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Photo: Marcel Reyners

Thematic Evaluation

of National Programmes and UNFPA Experience in the Campaign to End Fistula

Assessment of national programmes

VOLUME II: Synthesis Report

Final report – March 2010

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Photo: Marcel Reyners. Picture of women at the rehabilitation centre in Kano, taken after consent.

Thematic Evaluation

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The Evaluation Team

Reet, March 2010

List of abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ARO	Africa Regional Office
BemOC	Basic Emergency Obstetric Care
BCC	Behavioural Change Communication
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP	Comprehensive Council Health Plan (Tanzania)
CemOC	Comprehensive Emergency Obstetric Care
CFA	Community Fistula Advocates
CO	Country Office
CP	Country Programme
CPAP	Country Programme Action Plan
CPR	Contraceptive Prevalence Rate
CS	Caesarean section
CSBA	Community Skilled Birth Attendant (Bangladesh)
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DGHS	Directorate General of Health Services (Bangladesh)
DHS	Demographic and Health Survey
DMCH	Dhaka Medical College Hospital (Bangladesh)
DOS	Division for Oversight Services
DRC	Democratic Republic of Congo
EmOC	Emergency Obstetric Care
FBO	Faith Based Organisation
FCFA	African Financial Community Franc (Franc de la Communauté Financière Africaine)
FIGO	International Federation of Gynaecology and Obstetrics

FMoH	Federal Ministry of Health (Nigeria)
FP	Family Planning
FWG	Fistula Working Group
HDI	Health Development International (Niger)
GRD	Global Regional Divisions
HERA	Health Research For Action (Belgium)
HIV	Human Immunodeficiency Virus
HPSP	Health and Population Sector programme (Bangladesh)
HQ	Headquarters
ICPD	International Conference on Population and Development
ICRH	International Centre for Reproductive Health (Belgium)
IDB	Islamic Development Bank
IEC	Information, Education and Communication
IGA	Income-generating activities
ISOFS	International Society of Fistula Surgeons
LGA	Local Governmental Area (Nigeria)
MCH	Medical College Hospital (Bangladesh)
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MoH	Ministry of Health (DR Congo, Kenya, Niger, Pakistan, Sudan)
MoH&FW	Ministry of Health and Family Welfare (Bangladesh)
MoH&SW	Ministry of Health and Social Welfare (Tanzania)
MTEF	Medium Term Expenditure Framework
NFP	National Fistula Programme (Tanzania)
NGO	Non-Governmental Organisation
OB-GYN	Obstetrician-Gynaecologist
OECD	Organisation for Economic Cooperation and Development

OF	Obstetric Fistula
OFWG	Obstetric Fistula Working Group
PAUSA	Pan African Urological Surgeons´ Association
PDSN	Plan for Health Development (Plan de Développement Sanitaire, Niger)
REF	Network to Eliminate Fistula (Réseau d'éradication de la fistule, Niger)
RG	Reference Group
RH	Reproductive Health
RHCS	Reproductive Health Commodities Security
RO	Regional Office
RVF	Recto-vaginal fistula
SMAGHOMCH	Sylhet MAG Osmani Medical College Hospital (Bangladesh)
SMoWASD	State Ministry of Welfare and Social Development (Nigeria)
SRO	Sub-Regional Office
TBA	Traditional Birth Attendant
TD	Technical Division
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
US	United States (of America)
USAID	United States Agency for International Development
USD	United States Dollar
VMW	Village midwife
VVF	Vesico-Vaginal Fistula
WD	Women's Dignity
WHO	World Health Organisation

Executive Summary

Background

In 2003, the **United Nations Population Fund (UNFPA) and partners** launched a global *Campaign to End Fistula*[1]. The *Campaign* is currently in its second implementation phase (2006-2010). It has raised a total of 31 million US dollars between 2004 and 2008. The *Campaign* supports fistula prevention as well as treatment and psychosocial support of women living with fistula in more than 45 countries. At the regional and global level, the *Campaign* provides technical support to national programmes and engages in international advocacy for the elimination of fistula.

Between April and December 2009 the **HERA** Consortium made up of HERA (Health Research for Action, Belgium) and ICRH (International Centre for Reproductive Health, Belgium) carried out a mid-term evaluation of the current phase of the *Campaign*. We conducted field missions to Bangladesh, Nigeria, the Democratic Republic of the Congo and Niger; we performed desk reviews of national fistula programmes in Kenya, Pakistan, Sudan and Tanzania, and we sent questionnaires to 40 UNFPA country offices (CO) and received 24 replies for a response rate of 60%.

An estimated 97% percent of gynaecological fistula[2] are of obstetric origin, caused by prolonged obstructed labour. Iatrogenic fistula caused by gynaecological surgery and traumatic fistula caused by direct injury as a result of sexual violence or caused by cuts made into the vaginal tissue as part of traditional practices make up the remaining 3%. In some conflict situations, however, sexual violence is adopted as a weapon of war and there is a sudden rise in the incidence of traumatic fistula. This was documented in the Eastern Democratic Republic of Congo (DRC) at the beginning of the *Campaign.* Over a period of two to three years, the majority of fistula diagnosed and treated in this region were of traumatic origin.

The incidence and prevalence of obstetric fistula are not known. The most commonly quoted estimates are 2 million prevalent cases of obstetric fistula worldwide and 50,000 to 100,000 new cases annually. As part of the *Campaign*, UNFPA has encouraged the inclusion of questions about fistula in national Demographic and Health Surveys. The surveys report the proportion of women in the reproductive age group who state that they have or have had symptoms most likely caused by a fistula. The reports range from 0.3% in the DRC to 1.6 % in Malawi.

Advocacy and fistula prevention

At global, regional, national and community levels the *Campaign* has been effective in raising awareness about the causes of maternal mortality and morbidity. Fistula survivors have been outstanding ambassadors for the mobilisation of political and public support to maternal health services. The *Campaign* has paved the way for improved collaboration between UNFPA and the US Government. The community fistula advocates have helped raise the profile of the issue within their communities, their countries, and in international conferences and the international media.

The *Campaign* has created greater awareness about the issue of obstetric fistula among staff in the UNFPA country offices. Several country offices have included activities for the prevention and treatment of obstetric fistula in their Country Programmes. There are many potential synergies between *Campaign* activities and objectives, and the activities and objectives of the core mandate of UNFPA in reproductive health, gender equality and population. These synergies could be exploited more vigorously.

[1] In this document we will refer to the global Campaign as the *Campaign*. The Terms of Reference for this evaluation specified that the evaluation team was to address national programmes, and UNFPA's experience in the Campaign to End Fistula. One country, Tanzania, assessed by desk review in fact was included for comparison purposes. In Tanzania UNFPA's role in the national fistula programme has been marginal. The NGO Women's Dignity has had a key leadership role in promoting obstetric fistula issues in the country. Where relevant, e.g. in Bangladesh, the complementary experience of other partners such as Engender Health, has been discussed.

[2] In this report, the singular form "fistula" is used to denote the plural as well as the singular.

There is some evidence that national governments have increased their attention to maternal health in recent years. There are, however, still major gaps in implementation reflected in the slow progress on the reduction of maternal mortality. The *Campaign* is highly valued by national governments. In some countries, fistula prevention, treatment and care have been included in national reproductive health strategies. The *Campaign* has assisted countries in developing and implementing their maternal health strategy and contributed to raising the awareness about family planning, safe motherhood and fistula treatment. It has supported national efforts for the improvement of emergency obstetric care services. In most countries, however, the *Campaign* is perceived as being separate from the core collaboration on maternal and reproductive health between UNFPA and the Government. However, in some cases the 'vertical' fistula initiatives have also carved out a much-needed space for programming and policy work on fistula in countries where fistula was historically neglected and ignored. While it may still have contributed to the improvement of maternal health, the perceived vertical nature of the *Campaign* in some countries is a missed opportunity and a threat to sustainability.

In the countries studied, the *Campaign* has not provided direct support for the improvement of emergency obstetric care. In many countries these efforts are the core business of UNFPA, rather than specifically funded contributions of the *Campaign*. In most countries the contribution of the *Campaign* to increased access to, and utilisation of quality basic and emergency obstetric care has been through raising awareness of the need for accessing obstetric care for obstructed labour. Most of these efforts have been through IEC (Information, Education and Communication) rather than BCC (Behaviour Change Communication) and there have been few efforts to measure the success of this output. Prevention of obstructed labour and timely access to emergency obstetric care are key strategies for the prevention of fistula and for the reduction of maternal mortality. In some countries this message is sometimes displaced by other *Campaign* messages that are equally important but more distally related to the issue of fistula prevention, such as the messages for the prevention of child marriages in Nigeria and Bangladesh, and for the prevention of sexual violence in the DRC. User fees and transport costs are a major barrier to the timely use of emergency obstetric services in several countries studied. The evaluation team heard several testimonies of women who developed a fistula because their family could not raise the funds to pay for a Caesarean section in time.

Fistula treatment and care

In all countries studied, the main focus of the *Campaign* has been on increasing the access and utilisation to quality fistula repair services. This has included advocacy and community awareness activities to identify women in need of surgery, to reduce their social isolation, and to refer them for an effective treatment. It has included the establishment of training programmes and facilities for fistula surgery. In some countries the *Campaign* has supported mobile teams to provide treatment in campaign-style "fistula fortnights"; in others it has supported fistula treatment by expert teams in public or private hospitals. The level of decentralisation of services for fistula treatment is an important strategic consideration that needs to be evaluated within each country based on a number of local parameters in order to ascertain the ideal constellation of services (and training approaches) for each country.

In many countries, public communication about the availability of fistula repair services has yet to reach adequate coverage to produce the desired impact: identification of women requiring surgery, increase in the referral of women for treatment and in the number of fistula repairs performed. Due to resource limitations, a balance has to be struck between the use of mass media and direct communication. There are examples of successful community-based communication activities that are conducted in collaboration with the facility offering treatment as well as local and national NGOs (e.g. in Niger).

In all countries included in the evaluation, there were health facilities and individuals offering fistula repair services long before the *Campaign* was launched. Each country has its own champion(s) for fistula repair. UNFPA has drawn and built on this existing knowledge, expertise and infrastructure. In collaboration with other partners, UNFPA has supported the training of health care providers in fistula care, usually by supporting training programmes conducted by local experts and centres of excellence. There are some examples of training provided by internationally recognised centres in Ethiopia and Nigeria. Most countries have a number of "Master Trainers". In the eight countries

studied, a total of 1178 health care workers have been trained with the support of the *Campaign*, 374 of them in fistula surgery techniques. The remainder are nurses, anaesthetists, and social workers.

