganda
75.	Dr. Francis Mulwany	Hospital Director	Hoima RRH	Uganda
76.	Dr. Ian Asiimwe	Trainee Surgeon	Hoima RRH	Uganda
77.	Sr. Florence Aceng	Senior Principle Nursing Officer	Hoima RRH	Uganda
78.	Dr. Stuart Musisi	District Health Officer	Masaka District	Uganda
79.	Brenda Kiyongi	Assistant District Health Officer	Masaka District	Uganda
80.	Dr. Lynch Maura	Hospital Medical Director	Kitovu Mission Hospital	Uganda
81.	Dr. Florence Nalubega	Resident Surgeon	Kitovu Mission Hospital	Uganda
82.	Mother Winnie	Fistula Nurse	Kitovu Mission Hospital	Uganda
83.	Dr. Kirya Fred	Expert Surgeon	Ministry of Health	Uganda
84.	Dr. Barageine Justus	Expert Surgeon	Ministry of Health	Uganda
85.	Nathan Kyamanywa	Bishop	Bunyoro Kitara Diocese	Uganda
86.	Joram Kavuya	Diocesan Coordinator	Bunyoro Kitara Diocese	Uganda
87.	Rev. Can. Samuel Kahuma	Diocesan Secretary	Bunyoro Kitara Diocese	Uganda
88.	Rev. James Joloba Adyeri	Diocesan Health Coordinator	Kibaale/Hoima DHC	Uganda
89.	Alice Emasu	Executive Director	Terrewode	Uganda
90.	VHTs	Village Health Team	Buraru/Buseruka	Uganda
SURGEONS INTERVIEWED				
91.	Dr. Ahuka Ona Longombe	Fistula Surgeon/ Urologist/Medical Director	Imagerie des Grands Lacs	DRC
92.	Dr. Hangi Vumilia	Fistula Surgeon/General Surgeon	Imagerie des Grands Lacs	DRC
93.	Dr. Ngabo Deogratias	Fistula Surgeon/Consultant Gynecologist	Imagerie des Grands Lacs	DRC
94.	Dr. Cristophe Kimona	Fistula Surgeon/General Surgeon	Imagerie des Grands Lacs	DRC
95.	Dr. Justin Paluku Lusi	Fistula Surgeon/ Gynecologist	HEAL Africa	DRC
96.	Dr. Luc Malemo	Fistula Surgeon/General Surgeon	HEAL Africa	DRC
97.	Dr. Médard Kabuyaya	Fistula Surgeon/General Surgeon	HEAL Africa	DRC
98.	Dr. Benjamin Kalole	Fistula Surgeon/ Gynecologist	HEAL Africa	DRC

NO.	NAME	TITLE	ORGANIZATION	COUNTRY
99.	Prof. Dr. Jean Pascal Manga Okenge	Fistula Surgeon/ Senior Gynecologist	Maternité sans Risque	DRC
100.	Dr. Aime Manga Lomame	Fistula Surgeon/ Gynecologist	Maternité sans Risque	DRC
101.	Dr. Tubadi Nakuna	Fistula Surgeon/General Surgeon	HGR PANZI	DRC
102.	Dr. Kabiru Abubakar	Fistula Surgeon/ Gynecologist	Laure Madaki FC, Kano	Nigeria
103.	Dr. Aliyu Elladen	Fistula Surgeon/ Gynecologist	National VVF Centre, Katsina	Nigeria
104.	Dr. Sadiya Nasir	Fistula Surgeon/ Gynecologist	National VVF Centre, Katsina	Nigeria
105.	Dr. Mairo Hassan	Fistula Surgeon/ Gynecologist	Sokoto Specialist Hospityal	Nigeria
106.	Dr. Abubakar Bawa Dakingari	Fistula Surgeon/GMO	Gesse VVF Center, Birnin Kebbi	Nigeria
107.	Dr. Abubakar Bello	Fistula Surgeon/GMO	Maryam Abacha Hospital, Sokoto	Nigeria
108.	Dr. Lawal Bello	Fistula Surgeon/GMO	Maryam Abacha Hospital, Sokoto	Nigeria
109.	Dr. Muhammad Musa Birnin-Tsaba	Fistula Surgeon/GMO	Faridat Yakubu Hospital, Gusau	Nigeria

ANNEX IV. SOURCES OF INFORMATION

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ANNEX V. DATA COLLECTION INSTRUMENTS