One of the main challenges of training programmes is that many of the physicians trained in fistula surgery are not practicing their skill or are performing too few surgeries to preserve them. Fistula surgeons need to perform 40 to 50 repairs annually to retain their competence. There are many reasons why trained operators are not active, including lack of financial incentives or assignment to facilities where the conditions are not suitable for surgery or where there is no demand for the service.

The direct support of fistula treatment sites has been a major focus of *Campaign* activities. In addition to supporting training, UNFPA has supported the renovation of facilities, the provision of equipment, the procurement of medicines and materials for surgery, and the subsidisation of treatment costs, including nutrition during hospitalisation. Between 2004 and 2008, a total of 6280 fistula repairs were performed with *Campaign* support in seven of the eight countries studied[3]. However countries are at best managing to treat about one third of incident cases. Since all countries have a significant backlog of untreated cases, the *Campaign* goal to eliminate fistula by 2015 is not likely to be achieved unless there is a substantive scale up of treatment activities combined with major progress in fistula prevention.

An important strategic question of the *Campaign* is the service delivery model for fistula treatment. The observed service model for fistula repair in the countries included in the study is a combination of national referral centre(s), services provided at tertiary level facilities, decentralised service provision at lower level facilities and regular campaign style fistula treatment campaigns or “fistula fortnights”. Each of these modes of delivery responds to a specific demand, and the appropriate mix should be chosen in each country based on complementarity of services.

Psychosocial support for fistula survivors

Social rehabilitation and psychological support services for fistula survivors are a weak link in the fistula management process. Two main types of social reintegration services exist, (i) fistula rehabilitation centres or facilities, and (ii) community-based initiatives. In the countries included in the study these types of services are initiated by Government or by local NGOs, with or without support from UNFPA. They offer differing levels of pre- and post-operative support, including skills training and micro-credit to assist the reintegration of fistula survivors back to their families and communities. Overall the availability and accessibility of rehabilitation services is insufficient. The quality of rehabilitation services provided with support of the *Campaign* is variable but often poor.

Observations of the four country missions indicate that programmes for the social support of fistula survivors work well when they create access to existing activities or programmes for the empowerment of women, such as education and skills training programmes, programmes designed to build self esteem, or programmes to support income generation. Women who are fistula survivors, however, need specifically targeted support to be able to access these programmes.

In the questionnaire survey, most respondents pointed out that social reintegration services are best provided by community-based organisations. The main role suggested for UNFPA is to provide technical and financial support to civil society organisations that focus on the social reintegration of fistula survivors.

Monitoring, evaluation and information systems

Information on fistula related activities including health facilities providing repairs, trained doctors and nurses, repairs and backlog and new cases is scarce, scattered, incomplete and difficult to obtain. The relevant information is often not included in the data collected by the national health information system, and the system itself is often very weak, even in countries with high fistula prevalence. Support for the strengthening of the national health information systems is an area where UNFPA and other stakeholders working on fistula eradication could join forces. In addition to routine data collection, there is a need for dedicated research to explore specific issues related to obstetric fistula.

[3] Tanzania did not receive support from UNFPA for fistula programming

The International Obstetric Fistula Working Group has drafted an Indicator Compendium which contains a comprehensive list of 59 indicators. The intention with the elaboration of the Compendium is to provide countries with a tool from which programme planners would select a minimum set of appropriate indicators to monitor their respective programmes. Based on this list, we constructed an indicator framework for the evaluation. This was to be completed by the UNFPA Country Offices in the countries selected for in-depth study. In the countries visited, obtaining data on many of these indicators proved to be a difficult task due to the weaknesses of the data recording and reporting systems in the countries in general and in particular for data on obstetric fistula. As a result of the wide scope of issues covered by the Indicator Compendium, a number of sources needed to be consulted, and sometimes it was not easy to find out where to look for information. For a number of indicators no routine data collection system exists and information on them is presently available only as a result of specific studies or publications. For many of the indicators, however, no data could be found.The countries have similar difficulties in reporting on the six global indicators agreed upon in 2006. The following are key findings of the evaluation missions in four countries:

- Demographic and Health Surveys provide information on key indicators regarding the overall context, particularly those related to unmet family planning needs, contraceptive prevalence rate, skilled attendance at birth, female literacy and median age at first birth. They also include data on Caesarean section rates which are broken down by socio-economic variables which show the level of access of poor and uneducated women to emergency obstetric care for obstructed labour. Several of them also include a survey of fistula awareness and fistula prevalence.
- Specific data on obstructed labour are scarce. In some countries studies have been carried out, in others there are negotiations to include these data in the routine health information system.
- Information on fistula treatment services is available at each facility, but not consolidated nationally.
- There are no mechanisms to collect and report data on the overall human resources situation for fistula treatment. Specific projects providing support on this area have their respective data and should be contacted separately in order to obtain it. Data on trained human resources supported by UNFPA was available, though incomplete. The same situation exists with regard to data on social integration services.

Role of the UNFPA Regional Offices and Headquarters

UNFPA country offices received varying levels of support and technical assistance (TA) from regional offices and from UNFPA headquarters. The capacity to support the *Campaign* from central levels in UNFPA is limited (human resources). Each country office participating in the assessment could nevertheless point to some activity or achievement that was supported by UNFPA headquarters or by a regional office (see sections 4.6 and 4.7). It is, however, clear that country offices did not receive the necessary technical assistance to address critical issues of monitoring and evaluation and of quality control. These will be areas requiring close attention if the *Campaign* activities are mainstreamed into Country Programmes. This is further discussed in the Recommendations in terms of the new TA modality for provision of TA by national/regional institutions with co-ordination/oversight by the Regional offices.

UNFPA headquarters has a key role in generating and maintaining international attention on the topic of obstetric fistula and on the need to focus on maternal health. This would become even more important if the activities and objectives of the *Campaign* are integrated into Country Programmes.

Conclusions and recommendations

The *Campaign to End Fistula* has achieved much in terms of awareness building and service development and has been a catalyst to mobilise countries towards addressing fistula prevention, treatment and care. The *Campaign* has been instrumental in leveraging additional support and resources, but should associate itself more clearly with the need for improved maternal health services.

The main recommendation of this report is for the integration of fistula prevention, treatment and care into UNFPA Country Programmes and into national reproductive health programmes. Only through this step will it become possible to move out of the project mode towards the sustained delivery of services towards the goal of making obstetric fistula as rare in developing countries as they are in the

industrialised world. The integration should be country-specific reflecting and building upon the strengths of each actor in-country including government ministries, UNFPA country offices, local NGOs and other partners. However, integration carries the risk that the achievements of the *Campaign* in creating public awareness and political support may gradually be lost. It will therefore be necessary to maintain the specific focus on fistula in advocacy, monitoring and technical assistance at the global, regional and national level.

Another recommendation to UNFPA is to better document, monitor and evaluate their programmes through a systematic and planned methodology (i.e. operations research methodology).

1. Introduction

1.1 The Campaign to End Fistula

In 2003, UNFPA and partners launched a global *Campaign to End Fistula* with the goal of making obstetric fistula as rare in developing countries as it is in the industrialised world. The target date for fistula elimination is 2015, in line with the MDG´s targets (Millennium Development Goals) to improve maternal health[4]. A global thematic proposal for the *Campaign to End Fistula* was submitted by UNFPA to major donors in the autumn of 2003 for the period of 2004-2006. The Country needs have grown more rapidly than anticipated, so the initial period was closed in late 2005 and a new proposal submitted to donors for the period 2006-2010. Therefore, the *Campaign* is now at late mid-term of the current period (2006-2010).

The *Campaign* has two components:
- It supports national programmes to eliminate fistula, and
- It provides global and regional support in the fight to end fistula.

The main expected results at national level outlined in the proposal are as follows:
- Enhanced political and social environment for the reduction of maternal mortality and morbidity;
- Integration of fistula interventions into ongoing safe motherhood and reproductive health policies, services and programmes including training of doctors/surgeons and nurses;
- Increased national capacity to reduce maternal mortality and morbidity;
- Increased access to and utilisation of quality basic and emergency obstetric care services;
- Increased access to and utilisation of quality fistula treatment services;
- Increased availability of services to assist women with repaired fistula to reintegrate into their community.

The *Campaign* is now working in more than 45 countries in Africa, Asia and the Arab region and involves a range of partners. In each country, it focuses on three key areas: prevention, treatment and rehabilitation.

Globally and regionally, the *Campaign* is working to build the evidence base and capacity for fistula-related interventions, to raise awareness, to formulate international and regional partnerships, and to mobilise political and financial support.

The **HERA Consortium**, made up of HERA (Health Research for Action, Belgium) and ICRH (International Centre for Reproductive Health, Belgium), has been contracted by UNFPA to conduct the Thematic Evaluation of National Programmes and UNFPA's experience in the *Campaign to End Fistula*.

1.2 Purpose and objectives of the thematic evaluation

As indicated in the Terms of Reference (see Annex 1), the evaluation will contribute to the evidence base for answering critical questions about effectiveness of approaches in fistula-related programming used to date and their role in relation to maternal health programmes. The evaluation will also aim to understand whether and how the *Campaign*'s approach - with

[4] Source: http://www.endfistula.org/campaign_brief.htm (consulted on June 9, 2009).

multiple strategies undertaken simultaneously at national, regional and global levels - has assisted in advancing the programme. The two main objectives are to:

- Assess the relevance, effectiveness and efficiency of the current strategies and approaches for national fistula programming;
- Assess the coordination, management and support from UNFPA global and regional levels to national level efforts.

The findings of the evaluation and the recommendations will be used to:

- Adjust strategies and approaches to improve the quality of national programmes;
- Enhance global and regional support;
- Document lessons learnt.

The evaluation includes two components: i) an assessment of national programmes, and ii) an assessment of global/regional activities in support of national programmes. A separate report for each assessment has been prepared. The evaluation team recognises that both assessments are very much interlinked and that the separation into two reports is somewhat artificial. The assessment of global/regional activities in support of national programmes is presented as a separate report in Volume I "Assessment of global/regional activities". Specific reports for the in-depth country studies as well as for desk reviews studies are presented in Volumes III-X. **This document presents the synthesis report of the assessment of national programmes**.

1.3 Methods

The Terms of Reference request that the evaluation of the national programmes will address the five standard **evaluation criteria** of the OECD Development Assistance Committee (DAC), being relevance, effectiveness, efficiency, impact and sustainability. The evaluation team proposed in the inception report to address these issues as follows:

- *Relevance* – Determine:

  a) how much the *Campaign to End Fistula* has responded to national priorities, how much it has contributed to the integration of fistula into ongoing national health programmes and how it has contributed to UNFPA's overall objectives.

  b) what role the *Campaign to End fistula* has played in:
     - ✓ leveraging additional support and resources for reproductive health, particularly maternal mortality and morbidity reduction;
     - ✓ increasing access to treatment and reintegration services;
     - ✓ increasing availability of data on obstetric fistula.

     (Note: some of these issues are also addressed under impact and sustainability).

- *Effectiveness*: Determine how much the *Campaign to End Fistula* is achieving its intended objectives in the areas of prevention, treatment and reintegration.

- *Efficiency*: Its assessment will focus on determining whether or not the *Campaign to End Fistula* has taken measures during planning and implementation to ensure that resources are efficiently used.

- *Impact*: Its assessment will focus on determining the positive and negative, primary and secondary, long-term effects produced by the *Campaign to End Fistula* directly or indirectly, intended or unintended.

- *Sustainability*: The evaluation will assess to what extent planned (and unplanned) benefits have been generated, appreciated and utilised by the target group and to what extent the *Campaign* has strengthened local institutional capacity.

To enable answering the evaluation questions, a sample of eight countries with a variety of experiences and at different stages of implementation of their fistula programmes were selected for analysis. Four countries having initiated the implementation of a fistula programme no later than 2004 were selected for in-depth case studies (including a field visit to each country): Bangladesh, Democratic Republic of Congo (DRC), Niger and Nigeria. Additionally, a focused desk review of another four countries has been performed: Kenya, Pakistan, Sudan and Tanzania. All countries selected for in-depth review or for desk review, except Tanzania, have received financial support from UNFPA through the *Campaign to End Fistula*[5]. Additionally, a short questionnaire was sent out to 40 UNFPA Country Offices (CO) and 24 responses were received (60% response rate)[6].

The **in-depth country assessments** are based on the review and analysis of available national documents, reports and data on the *Campaign* and on related issues and information gathered during a field visit to the country. In all the field visits to countries (except Bangladesh) the evaluation team was accompanied by UNFPA staff of the CO and the Africa Regional Office (ARO). The field visits included interviews with government officials from the various Ministries involved in obstetric fistula activities in the country as well as with UN partners and representatives from other agencies involved either in obstetric fistula prevention, treatment or social support for reintegration. Site visits (at least two in each country) were made to public and private health facilities providing services for obstetric fistula repairs (mostly public facilities, but private facilities were also visited in Bangladesh and DRC). The site visits included meetings with service providers, community mobilisers for obstetric fistula, and fistula clients. In Bangladesh it also included observation of obstetric fistula repairs. Public and private facilities providing social support or reintegration services were also visited. Health facilities providing maternal and child services as well as maternity departments in hospitals were included in Bangladesh, DRC, Niger and Nigeria.

The field visits took place in the period May to October 2009:

- Nigeria — May 21st to June 4th 2009
- Bangladesh — August 15th to August 25th 2009
- Democratic Republic of Congo — September 7th to September 16th 2009
- Niger — October 15th to October 25th 2009

The field visit to each of the countries concluded with a working session with staff from the UNFPA CO and relevant partners of the *Campaign* to present and discuss the preliminary findings and recommendations of the assessment. A draft report for each country assessment has been elaborated and submitted to the UNFPA CO for comments. The relevant comments received were incorporated into a final draft report for each country (see Volumes III-X).

The **desk review studies** are complementary to the in-depth country assessments with the purpose of confirming some of the main findings, challenges and hypotheses of the in-depth studies. The issues to be addressed by the desk studies (human resources, national coordination mechanisms, quality of care, service delivery models, and south-south

[5] Tanzania was selected as one of the countries for desk review, because it was thought that it was important to review a programme where the UNFPA Campaign to End Fistula has not been directly involved as well as to capture lessons learnt from this experience that might be relevant for the overall efforts in the fight to end obstetric fistula.

[6] One reminder was sent to countries that did not send responses by the due date.

collaboration) were agreed with UNFPA Headquarters (HQ) in mid-June 2009, after the completion of the first field visit.

The desk studies are mostly based on the analysis of available national documents, reports and data on the *Campaign* and on related issues and other information gathered. Telephone interviews with one or more key informants complemented the document review to gain deeper insight into critical questions. In Tanzania, taking advantage of the participation of the consultant in the annual meeting of the International Obstetric Fistula Working Group (OFWG), selected key informants involved in obstetric fistula activities in the country were interviewed on the 3rd and 4th September 2009. Also a site visit was made to the fistula unit at the Comprehensive Community Based Rehabilitation in Tanzania Disability Hospital in Dar es Salaam. A draft report for each country desk review has been elaborated and submitted to the CO for comments. The relevant comments received were incorporated in the final country report.

The **mail questionnaire** (see Annex 2) to the UNFPA CO addressed a number of specific questions on selected topics addressed by the evaluation. The following table presents the list of countries that responded to the mail questionnaire.

TABLE 1 - COUNTRIES THAT RESPONDED TO MAIL QUESTIONNAIRE

Benin	Guinea	Pakistan
Burkina Faso	Ivory Coast	Rwanda
Burundi	Kenya	Senegal
Cameroon	Liberia	Sierra Leone
Chad	Malawi	Sudan (North)
Congo (Brazzaville)	Mali	Tanzania
Eritrea	Mauritania	Uganda
Ghana	Nepal	Zambia

The results of the **assessments of the national programmes** are based on the findings from the in-depth country studies, the desk reviews, the responses to the questionnaires sent out to the UNFPA CO and interviews with staff from UNFPA HQ and sub-regional offices (SRO).

1.4 Limitations of the evaluation

Availability of data was scarce, difficult to find and often incomplete and non-reliable. The evaluation team was not to carry out primary data collection and therefore used as much as possible the information provided by the countries or existing information from other relevant sources. The Global Programme Proposal submitted to donors “Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010” (see chapter 3) does not identify specific indicators to monitor progress or targets to be achieved, except by the one expressed in the *Campaign*’s goal “to make fistula as rare in developing countries as it is in the industrialised world today as part of the global efforts to improve maternal health”, therefore it is not possible to measure progress against targets or indicators. The financial information provided by the UNFPA CO and HQ was also limited and allowed only the analysis of overall allocations and expenditures. It was not possible to make an analysis by type of expenditures or by activity - as intended - which could have provided better guidance for future investments.

1.5 Structure of the report

This document presents the findings and recommendations for the assessment of national programmes. Chapter 2 presents an overview on the epidemiology of fistula and how obstetric fistula relates to progress made towards reducing maternal mortality in the countries included in the evaluation. Chapter 3 presents a brief description of how the *Campaign* has been implemented in the respective countries and how it has been incorporated within the UNFPA country programmes (CP). It also presents who have been the partners of the *Campaign* at country level. The main findings of the evaluation are presented in Chapter 4. The progress towards achievements of expected results for national programmes are presented in section 4.1, including also a discussion on where obstetric fistula treatment services should be provided as well as on facilitating and constraining factors for the achievement of expected results. Issues related to national commitment and coordination, management of the *Campaign* at the CO, financial aspects, role/assistance from UNFPA HQ and regional level, south-south collaboration, and perceptions of stakeholders of UNFPA's role on obstetric fistula are addressed in sections 4.2 to 4.8. Chapter 5 presents the conclusions of the evaluation for each one of the evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability). The lessons learnt and the recommendations are presented in Chapter 6 and 7 respectively.

The results from the different in-depth country studies are compared with and, where relevant, complemented with the results of the desk studies and responses to the questionnaire to countries: both a vertical - by country - and horizontal analysis - by theme - have been performed. Key findings from the different phases of the evaluation are synthesised and main recommendations developed in this report.

2. Obstetric Fistula

2.1 What is Obstetric Fistula?

Obstetric fistula is a medical condition that arises most often as a complication of obstructed labour and results in an opening (fistula) between the bladder and the vagina (vesico-vaginal fistula; VVF) or between the rectum and the vagina (recto-vaginal fistula; RVF). In the case of VVF, a woman passes urine uncontrollably through the vagina, while in the case of RVF a woman passes faeces through the vagina. In some cases, these two conditions occur together. While obstetric fistula is both preventable and treatable, once it occurs it has severe health as well as psychological and socio-economic consequences. Women with this condition may not be aware that a treatment exists or may be too poor or too ashamed of their condition to seek and access care and surgical repair of the fistula. Additionally, they are often stigmatised by society and frequently abandoned by their families. Not all service providers know that a fistula sometimes can be cured without operation but with in-dwelling bladder catheterisation started immediately after the first fistula sign appears[7].

2.2 The epidemiology of obstetric fistula

There is limited data on obstetric fistula available and most of the data comes from hospitals where obstetric fistula repairs are conducted or from studies with a small sample size. Few population based studies are available. A literature review done by Stanton, et al.[8] with the purpose of identifying population based estimates of obstetric fistula concluded that "this literature review suggests that there are only two estimates of incidence and two of prevalence for which methods are described. The estimates of incidence range from an empirical estimate in Sub-Saharan Africa of 124 per 100,000 deliveries (or 33,000 annual cases) to a model-based estimate for all of sub-Saharan Africa of 18.8 per 100,000 women of reproductive age (20,000 annual cases). The **global prevalence** of obstetric fistula was estimated at 654,000 cases in 1990, and 262,000 of these cases are in sub-Saharan Africa".

The most commonly quoted estimates are two million prevalent cases of obstetric fistula worldwide, with 50,000 to 100,000 new cases annually[9]. However, the two million prevalence has been reported as a global total as well as the estimate for Africa, or for Africa and Asia.

With the greater attention to obstetric fistula both at national and international level, there is a demand for better epidemiological data on this condition. Efforts to acquire more reliable and accurate data are being made by some countries. For example, the 2004 Malawi DHS reports that 1.6% of women who gave birth in the five years preceding the survey have experienced leakage of urine or stools from the vagina. The 2006 **Niger** DHS reports that 0.2% of women of reproductive age referred to "have already had one obstetric fistula". The 2006-2007 DHS of **Pakistan** reports that less than 3% of ever married women who gave birth experienced the most common symptom of obstetric fistula, the dribbling of urine. In the 2007 DHS in the **DRC** 0.3% of women aged 15-49 reported having or having had a fistula. In **Bangladesh**, a small hospital based study conducted by Engender Health and funded by UNFPA in 2003 found that 1.69 per 1,000 ever married women were suffering from fistula. Until 2008, countries including and obstetric fistula module on their DHS were using non-standardized modules. This has resulted in a great variability in data. In recognition of this

[7] It is estimated that approximately 15% of fistula can be treated successfully with early catheterisation, but this is not well documented.
[8] C. Stanton, S.A. Holtz, S. Ahmed, Challenges in measuring obstetric fistula, International Journal of Gynaecology and Obstetrics (2007) 99, s4-s9.
[9] Idem.

variability, UNFPA and partners worked to develop a standard DHS module on obstetric fistula. Within the framework of the *Campaign to End Fistula*, UNFPA has been encouraging countries to include this module in their upcoming DHS. In fact, this standard module has been used by **Kenya and Nigeria** (2008) and **Burkina Faso** in their latest DHS[10]. **Bangladesh** may include this module in the next DHS, pending clarification of academic assessment of the module. In most countries the incidence rate for obstetric fistula has been calculated at 1-2 per thousand deliveries where the mother survives in situations where there is no easy access to a functioning obstetric care unit, as it has been suggested by Kees Waaldijk[11] based on his experience in northern Nigeria. The following table shows the estimated incidence and prevalence rates for obstetric fistula as well as the estimated number of fistula repairs done per year in the eight countries included in the evaluation.