Interview Guide for Fistula Patients

4. Where are you from? Currently Married? Children- any? How many?
5. How long have you been living with fistula?
6. How did you come to have fistula?
7. How did you learn that there are services to repair fistula? How long did it take for your to go for screening? What difficulties did you face in accessing care?
8. Do you know other women in your community that have fistula? What challenges do they face? Are they accessing care? (why not) Where?
9. What were you told during the screening session when you first sought care to repair your fistula?
10. What questions did you want to ask during the screening? Were you able to ask them? How satisfied were you with the answers?
11. How long did you have to wait between getting screened and having your surgery?
12. Where did you stay during this time?
13. What kind of concerns did you have before having your surgery? Were you able to discuss your concerns with the provider?
14. After the surgery, how long was your hospital stay?
15. What were you told about the results of your surgery?
16. What were the messages you were given about how to care for yourself after your leave the hospital?
17. What have you learned about family planning (as a fistula patient)? Did you husband or family member attend the counseling session?
18. How satisfied were you with the information and services you received in the facility?
19. Have you been offered any reintegration services? Please describe. How useful is it to you? What services would be useful?
20. What did you like most about fistula services?
21. What did you like the least?
22. What changes could be made to improve the program for women like you?

Interview Guide for Fistula Ward Nurses

1. How frequently are fistula surgeries performed?
2. Besides working on the fistula ward, what other duties in the hospital are fistula nurses expected to do?
3. Are you receiving the information you need about individual patients to provide appropriate care for them? Please describe the type of information, and who normally gives it to you.
4. Do you have enough information to care for a patient after surgery? If not, what information is missing?
5. What kind of specialized training in fistula care did you receive? Who provided it? How long was the training?
6. What role do family members play in patients' post-operative care? How do women without a family manage?
7. When do you provide counseling services? What topics do you cover?
8. In what areas of fistula care would you like to develop additional skills or knowledge through training? Do you have access to these opportunities?
9. How would you improve care for fistula patients? Any suggestions?

Interview Guide for Outpatient Nurses

1. What are the steps involved in fistula screening?
2. Who screens the patients?
3. What days do you screen for fistula?
4. Once you confirm a woman does have a fistula, what happens next?
5. What kind of counseling is provided to women identified after screening?
6. Who besides the woman is present during screening?
7. At what point in the screening process are women or family members allowed to ask questions?
8. Who obtains and gives consent for the woman to have surgery?
9. What costs does the woman have related to screening?
10. If a woman is scheduled for surgery at a future date, what are her options for where to stay during the waiting period? How long is the typical waiting period between screening and surgery?
11. If a woman goes home during the waiting period, who pays her transportation costs to go home and come back?
12. What other costs associated with surgery and recovery is the woman responsible for?
13. What happens to women who cannot afford fistula services? What are her options?
14. What are the challenges health workers face in screening for fistula?
15. How do you identify which women with fistula are eligible for surgery?
16. What happens when a woman comes for screening who does not speak any of the languages spoken by staff at the hospital?
17. Are staff involved in fistula care compensated differently than other staff performing similar duties?
18. What happens when a woman is found not to have fistula, but instead has prolapse or some other cause of incontinence?
19. In your experience, what percentage of fistula patients discharged return for follow-up visits? What is the average time between discharge and follow up?
20. When do you provide counseling services? What topics (probe: FP, sexual relations, future pregnancies, signs of infection)?

Interview Guide for Healthcare Providers and Administrators

Advocacy/Policy (Hospital Administrators)

1. What do you know about the Fistula Care project?
2. What model of implementation is used here (camp or routine services)?
3. What are the implications of the different models for developing sustainable prevention, treatment, and reintegration services?
4. What determines where services are located? Are these decisions need-based; supply or demand driven (age and other social and economic determinants); politically; or other?
5. What have been the policy oriented activities at the country level?
6. What have been the greatest policy challenges?
7. What have been the most notable policy achievements, so far?
8. What kinds of changes in policy are needed in the future?
9. What are the implications for countries of free c-section policies? What are some potential funding mechanisms for free services and how can different mechanisms expand access?
10. In addition to the project, where do other sources of financial support for fistula care at your facility come from? What is the relative proportion of these different sources of funding?
11. Has your site been involved in the integration of prolapse and fistula services?
12. Can you describe the outreach activities you have in place for recruitment of women for fistula and prolapse repair? Who is in charge of outreach and how are their efforts evaluated?
13. What type of support is provided for women who pass basic screening?
14. Reimbursement for cost of transport
 - Financial support for family care giver
 - Lodging facilities at site
 - Provision for babies and young children, and companions
 - Food
 - Cell phones for transfer of funds and referral
 - Sources of livelihood
 - Translation services for women from ethnic groups from outside of catchment area
15. How can policies be operationalized?
 - Costs to facilities?
 - Cost of post-repair care
 - Cost of post-repair c-sections for future births
 - Costs to patients and families beyond direct service costs
16. How do they work with non-fistula partners, like the Safe Motherhood community and others?

Prevention (Administrators, Physicians, and Nurses)

17. Are there public information messages about fistula services in your region? How well is the information understood by women and their families?
18. Are there tangible indications of reduced stigma (e.g. greater numbers of women, referred for care, who are accompanied by family members)?
19. Are the health primary care facilities/hospitals or any other group doing anything to reduce stigma and discrimination in the areas they work in?
20. Is the project taking advantage of facility-based opportunities for bridging from fistula care to facility level obstetric care prevention (e.g., 3rd delay and c-section competency and quality)?
21. Is the project doing anything to increase the competency for c-sections among general practitioners?
22. How effectively are MH efforts being linked to Fistula care?
23. Has the project also trained midwives, and nurses in BEmOC, and doctors in CEmOC?
24. What is the project doing to improve early diagnosis? How soon after delivery can you diagnose?
 - Before discharge after giving birth?
 - At first post-partum visit?
25. How receptive is your fistula repair facility to integrating FP into their services? Are there some examples where the integration has taken place, and what are the challenges/successes?

Treatment

26. What is the available capacity of services and to what extent do they meet the need?
27. What are the biggest barriers to providing quality of care?
28. Whose responsibility is it to resolve quality of care problems?
29. What quality interventions (tools and procedures) have been implemented in fistula facilities?
30. Which of the tools that have been developed by FC are being used at facilities?
31. What are some of the challenges to using the tools?
32. Which tools and procedures are easiest or hardest to use?
33. Are there any changes that have occurred as result of using the FC tools (describe)?
34. How can the tools that are difficult to use or not so relevant to the institutional environment be made more useful?
35. What type of feedback do facilities get from clients on satisfaction or quality of care?
36. How do facilities use patient feedback information?

37. Are there any mechanisms to involve patients (or the community) in program planning or oversight of the facility?
38. What is the standard for successful repair?

Demand for Services

39. How is demand created?
40. How is information on fistula disseminated (by word of mouth, mass media, referral, other)?
41. To what extent does quality of care influence demand?
42. What kind of outreach do women respond best to?
43. What kind of information is provided to women and their families about where to go for services?

Access/Availability

44. What are the constraints to access and how is the project or the facility addressing these?
45. What are the constraints to availability of services and how are these being addressed by the project and the facility? How do these affect access?
46. What is an efficient model for screening and preparing patients for surgery in numbers in balance with the capacity of services to provide treatment and post-operative care?
47. How can this information about **real** (i.e. ability to meet the demand) availability of services be better communicated to potential clients?
48. What are the referral models (Those that are part of the health system and those “outside” of the health system (i.e., self-referral and word of mouth)?
49. What are FC and others doing to improve fistula referral and counter referral systems?
50. Are all opportunities taken advantage of to ask about women’s health:
 - Post-partum visits
 - Post-partum family planning
 - Child health visits

Monitoring and Evaluation of Progress:

51. Is the quarterly monitoring information collected by EH, useful input for decision-making for the fistula care facility?
52. Has the process for reporting the indicator data served both project management the hospital’s needs?
53. What have been some of the data collection, recording, and reporting challenges? How can these problems be overcome?

Training and Research

54. What are the different training models in your country?
55. What are the training models supported by the project in your facility?
56. Are you aware of the FIGO/WHO model? Are using it?
57. How well does the FIGO/WHO training model meet the needs of the capacity- building needs in your facility and in the rest of the country?
58. Is there a need for certification in fistula repair for all types of surgeons and nurses to be considered qualified?
59. What is the required level needed for doctors and nurses for
 - Competency
 - Technical knowledge and assistance
60. Training Nurses and Midwives: Are nursing and midwifery schools teaching students to detect prolonged labor, to use the partograph, and to detect incontinence related to fistula?
61. To what extent are the counseling and fistula nursing care curricula being used in your country? How effective are they in training nurses and midwives (challenges/successes)?
62. To what extent are job aids developed by the project being used in your facility? Is their use confined only to FC supported facilities or are they being used more widely?
63. How were research topics supported by the project identified and selected?
64. Were national researchers involved in research design? What has been local level involvement in planned or current research and dissemination activities?
65. Who sets the research agenda?
66. How has the project built research capacity at the local level?
67. What areas of your program would benefit from research?
68. To what extent are the research findings informing your service delivery?

Sustainability

69. If FC ends what happens?
70. Are there transition plans in place?
71. What is the required level needed of
 - Competency
 - Technical knowledge and assistance
 - Financing
 - Political will
72. What should the project do in your country to sustain services?

73. In the next year, 2 years, and beyond, which activities could you phase out without affecting outcomes? What would you add or do differently with regard to partnerships and strategy?