TABLE 2 - ESTIMATED INCIDENCE, PREVALENCE OF OBSTETRIC FISTULA AND NUMBER OF ANNUAL FISTULA REPAIRS IN THE COUNTRIES UNDER REVIEW

Country	Obstetric Fistula Incidence (new cases per year)	Obstetric Fistula Prevalence (number of cases)	OF repairs done per year
Bangladesh	4,000 - 8,000	71,000	500 – 600
Democratic Republic of Congo	2,600 - 5,200	42,000	1,225 (2008)
Kenya	3,000	300,000***	900 - 1,000
Niger	700 - 1,400	6,000 (2006)	618 (2008)
Nigeria	20,000	200,000 - 250,000*	2,000 - 4,000
Pakistan	5,000 - 8,000	n.a.	390 (2006-2008)
Sudan	5,000	n.a.	100 - 200?
Tanzania	2,500 - 3,000°	n.a.	1,000

Source: See individual country reports, prepared for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.
Note: * Interview with Kees Waaldijk; ***Ministry of Health Division of Reproductive Health & UNFPA Kenya (2004), Needs assessment of Obstetric Fistula in Kenya, Final Report, February 2004; estimate developed by Tom Raassen, based on work of Kees Waaldijk in Nigeria; n.a.: not available.

The country data in the table reflect the mentioned weaknesses of the data on incidence and prevalence of fistula. The wide ranges in some countries could be an indication of the non-accuracy of the data or maybe an overestimation; these are though the available estimates for each country. Obstructed labour causes 97%[12],[13] of cases of obstetric fistula and at least 10% of maternal deaths. Therefore, tracking this would also help estimate fistula prevalence. The only data which currently can act as a proxy for an obstructed labour estimate is Caesarean section rates. However, it is important that these rates be analysed by socio-economic group in order to assess accessibility of services and determine service gaps between poor and non-poor. Caesarean section rates are also subject to overinterpretation,

[10] Preliminary results for the 2008 DHS for Kenya and Nigeria are available, but they do not include information on obstetric fistula.
[11] Kees Waaldijk is a fistula surgeon from The Netherlands who has worked in northern Nigeria doing fistula repairs since 1983. He has done some 15,000 repairs and has been actively involved in training of fistula surgeons as well as in establishment of fistula treatment centres in Nigeria. He is the current president of the International Society of Fistula Surgeons.
[12] Spurlock, John, Director of Urogynaecology and Pelvic Reconstructive Surgery, Department of Obstetrics and Gynaecology, St. Luke's Hospital of Bethlehem, updated on October 1, 2009, reported on http://emedicine.medscape.com/article/267943-overview, consulted on Dec. 8, 2009.
[13] Other estimates are lower an estimate that at least 80% of fistula are from obstructed labour, approximately 15% can be iatrogenic from C-section, forceps deliveries, vacuum extraction, and 2% secondary to sexual violence including FGC (Gishiri cut).

as Caesarean sections can be done for other reasons such as foetal distress or in higher socioeconomic groups, Caesarean sections have been done for non medical reasons. *It would be possible for most countries to track Caesarean section rates with further subanalysis of socio-economic breakdown in their DHS. This would help to strengthen the link between preventing fistula, and strengthening access to emergency obstetric care (EmOC), one of the three main interventions to reduce maternal mortality. UNFPA could encourage and support countries to carry out this analysis.*

A good proportion of women affected by obstetric fistula are not receiving the fistula treatment required. This gap is increasingly growing. In three of the eight countries reviewed (**Niger**, **Kenya** and **Tanzania**) the number of annual fistula repairs performed covers approximately only one third of the estimated number of new cases taking place each year (and therefore not addressing the existing backlog of cases). In the other countries this percentage is much lower, for example, 7.5%-12.5% in **Bangladesh** or 10%-20% in **Nigeria**. *Therefore the need to scale up efforts for both the prevention as well treatment of obstetric fistula is urgent. This will require increased national commitment, funding, and more efficient co-ordination.*

> ***"The main cause of obstetric fistula is obstructed labour which is not treated. Age, parity, religion, education, and social status are only contributing factors. We need to focus our messages on explaining the mechanics of obstructed labour and making EmOC services readily accessible through better Community Based Skilled Birth Attendance (CSBA) using partographs and timely referral."***
>
> ***Head, Gynae & Obs Dept, at Sylhet MAG Osmani Medical College Hospital, Bangladesh, August 2009***

A multitude of inter-linked risk factors acting negatively and simultaneously towards fistula risk seem to exist in most countries, often these factors being more pronounced in the lowest socio-economic segments of the population. For illustration purposes, the situation in **Bangladesh** is described below:

- *Poor socio-economic environment and abject poverty* which makes it impossible for poor women to mobilise money for transport and medical costs for obstructed labour – ambulances may cost 4,000 taka (or about 58 USD – impossible for families living below the poverty line of 1 USD per day);
- *Low education*, literacy, and status of women which makes it less likely for them to influence the decision-makers of the family, the husband and the mother-in-law for timely referral for obstetric complications;
- *Harmful traditional beliefs* such as believing witchcraft causes prolonged labours;
- *Female seclusion* and limited access to medical care and gender inequity in decision making;
- Early marriage, early pregnancy, short stature and chronic undernutrition leading to *narrow female pelvis* and more likelihood of obstructed labour;
- *Weak health system, poor quality of and lack of access to maternal health services*: antenatal care, infrastructure, equipment, medicines and consumables; maldistribution of trained staff; inappropriate Caesarean section rate (under 2% for the poorest, overuse at 25% for the richest urban quintiles as reported by Bangladesh DHS, 2007); low presence and utilisation of EmOC; persisting weak collaboration between the health and family planning directorates of the Ministry of Health and Family Welfare (MoH&FW), both of which have EmOC capability but which do not easily pool or share resources; the inappropriate nurse/physician ratio with more doctors than nurses; less than 8% of the national government budget is allocated to health and family planning; insufficient

number of skilled birth attendants, delays and late referrals, and insufficient use of the partograph;

- Though the road and waterways networks are steadily improving, many women are *travelling at least twelve hours* (boat, rickshaw, baby taxi etc.) to receive EmOC services;
- *Preference of home delivery* with traditional birth attendants (TBA) performing approximately up to 80% of all deliveries – this is in the slow process of transition to Community Skilled Birth Attendants (CSBA, currently around 5000, with a plan to train 13,000 by 2015) who combine the community preference for home births, with safe delivery skills and timely referral based on the use of partograph;
- *Resistance to operative delivery* which is increasingly problematic as Caesarean sections appear to be used inappropriately in some instances, instead of a well-timed vacuum assisted delivery. 25% of the urban deliveries and those in the highest socio-economic quintile are by Caesarean section. Communities are saying "Don't go to hospital to give birth, they will operate on you" which makes it difficult to communicate the message about the need for timely referral for prolonged labour, which indeed may require operative delivery.

The *Campaign* cannot effectively address all of these socio-economic factors. However, when developing programmes to address obstetric fistula these factors should be taken into consideration.

Obstetric fistula is commonly viewed as a condition that primarily affects adolescents and girls during their first pregnancies (unfortunately, very few adolescents' sexual and reproductive health programmes integrate Fistula issues). However, obstetric fistula can affect women of all ages, in first and later pregnancies. Selected variables reported on studies of women with obstetric fistula in **Bangladesh**, **Kenya**, **Niger**, and **Tanzania** are listed below. It should be noted that study samples are small and that no firm conclusions can be made regarding the profile of women with obstetric fistula (e.g. education and occupation).

TABLE 3 - SELECTED VARIABLES REPORTED IN STUDIES OF WOMEN WITH OBSTETRIC FISTULA

	Bangladesh	Kenya	Niger	Tanzania
Number of women	275	66	104	25
Age at onset of fistula	--	14 -38 (mean 20.5; median 19)	--	23 (median 21)
Pregnancy at which OF occurred	First: 43%	First : 55%	First: 43%	First: 44%
Had prolonged labour	86%	75%	93%	--
Perinatal mortality	--	72%	100%	88%
No formal education	--	59%	--	20%
Occupation	--	No occupation: 72%	--	All farmers, except two who were students and one teacher

Sources: Bangladesh: Dr. Shamsum Nahar Begun, Success Story of VVF repair at peripheral hospital in Bangladesh, Dept of Obstetrics and Gynaecology, SMAGOMCH Hospital, Sylhet. Kenya: Mabeya, Hillary M., Characteristics of women admitted with obstetric fistula in the rural hospitals in West Pokot, Kenya, Postgraduate training course in Reproductive Health 2004, Geneva Foundation for Medical Education and Research, on www.gfmer.ch/Medical_education_En/PGC_RH_2004, consulted on July 14, 2009. Niger: patients treated at the Niamey National Hospital between 2003 and 2005. Tanzania: Rachel J. Pope, Social Reintegration after repair of Obstetric Fistula in Tanzania, Women's Dignity Project, 2007.

Note: -- variable not reported in the study.

As stated above, it is estimated that the vast majority (80-97%) of obstetric fistula are caused by obstructed labour. However, gynaecological fistula can be caused by non-obstetric causes such as surgical interventions, sexual violence (e.g. in **Democratic Republic Congo**) and gishiri[14] cut (e.g. in northern **Nigeria**[15]) might result in a fistula.

❖ Traumatic gynaecological fistula

Traumatic gynaecological fistula are the result of a severe direct injury to the vaginal tissue, usually caused by brutal rape or gang rape, often involving the insertion of a sharp object into the vagina. Although the consequences of traumatic fistula are the same as for obstetric fistula, treatment is often more complicated, and the approach to prevention is obviously very different. On a global level, the majority of accounts of traumatic fistula have emerged from the eastern part of the **DRC**[16]**.** This was highlighted in a conference organised in Addis Ababa in 2005 (Acquire Project). There is documented evidence that there was a sudden explosion of the incidence of traumatic fistula during the war in the eastern DRC. This is best illustrated by the surgical records of 534 fistula repairs performed at the Maternité sans Risque in Kindu between January 2006 and August 2009. In 2009 (post conflict) 100% of the cases reported were obstetric fistula.