Interview Guide for Village Health Teams

1. Tell us about your training to be a village health worker. What kind of additional training did you receive from Fistula Care +?
2. Tell us about your outreach to the community. Door-to-door? How do you conduct outreach? How often?
3. Tell us about your efforts to increase utilization of FP, ANC and delivery services. What approaches are successful? Which area is still the most challenging? Why?
4. In your opinion, how important is men's involvement in fistula prevention and treatment services? Please tell us about your successes and challenges in involving men.
5. Tell us about your relationship with the nearest health facility and with your supervisor. How often do you talk with your supervisor (in person, phone)?
6. Please tell us about the community beliefs about fistula. Is stigma still a problem for women living with fistula? Please give examples.
7. Please tell about the reintegration of women after repair. How successful is reintegration with family and community? What challenges remain?
8. In your opinion, do most women living with fistula come forward for repair services? Do you know about any women that do not? (If yes, why? What barriers?)

Interview Guide for Sub-Awardees (MHTF, Dimagi, Fistula Foundation, Population Council, and Terrawode) and International Partners (UNFPA, WHO, FIGO, ISOFS)

1. Briefly describe your role on or involvement with FC+
2. To what extent has Fistula Care Plus supported country ownership of fistula programming?
3. Based on your knowledge to in what ways has FC+ contributed to:
 - a. Scale up of fistula services and related programming?
 - b. Sustainability of fistula services and related programming?
 - c. Quality of services?
4. What contributions has FC+ contributed to global leadership on fistula?
 - a. On advancing research?
 - b. Promoting innovation?
 - c. Transfer of new technologies
5. What changes have you detected in technical direction and management of FC+ compared to FC? Are these positive or negative?
6. What are some other promising fistula models and approaches not addressed by FC+?
7. What are some of the continuing challenges and gaps that are not being addressed by FC+?
8. What other directions or key initiatives, activities, or approaches warrant future investment by USAID beyond the end of FC+?

Interview Guide for Follow-up Questions on Management for USAID

1. We are still struggling with question #3 and would greatly benefit from a bit of history on what changes this question refers to and when they took place. We are also interested in hearing about the impetus for the changes in key personnel and other critical positions on the team.
 - a. What was the status of the technical direction at the end of FC
 - b. What is the status of technical direction now?
 - c. What accounts for the change?
 - d. How has the management style changed and what are the implications of that change?
2. What is your understanding of who among the FC+ Team provides global leadership for :
 - e. Quality of Care
 - f. Detection and Treatment
 - g. Family Planning integration
 - h. Prolapse integration
 - i. Prevention
 - j. Reintegration

For instance, at this point in the project, how advanced did you expect the prolapse integration to be in different countries?

1. The other issue we are finding challenging to address is the question about sustainable capacity for prevention, detection, treatment, and integration. We are not clear if there is some ultimate measure of each of those dimensions of fistula programming, or if sustainability should be measured more relatively, for instance as a relative decline in the need for repairs with increased focus and investment on prevention? At what point should there be a pivot?

Interview Guide for Males (country specific)

1. How did you learn about fistula?
2. What brought you to XXX Hospital?
3. What is your relationship to the fistula patient you came with?
4. Who made the decision to come to the services?
5. Can you explain what a fistula is?
6. What causes fistula?
7. How can you prevent fistula?
8. What can be done once a woman has it?
9. How much does the screening cost? What additional costs are there for the surgery?
10. Who will pay?
11. Can a man suffer from this condition?
12. How many days have you spent on this trip with your wife, sister, mother, or other?
13. How long ago did she develop fistula?
14. When a woman is in labor, who decides if and when she should seek care at a health facility?
15. Did your wife, sister, mother, etc, give birth at a health facility?
16. How long was she in labor before she went? Who went with her?
17. How long did it take to get there? What were some of the difficulties encountered in getting there?
18. How long did she wait after arriving at the health facility before someone helped her?
19. What is your opinion about her care so far at this facility?
20. What do you like most? What do you like least about the care and how she is treated? What do you like most about how you were treated? What do you like least?
21. What parts of the screening process and counseling sessions did you participate in?
22. What did you learn through your participation about fistula? About FP? About whether your wife, sister, mother can have children in the future?
23. If she does get pregnant again, what should she do differently? What would you do differently?
24. What will happen if her surgery is not successful? What will you do?
25. What would you recommend to make the services at this hospital better?

ANNEX VI. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law, or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE The undersigned accepts the terms and conditions of this Agreement.

<u>Deborah A. Caro</u>	<u>3/3/2106</u>
Signature	Date
<u>Deborah A. Caro</u>	<u>Consultant</u>
Name	Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
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6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
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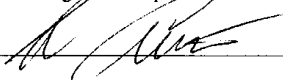
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	APR 19, 2016
Signature	Date
STEVEN ARROWOOD	CONSULTANT FISTULA SURGEON
Name	Title

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