TABLE 4 - FISTULA REPAIRS AT THE MATERNITÉ SANS RISQUE - KINDU, JANUARY 2006-AUGUST 2009

	All fistula	Obstetric fistula	% obstetric in total fistula
2006	311	0	0 %
2007	110	33	36 %
2008	72	59	82 %
2009	60	60	100 %

Source: Maternité sans Risque in Kindu.

Cases of traumatic gynaecological fistula were also seen in **Kenya** during the political riots in 2008 particularly in the northern part of Kenya[17].

The discussion of the aetiology of fistula is sometimes complicated by the consideration that young girls who are pregnant following a rape may be at a higher risk for prolonged unattended labour. If this results in the formation of a fistula, this is nevertheless an obstetric fistula, even if the underlying cause was an act of sexual violence.

❖ Iatrogenic fistula

When a fistula is caused as a result of a surgical procedure, this injury is called iatrogenic fistula. For instance, during a Caesarean section, it is possible that the bladder is accidentally cut, resulting in a hole or abnormal opening through which urine leaks. Iatrogenic fistula can also occur during surgery unrelated to childbirth. Other non-obstetric causes of fistula are weakened tissues from malignancy, radiotherapy or

[14] Gishiri cut is among the harmful traditional practices: cutting the vaginal wall causes bleeding which is supposed to heal gynaecological illness. When the cut goes too deep, the bladder and /or urethra might be opened.
[15] Report of the Rapid Assessment of Vesico-Vaginal Fistula in Nigeria, The National Foundation on Vesico-Vaginal Fistula, August 2003.
[16] DRC is probably the only country that collects data on traumatic fistula. The reason is that victims of sexual violence receive free health services in East Congo. This is also an explanation why there can be confusion being traumatic fistula that occur after a rape and OF; only to allow these women to get free treatment.
[17] Telephone interview with Dr. Hillary Mabeya.

inflammatory tuberculosis[18] which lead to tissue breakdown and fistula formation. Recent quarterly reports from the *Campaign to End Fistula* in **Pakistan** describe that more than 30%[19] of the fistula cases reported in all regional centres resulted after pelvic surgery[20]. The Fistula Care Project (implemented by Engender Health in twelve countries) estimates that in the countries they work in, approximately 10-15% of the overall fistula patients' caseload is due to iatrogenic causes[21]. The role of Caesarean sections as cause of iatrogenic fistula needs further investigation, in view of the efforts towards increasing access to emergency obstetric services. During the country visits we received anecdotal information from service providers on an observed increased number of iatrogenic fistula due to Caesarean section (e.g. in **Bangladesh**, **Nigeria**). From talking to service providers we also got the impression that the possibility that women that have been in labour for many hours or days have already developed their fistula by the time they got the Caesarean section, but they did not become aware of this problem until after the surgery and therefore report that the Caesarean section was the cause of fistula. In any case, training surgeons and other health care staff in emergency obstetric care and other surgical skills is essential to preventing new cases of iatrogenic fistula. *This will help to further strengthen the links between the reduction of the specific morbidity – fistula – with the reduction of maternal mortality by strengthening emergency obstetric care. This will further broaden the impact of the vertical Campaign style strategy*.

2.3 Maternal mortality

Direct causes of maternal mortality include haemorrhage (28%), unsafe abortions (19%), eclampsia (17%), obstructed labour (11%), infections (11%) and others (14%)[22]. Obstructed labour is the main cause of obstetric fistula. *Direct prevention of obstetric fistula is achieved by early diagnosis of obstructed labour by skilled birth attendants and universal use of the partograph followed by timely provision of emergency obstetric care and delivery by Caesarean section or other obstetric interventions, such as symphysiotomy[23].*

Contributing to an enhanced political and social environment for the reduction of maternal mortality and morbidity is one of the expected results of the *Campaign to End Fistula* (see section 4.1.1). The *Campaign* efforts are only one of many components that contribute to national and global efforts to effectively address maternal mortality. Measuring the specific *Campaign's* contribution/attribution in the reduction of maternal mortality has not been possible in the countries visited. However the evaluation team (ET) was able to identify interventions supported by the *Campaign* that may contribute to increase the capacity of countries to reduce maternal mortality and morbidity (see section 4.1.3.)

Most of the interventions aiming at preventing maternal mortality will also prevent obstetric fistula. In general, progress on reducing maternal mortality is particularly disappointing, reverse trends being observed in some low-income countries. Annex 3 shows the trends in

[18] Dr. Shamsun Nahar Begun, Success Story of VVF Repair at Peripheral Hospital in Bangladesh, Department of Obstetrics and Gynaecology, Sylhet MAG Osmani Medical College Hospital, Sylhet, Bangladesh (study of 275 VVF cases treated at the hospital).
[19] Mali also reports 31% of iatrogenic fistula with first C-section, then forceps deliveries and finally hysterectomy. Ref: 'Situation des Fistules Obstétricales au Mali' – Dec. 2003.
[20] More worrisome is the data for Punjab and Multan show that more than 50 respectively 70 per cent of the fistula surgeries are iatrogenic. UNFPA should encourage the Government to investigate this situation and take necessary measures.
[21] http://www.fistulacare.org/pages/what-is-fistula/iatrogenic-fistula.php, consulted on December 8, 2009.
[22] The World Health Report 2005.
[23] For reasons why symphysiotomy never became popular as an intervention in middle and low income countries: http://www.plosmedicine.org/article/info:doi%2F10.1371%2Fjournal.pmed.0040071.

maternal mortality by world regions in 1990 and 2005. All countries included in the evaluation have high maternal mortality rates. The progress towards reducing maternal mortality in these countries varies from steady decrease to none or very small progress as shown in the table below. Six of eight countries included in the evaluation are making small or no progress in reducing maternal mortality. **Pakistan** shows a steady decrease (but still having high rates). **Bangladesh** shows a 22% drop in MMR in the 15 years prior to 2001.

TABLE 5 - MATERNAL MORTALITY RATE IN COUNTRIES UNDER REVIEW

Country	Maternal Mortality rate	Year, source	Observations
Bangladesh	320	2001, Maternal Mortality Survey	22% drop in maternal mortality in the previous 15 years presumably largely attributable to strong FP programme. Recently strong efforts towards EmOC, Community Skilled Birth Attendants and demand side financing.
Democratic Republic of Congo	549	2007, DHS	MMR exploded between 1995-1998 passing from 870/100,000 to 1,837/100,000 live births. Since then there has been a steady decrease. User fees for all services are the rule, from antenatal to Caesarean section.
Kenya	414	2003, DHS	Decreasing trend in MMR estimated at 670 in 1990, 590 in 1998. Declining proportion of births attended by skilled personnel (51% in 1989 to 42% in 2003). Contraceptive use by currently married women has not changed in the period 1998-2003 (39%).
Niger	648	2006, DHS	Almost not changed since 1992 when the MMR was estimated at 652/100,000 (1992 DHS).
Nigeria	1,100	2005, Human Development Report 2007/08	Other indicators critical for the reduction of maternal mortality show no or rather slow progress in the last 10 years: 15% CPR in 2008 (the same as in 1990; 58% coverage with ANC in 2008 vs. 57% in 1990; skilled attendant at delivery 39% in 2008 vs. 35.2 % in 2003).
Pakistan	276	2006/07, DHS	Downward trend when compared with the situation in 2000/01 where MMR was estimated at 350-700/100,000 live births. Only 39% of deliveries are attended by qualified health personnel and 90% of deliveries in rural areas are made by TBA.
Sudan	1,107	2006/07 Sudan Household Survey	Less than half of all births (49%) are attended by qualified health personnel. Low access to EmOC with CS rate of 2.4% with marked socio-economic and geographic inequities.
Tanzania	578	2004/05 DHS	Increased trend when compared with the reported MMR of 529/100,000 live births in the 1996 DHS. The proportion of births assisted by skilled attendant has increased from 41% in 1999 and 46% in 2004/05. Increase in the proportion of births in health facilities from 41% in 2004/05 to 51% in 2007. Only one in five women who need EmOC receives it.

Sources: See individual country reports, prepared for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.

UNFPA has traditionally supported countries in the implementation of - among others - family planning interventions, provision of emergency obstetric care, and provision of skilled attendance at birth. These interventions are necessary to reduce maternal mortality as well as to prevent fistula. The maternal health situation in the countries reviewed points at the need to scale up and significantly strengthen efforts in all these areas in order to guarantee the right to health to the women and girls who otherwise might die when giving birth or would live with a fistula because their right to health has not been guaranteed. Sustained efforts towards the implementation of cost-effective interventions to reduce maternal mortality and morbidity are required.

3. The Campaign to End Fistula

The Global Programme Proposal submitted by UNFPA to donors "Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010" specifies the type of activities to be carried out by UNFPA to spearhead the *Campaign to End Fistula.* The Proposal describes the activities to be supported both at national as well as global/regional levels and it describes the broad expected outcomes at these levels. However, the document does not specify specific indicators to monitor progress or targets to be achieved, except by the one expressed in the *Campaign*'s goal "to make fistula as rare in developing countries as it is in the industrialised world today as part of the global efforts to improve maternal health". The target for achieving fistula elimination in 2015 is in line with the International Conference on Population and Development (ICPD) and MDG targets. Given the overall state of health care systems in most countries this target was unrealistic.

The proposal outlines two levels of work: national efforts and global /regional efforts. *At **national level***, country activities will take place in three phases (which can run in parallel): (i) needs assessment, (ii) planning phase for national strategy or programme to end fistula, and (iii) implementation of the national strategy or programme. Five broad areas of support to national efforts are envisaged in the proposal: (1) capacity development, (2) advocacy for obstetric fistula with a view to improving maternal health, (3) preventing fistula as a component of improving maternal health, (4) providing high quality treatment services and (5) ensuring comprehensive rehabilitation and reintegration. Likely activities to be supported within each area of work are also suggested.

The ***global/regional*** *efforts* include support to activities in the following areas: (1) capacity development, research and documentation, (2) measuring monitoring and evaluation, (3) awareness raising and resource mobilization, and (4) partnership building.

The proposal envisages a duration of the *Campaign* up to 2015 with three phases of implementation: first phase 2003-2005; second phase (under implementation) 2006-2010; and third phase: 2011-2015. The estimated budget envelop for the second phase was USD 78.3 million (66% for national efforts, 27% for global/regional efforts, and 7% for indirect costs).

3.1 Launch and implementation of the Campaign

3.1.1 Needs assessments

UNFPA and partners launched the global *Campaign to End Fistula* in 2003. Currently there are more than 45 countries in Africa, Asia and the Arab region involved in obstetric fistula activities. As of March 2010, more than 38 countries have been supported to carry out needs assessments of obstetric fistula; this is more than the 17 initially planned in the budget for the second phase. A few countries have been provided support only to carry out a needs assessment study (e.g. Rwanda and Mozambique) or for the implementation of limited obstetric fistula treatment campaigns (e.g. Somalia). A list of countries supported by UNFPA, year of initiation of the support and the year the needs assessments were carried out is presented in Table 33, Annex 4.

The needs assessment studies vary from country to country. Sometimes they have mapped the existing treatment services in the country, others have concentrated on analysing the situation in a selected number of districts or states, analysed issues related to access and availability of EmOC services, fistula treatment services and rehabilitation services, or

included an analysis of socio-cultural factors. Others have made an attempt to estimate fistula prevalence. The needs assessments do not provide national baseline data on the situation, but an overview of needs and service availability in the areas under study.

In the recent EmOC assessment revision made by UNFPA, a module on obstetric fistula was included as part of this assessment. In the future, when countries consider conducting EmOC assessments, they may have opportunity to gather new/more data on obstetric fistula in country.

In the countries selected for in-depth study, the needs assessments studies have been very useful in bringing the issue of obstetric fistula to public attention. Additionally, they have provided information on the availability of treatment services and the existing constraints to provide obstetric fistula repair services. *The needs assessments have been very useful for the objective of increasing the awareness about obstetric fistula and were used as input to formulate the project proposals for the Campaign* (i.e. in **Bangladesh** and **Kenya**).

3.1.2 Launch of the Campaign

Approximately 40 countries have been provided with support from UNFPA for the implementation of specific projects/programmes to eliminate obstetric fistula. Fourteen of them initiated activities in 2003-2004. Table 32 in Annex 4 presents a list of the countries by year of initiation of support from UNFPA for *Campaign* activities.

All countries under review launched a national fistula campaign soon after the results of the needs assessments were available, because the findings showed a great need for more specific action (see Table 32 in Annex 4). No needs assessment has been conducted in **Pakistan**, where the national *Campaign to End Fistula* was launched in January 2006. **Tanzania** is a particular case as UNFPA in 2001 provided financial support to carry out a survey of health facilities providing obstetric fistula repair services but afterwards it was not directly involved in supporting the National Fistula Programme (NFP).

3.1.3 Implementation of the Campaign

In most countries the *Campaign* includes activities within (1) prevention, including also advocacy and awareness raising; (2) provision of treatment services, and (3) social reintegration and support services.

Within the countries evaluated the *Campaign*'s activities focused on specific geographic areas. Not all components were always included in the activities in each geographic area. In all cases where the provision of treatment services was supported, **advocacy and awareness raising** activities at local level also took place. Among others, advocacy and awareness raising activities at local level include contacting community leaders to sensitise them on early identification of signs of obstructed labour and the need to secure the referral of women to the nearest health facility when this occur. It includes as well sensitisation of communities on the signs for obstetric fistula and informing them on where to go for treatment (a more detailed discussion on this issue is presented in section 4.1.5). The ET was not provided with data to show the types of expenditures allocated to awareness-raising activities.

Treatment services activities include: capacity building through training of medical teams (doctors, nurses, anaesthetists, social workers, physiotherapists), minor rehabilitation of infrastructure, provision of medical equipment and supplies, outreach campaigns (also called workshops or fistula fortnights) to provide obstetric fistula repair services as well as training,

and in some instances payment of reimbursement costs to hospitals for each repair performed. Table 6 summarises the components addressed by the *Campaign to End Fistula* in the eight countries under review.

A number of actors are involved in obstetric fistula activities in a specific country, within or outside of the framework of the support provided by UNFPA through the *Campaign (*see section 3.3). Some countries have established national country coordination mechanisms, under the leadership of the Ministry of Health (MoH), aiming at better coordination, avoiding duplication of efforts and working towards the implementation of common goals, strategies and plans (see section 4.3). This is the case for example of the "National Fistula Task Force" in **Bangladesh**, the « Réseau d'éradication de la fistule (REF) » in Niger, or the "Comité de pilotage" in **DRC**. In other countries such mechanism is not present. During the field visits and in some of the questionnaire responses, it is recognised that the coordination of all actors is a role for the national authorities, however there is also a role for UNFPA here, supporting capacity strengthening at the MoH to take on the leading and coordinating role. Among others, low level of priority to obstetric fistula, lack of ownership of the fistula project/programme, weak leadership of MoH are mentioned as reasons for weak coordination among partners. Table 34 in Annex 5 presents a summary of the partners involved in the *Campaign* (compiled from the in-depth country assessments and desk review studies).

TABLE 6 – COMPONENTS OF CAMPAIGN TO END FISTULA IN COUNTRIES UNDER REVIEW

Year of initiation of UNFPA support	Country	Year of needs assess-ment	Focus of UNFPA OF activities		
			Prevention, incl. advocacy & awareness	Treatment	Social reintegration services
2003	**Bangladesh**	2003	(✓)	✓	✓
2004	**Kenya**	2004	✓	✓	
	Niger	2003	✓	✓	✓
	Sudan	2005	✓	✓	✓
2005	**Nigeria**	2003	✓	✓	✓
	Pakistan	-	✓	✓	(✓)
2006	**DR Congo**	2005	✓	✓	✓
-	**Tanzania***	2001	✓	✓	

Sources: Information provided by UNFPA HQ. See also individual country reports for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.
Note: * Tanzania has not received financial support from UNFPA Campaign to End Fistula.

3.2 Integration of Campaign activities within UNFPA CP

The integration of the *Campaign to End fistula* activities within the UNFPA Country Programmes (CP) or Country Programme Action Plan (CPAP) varies from country to country. In some countries, the integration has taken place with positive results (e.g. **Bangladesh**, **Niger** and **DRC**). Others, like **Nigeria**, have only recently integrated them into their CP. Other countries are making efforts to integrate these activities in their CP (e.g. **Sudan**). The table below presents a summary of the findings on integration of fistula care in UNFPA CP in the countries reviewed.

TABLE 7 - INTEGRATION OF FISTULA CARE IN UNFPA COUNTRY PROGRAMMES

Obstetric Fistula integrated in UNFPA Country Programme (Action Plan)	Obstetric Fistula not (fully) integrated in UNFPA Country Programme (Action Plan)
Bangladesh 7th CP: OF integrated into the reproductive health sub-component as part of the programme "Capacity Development through Training for Reproductive Health"	**Nigeria** 6th CPAP: OF included, but it seems that much more effort is needed to sensitise authorities and programme managers on the need to make fistula management part of the maternal health policy
DR Congo 3rd CP: OF under the specific result of "the creation of two centres of excellence for fistula repair and training of physicians and nurses"; social support and rehabilitation of OF patients is said to be included under the gender component of the country programme	**Sudan** Making efforts to integrate fistula into the new CP/CPAP
Kenya 7th CP: OF included under the output "maternal health services including services to prevent and manage fistula are available, especially for young people and vulnerable groups in selected districts"	
Niger 6th CP: OF activities in the RH component	
Pakistan 7th CP: OF included as strategy 1.1.6 focusing specifically on "Prevention and Treatment of postpartum complications (Fistula) in Pakistan"	

Sources: See individual country reports, prepared for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.

Since the *Campaign* activities started in the countries, increased awareness on obstetric fistula among UNFPA CO staff has been observed. However, better communication among the staff is needed in order to take advantage of the opportunities for better synergy between the various components of the CP (reproductive health (RH), gender, population and development). The relevant staff should be briefed on fistula activities and vice-versa, so opportunities for better synergy can be found. For example, efforts could have started earlier in **Bangladesh** to push for a fistula module in both the next round of the DHS, and in the upcoming maternal mortality survey 2010.

3.3 Main partners of the Campaign

Many players have been or are active in the *Campaign.* In most countries the **MoH** is the main actor working on obstetric fistula because it is responsible for the elaboration, implementation and coordination of the national programme to End Fistula (or broader: reproductive health programme). Countries that do not specify MoH as partners for the *Campaign* are Nepal, Pakistan, and Rwanda.

In a few countries **other Ministries** or ministerial departments are involved in obstetric fistula activities as well: Ministry of Education (Benin, Liberia), Ministry of Social Affairs (Guinea), MoH's department of Social Affairs (Congo), Ministry of Promotion of the Woman and the Family (Cameroon), the Ministry of Gender, Family and Children (DR Congo), the Ministry of Women Affairs and Social Development (Nigeria) and MoH's department of Women's Integration in Development (Congo), the Ministère de Promotion de la Femme et de Promotion de l'Enfant (Niger).

Some countries mention that the **local administrative authorities and traditional chiefs** are important *Campaign* partners because they encourage the population's engagement in the elimination of obstetric fistula. The media (TV, journals, radio, traditional communication) is also an important partners to raise awareness of obstetric fistula and prevention methods.

Some **national, regional and/or international NGOs and CSOs** active in awareness raising, community mobilisation, treatment and social reintegration activities are: MSF/Switzerland (Chad), Médecins du Monde (Chad), EngenderHealth (Bangladesh, Guinea, Rwanda, Uganda, Nigeria, Niger), Equilibres & Populations (Mauritania, Mali) and Marie Stopes (Sierra Leone), IAMANEH Switzerland (Mali). Regional NGOs/CSOs referred to are AMREF (Kenya, Tanzania, Uganda), the West African Fistula Foundation (Sierra Leone) and Women's Dignity (Tanzania).

Other partners are the various **hospitals** where training in fistula care and management takes place and/or where obstetric fistula repair services are provided.

Treated fistula patients are seen as potential RH advocates and peer educators in the communities and help, through their testimonies, to prevent future fistula and to motivate women with fistula to search for treatment.

UNFPA is by most countries considered to be an important actor in the obstetric fistula activities as provider of both technical assistance and financial resources.

Issues related to partnership building at global/regional level are described in Volume I.

Although obstetric fistula activities are often financed by UNFPA, the Ministry of Health is responsible for the national RH/safe motherhood or fistula programme and therefore has the "ownership". Countries that refer to UNFPA as the leading actor appreciate it for its expertise and orientation to end fistula ("UNFPA is the locomotive pulling all other actors in the fight against obstetric fistula").

4. Main findings

4.1 Progress towards achievement of expected results for national programmes

4.1.1 Enhanced political and social environment for the reduction of maternal mortality and morbidity

There is no doubt in that in the eight countries reviewed there has been political and social mobilisation for the reduction of maternal mortality and morbidity. In all countries, over the last several years multiple stakeholders have mobilised attention to the maternal health agenda. Therefore, it is difficult to attribute any results of this mobilisation to UNFPA or to the *Campaign to End Fistula*. Certainly, UNFPA and the *Campaign* have been an important additional voice.

An important contribution of UNFPA, through the *Campaign to End Fistula* to an improved political and social environment for the reduction of maternal mortality and morbidity has been made through advocacy and awareness raising activities with policy makers (at all levels) as well as with religious and traditional leaders. Similarly, the awareness raising and health education activities at community level related to prevention of obstetric fistula have contributed to better knowledge and understanding on the causes of fistula and how to prevent it, therefore also contributing to prevention of maternal mortality and morbidity. However, these activities have had limited geographic coverage. Unfortunately, in this area no baselines have been done nor indicators of quantifiable success developed or measured.

Within the reproductive health (RH) component of UNFPA CP in the various countries, support has been provided among others for the elaboration of RH policies and strategies, formulation of adolescents' health policy, family planning, capacity building for EmOC and skilled birth attendants.

Examples of policies and strategies adopted in the countries aiming at influencing a number of factors contributing to maternal mortality and morbidity include:

- Several countries have formulated Road Maps or an Integrated Maternal, Newborn and Child Health Strategy (**Nigeria**, **Tanzania**, the **DRC**, **Sudan**, and **Pakistan**). These documents present the government strategy to address in an integral and comprehensive way the issues regarding maternal, newborn and child health as a continuum;
- Adoption of a national policy for reproductive health or national reproductive health strategies (the **DRC**, **Bangladesh**, **Niger**, **Sudan**, and **Kenya**);
- Payment for services is one of the most important barriers for access and utilisation of both obstetric as well as fistula treatment services. Several countries have stated a policy for the provision of *free maternal health services* (Niger[24], **Nigeria**[25],**Tanzania**, and **Bangladesh**);

Some **gender** policies can also influence factors contributing to maternal mortality and morbidity, for example, the **l**egislation enacted to increase the minimum age of marriage

[24] In Niger, deliveries requiring Caesarean sections are free and, starting from January 1, 2010, every delivery.
[25] The Federal Government has stated a policy for the provision of free maternal health services. The enactment of a Federal Policy does not guarantee that the states will adopt that policy. Therefore, not all the states are providing free maternal services (in some cases free maternal services are provided only in a limited number of facilities). Additionally, within some of the states a bill has to be passed by the State Assembly so that the LGA will also provide free services. This policy has not been accompanied by an increase in resources to cater for the additional demand generated after its declaration.

for women at 18 years of age (e.g. in **Bangladesh**, **Nigeria**[26], **Kenya).** A draft proposal for a law on age of marriage has been elaborated in **Niger** and **DRC** but not adopted yet. As one of the successful countries at MMR reduction, Bangladesh is looked at below for lessons learned.

BOX 1 - BANGLADESH'S EFFORTS TO REDUCE MATERNAL MORTALITY

In 2001, Bangladesh had seen a 22% drop in maternal mortality in the previous 15 years due to the implementation of several interventions. The strongest initial strategy was enhanced access to family planning – the most cost effective maternal mortality reduction strategy. In addition, while abortion is not legal, menstrual regulation is – which is removal of uterine contents by manual vacuum aspiration and now pharmacologically, in women with late periods in whom the pregnancy status has not been determined. In addition, for several decades there has been legislation establishing 18 as the legal youngest age at marriage for girls, but this is seldom enforced and adolescent pregnancy has not gone down.

In 1998, the review of the Fourth Population and Health Project concluded that the maternal health objectives of reducing the MMR had not been achieved. This was followed by the Health and Population Sector programme (HPSP) which proposed more explicit targets for improving maternal health. The annual sector review in 2000 concluded that activities were not on track, leading the government to request external technical assistance to facilitate a national process of all key stakeholders including UNFPA to develop a maternal health strategy in 2001. Included in this strategy was the intention to scale up the availability of EmOC, and to convert existing Health Assistants and Family Welfare Assistants into Community Skilled Birth Attendants. UNFPA has been a strong partner in these initiatives since 2001. Since the Campaign to End Fistula was initiated in 2003, an additional voice has been added, led by the government, with strong support from UNFPA, but also from other stakeholders in maternal and reproductive health such as women's health NGOs, EngenderHealth and USAID, other health and family planning NGOs. Similarly a Reproductive Health Strategy which includes strategies to reduce maternal mortality and morbidity had been developed by national stakeholders, building on the Cairo agenda. All of these have led to considerable political momentum.

Skilled birth attendance and EmOC have both improved since 2001, and more so since 2003 but this cannot be attributed to the *Campaign* alone. Strong links are noted between the *Campaign*, and the role of Community Skilled Birth Attendants as well as improved referrals for EmOC for obstructed labour and awareness of how to prevent and where to go for treatment of obstetric fistula. Payment for services is one the most important barriers for access and utilisation of both obstetric as well as fistula treatment services. Although in theory government provides free maternal health services, there are hidden and multiple illicit charges as well as transportation costs. A pilot initiated by WHO and continued by UNFPA and the World Bank on Demand Side Financing provides money and vouchers for free maternal health services for women who deliver in health facilities. It is expected that the upcoming MMR Survey in 2010 will show further drops in maternal mortality since 2001, which may be attributable to these strategies.

[26] In Nigeria, the Child Rights Act has been passed by the Federal Government. The challenge now is the passing of similar legislation at the State level and setting up the mechanisms for its enforcement.

In summary, a number of policies and strategic frameworks exist providing a platform for action on reduction of maternal mortality and morbidity. However, the impact of this conducive environment is yet to be reflected into a faster and sustained action and investment on reduction of maternal mortality and morbidity (see section 2.3). The challenge for most countries is the effective enforcement and implementation of these policies and strategies, overcoming health systems weaknesses and lack of political leadership on maternal health, and increased investment on maternal health.

4.1.2 Introduction of fistula intervention into ongoing safe motherhood and reproductive health programme

The integration of fistula interventions into current safe motherhood and reproductive health programmes is an ongoing process, with UNFPA being an important advocate in this process. The **integration of obstetric fistula activities in the policy or programme documents** is no guarantee that implementation takes place. Some countries include fistula prevention and treatment strategies in their national programme for reproductive health (e.g. Mali, Sudan), some have included it in the national annual work plans (e.g. Zambia), and others have not included it at all (e.g. Rwanda). The situation in the countries included in the evaluation is as follows:

- in **Niger** and **Sudan**, the integration of obstetric fistula in major RH and safe motherhood policy documents with specific targets or results has taken place;
- efforts towards integration of obstetric fistula into ongoing reproductive health programmes are taking place in the **DRC** and **Nigeria** and can be found in a number of draft papers and strategies, but need to be approved and implemented;
- **Bangladesh**, **Pakistan** and **Tanzania** have yet to integrate obstetric fistula interventions into RH and safe motherhood programmes.

Some countries have **Gender policies** which can help indirectly with delayed marriage and reintegration services, but obstetric fistula has not been specifically included as a topic in Gender policies. Another missed opportunity is to link obstetric fistula with Adolescent´s Sexual and Reproductive Health programmes (ASRH).

TABLE 8 - INTEGRATION OF FISTULA CARE IN NATIONAL PROGRAMMES AND POLICIES

Obstetric fistula integrated in reproductive health and safe motherhood programmes	Obstetric fistula not (fully) integrated in reproductive health and safe motherhood programmes
Niger The prevention, treatment and social integration of obstetric fistula patients has been included in the National Health Development Plan 2005-2009 (PDSN). Additionally, the National Reproductive Health Programme 2005-2009 addresses treatment and social reintegration of obstetric fistula patients and includes five specific results.	**Bangladesh** Only reference to obstetric fistula in the National Reproductive Health Strategy (1997) and in the Bangladesh National Strategy for Maternal Health (2001).
Sudan One of the targets of the National RH Strategy 2006-2010 for Maternal Neonatal Health is the reduction of major obstetric morbidities especially VVF and provide needed health care for those affected.	**DR Congo** Intentions to introduce fistula interventions into ongoing reproductive health programmes can be found in a number of draft papers and strategies, but there are few signs of implementation.
	Nigeria Draft text which integrates fistula policy in the national/federal reproductive health policy plan exists but needs to be approved.

	Pakistan No reference in Maternal, Newborn and Child Health Programme 2006-2012, but discussions to integrate fistula project activities in the respective RH and safe motherhood programmes have started.
	Tanzania No reference to OF care in National Package of Essential Reproductive and Child Health Interventions, nor in the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015.

Sources: See individual country reports, prepared for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.

Integration of obstetric fistula activities in initiatives to increase availability of skilled birth attendants have taken place in **Kenya** (community midwives), in **Bangladesh** (community skilled birth attendants) and in **Sudan** (village midwives).

Existing opportunities are sometimes overlooked and efforts need to be made to take advantage of these windows of opportunities. For example in **Bangladesh**, the integration of the fistula programme into the next Health, Nutrition and Population Sector Programme as well as into the existing Joint UN Maternal and Newborn Health Initiative seems to be a priority policy and a programmatic space where mainstreaming of obstetric fistula programming could take place. In **Tanzania**, it is unfortunate that obstetric fistula care is not included as a component of the National Package of Essential Reproductive and Child Health Interventions. However, it is encouraging to see in Tanzania that budget allocations for fistula have been included in the MTEF 2007/2008 as a budget line "reduction of obstetric complications (VVF)" with an allocation of USD 300,000.

As the Campaign gains momentum in the countries, the need for better integration and streamlining of obstetric fistula within safe motherhood and reproductive health programmes becomes more evident.

4.1.3 Increased national capacity to reduce maternal mortality and morbidity

In most countries reviewed, the interventions to address reduction of maternal mortality and morbidity are seen as part of the UNFPA mandate and therefore these activities are included within the reproductive health component of the UNFPA CP in each country. Only in some countries the *Campaign* has provided limited financial support for the implementation of a number of interventions aiming at increasing the national capacity of countries to reduce maternal mortality and morbidity. For example, the training of community skill birth attendants in **Bangladesh**, community midwives in **Kenya** and midwives in **Pakistan** has been supported by the *Campaign.* In **Niger** the *Campaign* provided medical equipment to one hospital and carried out activities for awareness raising on obstetric fistula as well as on reproductive and maternal health. It has also provided support for training of Emergency Obstetric and Neonatal Care and training of agents for obstetric and neonatal emergency services (financed through the CP in 2009). In the **DRC** there have been significant investments of *Campaign* funds in the training of health workers, improvement of maternity clinics, and introduction of the use of partographs in Maniema Province and Ituri district. In all countries the advocacy, community mobilisation, sensitisation and awareness raising

activities carried out with the purpose to increase knowledge and understanding of obstetric fistula and identification of women with fistula have also contributed to increased knowledge and understanding of other maternal health issues.

A number of interventions required to prevent or reduce maternal mortality and morbidity are also effective for the prevention of obstetric fistula. These include: regular antenatal care including an emphasis on birth preparedness, skilled birth attendance with systematic use of the partograph, timely referral to emergency obstetric care where adequate interventions can be offered immediately (e.g. vacuum extraction, symphysiotomy, or Caesarean section). The provision of EmOC requires skilled birth attendants, practicing in well equipped health facilities with available medicines and supplies and a functioning referral system. The current level of services provision for these interventions in the countries reviewed indicates that greater coverage is required to achieve the desired impact. Availability of resources (financial and human), barriers to access care (availability of roads, transport cost, unaffordable payments for services) are some of the reasons for this low coverage. The provision of adequate maternal health care is a critical indicator of a functional health delivery system. In the section below we include a discussion on some of these issues, acknowledging that the *Campaign* did not commit to specifically address them. With this discussion the ET wants to point out the need for an integrated approach to address obstetric fistula within maternal health initiatives.

Box 2
The Mother and Child Care Initiative in Ebonyi State, Nigeria (MCCI)
Potential for an integrated approach for OF

- **Strong leadership from the First Lady of Ebonyi State**
- **Strong commitment by the State Government, the relevant State Ministries involved in the implementation of the MCCI.**
- **Components of the MCCI: VVF elimination, safe motherhood, early detection of breast/cervical cancer, youth development, rural girl child education.**
- **Partnership with Faith Based Organisations**
- **Free maternal services**
- **Training of midwives and traditional birth attendants**
- **Maternal mortality monitoring law, promoting among others that proper referral of women in labour be done latest after 10 hours of labour.**
- **Construction of VVF treatment centre**
- **Linkages with LGAs for rehabilitation and reintegration (social support) of fistula patients after surgery.**
- **Common funding through State Planning Commission and mobilisation of additional resources.**

In the in-depth study countries, the **coverage with antenatal care** (ANC) services ranges from 46% to 85% (see table below). In **DRC** despite high ANC coverage (85%) and 74% of deliveries attended by qualified personnel, high levels of maternal mortality are still present. This may indicate that there are problems in the quality of the care provided[27]. It may also be an indicator of financial barriers to quality care. User payments are the rule for all services, from antenatal care to Caesarean section. Many of these services are not affordable. In the meeting with women who had undergone fistula surgery, we heard several stories of delayed Caesarean section that were related to the inability to pay. In **Niger**, there has been an increase in ANC coverage from 36% in 2006 to 80% in 2008 and 85% in the first semester of 2009 (MoH Niger, August 2009).

The **proportion of deliveries attended by qualified personnel** is low. In **Bangladesh** and **Niger**, approximately 80% of women - a large majority of them non-educated, poor, and living in rural areas - deliver with non-skilled birth attendants. However, small but improving

[27] This might be worth discussing with the colleagues working with the MHTF

gains in the proportion of deliveries attended by qualified personnel are observed in the four countries.

TABLE 9 - ANC COVERAGE, PROPORTION OF DELIVERIES ATTENDED BY QUALIFIED PERSONNEL, IN THE FOUR IN-DEPTH STUDY COUNTRIES

Country	ANC Coverage	Deliveries attended by qualified personnel	Trends in proportion of deliveries attended by qualified personnel
Bangladesh	60% (2007)	18% (2007)	increase from 13.5% in 2004 to 18% in 2007
Democratic Republic of Congo	85% (2007)	74% (2007)	Increase from 61% in 2001 (MICS2) to 74 % in 2007.
Niger	46% (2006)	17.7% (2006)	small increase in 14 years, from 14.8% in 1992 to 17.7% in 2006
Nigeria	58% (2008)	39% (2008)	increase from 35.2% in 2003 to 39% in 2008

Sources: Bangladesh: 2007 Bangladesh Demographic and Health Survey. DR Congo: 2007 DRC Demographic and Health Survey. Niger: Enquêtes Démographiques et Santé du Niger 1992, 2006. Nigeria: Nigerian Demographic Health Survey 2008, preliminary report.

Some elements can be added for the four desk review countries. **Kenya** reports a high level of antenatal care coverage of 91.5% (2008 Kenya DHS). A reversing trend in the proportion of mothers assisted by skilled health personnel during delivery is observed, with a consistent decline from 51% in 1989 to 45% in 1993 and further down to 43.8% in 2008. Lack of or unreliable means of transport, bad roads (not being able to transit all year round), lack of health facility or health facility too far, too few community midwives, lack of money to pay for hospital services fee and insecurity are among the factors that hinder mothers with complicated labour to seek skilled care[28]. Issues of quality of care need attention as well. For example, in the four districts included in the needs assessment of obstetric fistula, although some nurses have acquired the skills, monitoring of labour with partographs is not widely practiced increasing the risk for a late intervention in case of obstructed labour – the major cause of obstetric fistula. In **Sudan**, less than half of all births (49.2%) are attended by a qualified health professional (Sudan Household Health Survey 2006-2007). The recent Roadmap for the Reduction of Maternal and Child Mortality highlighted some concerns: huge gap in numbers of health care providers at all

The Community Based Skilled Birth Attendant (CSBA) is a health cadre being trained in Bangladesh in an effort to increase access to skilled attendant at birth. Among others she can attend non-complicated deliveries at home, she can use the partograph, refer complicated deliveries and provide health education. To become CSBA she is required to have two years experience as community health worker and having passed secondary school certificate. She receives a 6-month basic training including theory (4 weeks), clinical practice (13 weeks), community practice (6 weeks), and final exam (1 week). During training she conducts 25 deliveries. After these 6 months she is assigned to an area where she performs 36 deliveries before going for 3 month additional training. The training is carefully monitored and when in the field they are supervised by the family welfare visitor.

[28] Warren Charlotte and Mwangi Annie (2008), Obstetric fistula: can community midwives make a difference? Final draft for discussion with UNFPA, UNFPA, Population Council, July 2008.

levels; poor infrastructure (premises, furniture) at hospital level and lack of equipment and supplies including consumables that are needed by the village midwives (VMW), poor quality of the basic training of midwifery. In **Tanzania**, the proportion of births assisted by a skilled attendant has increased from 41% in 1999 and 46% in 2004/05. There is also an increase in the proportion of births in health facilities from 41% in 2004/05 to 51% in 2007. In **Pakistan**, questions remain as to which factors have contributed to the decrease in maternal mortality, as the proportion of pregnant women having at least one antenatal visit is 61 per cent and only 39 per cent of the deliveries are assisted by a skilled birth attendant.

While the *Campaign* was not tasked to increase contraceptive prevalence rate (CPR), a discussion on access to and utilization of family planning services in the countries reviewed follows due to the potential contribution these services can have on reducing maternal mortality and related morbidities. It is well known that **family planning** is the most cost-effective intervention for reducing maternal mortality and related morbidities. In fact, a third of maternal deaths could be prevented through family planning**.**

The trends in the utilisation and access to family planning services in the countries reviewed show little or no improvement, revealing great gaps. There has been a plateau in **Bangladesh** with regard to use of contraceptive methods, and more effort is needed for improved access to long term and clinical methods, there have been also frequent stock-outs of reproductive health commodities leading to method discontinuation. In **Nigeria**, use of contraceptive methods is low, particularly among youth (utilisation of modern FP methods, estimated at 4.7 per cent of all currently married female aged 15-19 years)[29].

TABLE 10 - SELECTED INDICATORS RELATED TO FAMILY PLANNING FOR 4 IN-DEPTH STUDY COUNTRIES

Country	CPR (modern methods)	Unmet need for family planning
Bangladesh	No change from 2004-2007 (47.3%-47.5%)	Increased from 11% in 2004 to 18% in 2007
DR Congo	6.0% (2007)	37.4 % (2007)
Niger	Doubled from 2.3% in 1992 to 5.0% in 2006	Increased from 14 % in 1992 to 19% in 1998
Nigeria	No change since 1990 (57% in 1990; 60% in 2003, 58% in 2008)	17 % (2003)

Sources: Bangladesh: Bangladesh Demographic and Health Survey 2004 and 2007. DR Congo: 2007 DRC Demographic and Health Survey. Niger: Enquêtes Démographiques et Santé du Niger 1992, 1998, 2006. Nigeria: 2003 Nigerian Demographic and Health Survey.

In 2006, an independent review[30], on district health services delivery in **Tanzania** pointed out that there are "worrisome developments where it concerns Maternal and Obstetric Care" and stressed "that on these matters it is the health delivery system itself that is answerable". The review recognised that there are financial constraints in the system but states that more can and should be done with the existing resource envelope, through more efficient functioning of the referral chain, improvements in existing infrastructure, improvements in skilled personnel (qualified, better distributed and better managed), improved equipment and supply systems as well as focussed management attention to this problem. The review also stressed the need for greater resource mobilisation for sexual and reproductive health care (excluding care and treatment for HIV/AIDS which appears disproportionately supported by internal and external funds). It is the assessment of the ET that the above statement applies not only to Tanzania, it can as well be applied to the other countries in this evaluation.

[29] Nigeria DHS 2003.
[30] Ministry of Health and Social Welfare (2006), Technical Review 2006, District Health Services Delivery in Tanzania, Where are we in terms of quantity and quality of health care provision? Final Report, Independent Technical Review on behalf of the Ministry of Health, the Prime Minister's Office, Regional Administration and Local Government and the Government of Tanzania, Review conducted by HERA, March 2006.

4.1.4 Increased access and utilisation of quality basic and emergency obstetric care

Access to Emergency Obstetric Care and skilled attendance during birth are key elements for addressing maternal mortality and morbidity, including obstetric fistula.

As mentioned in section 4.1.3 UNFPA support towards increased access and utilisation of quality basic and emergency obstetric care is covered under the Reproductive Health components of the UNFPA CP. In most countries the contribution of the *Campaign* to increased access and utilisation of quality basic and emergency obstetric has been done through advocacy and raising awareness of the need for accessing obstetric care particularly when women confront obstructed labour (see section 4.1.5). This message has been emphasised during community mobilisation and sensitisation activities when obstetric fistula outreach campaigns are being organised, during the health education messages given to treated fistula patients in the post-operative period, during the awareness raising activities directed to decision makers and leaders when the link between fistula and obstructed labour is presented, during the training of health personnel on obstetric fistula care and management, during training of community skilled birth attendants (CSBA) and community midwives.

In the countries under review, UNFPA is one of several partners working with the government in improving maternal health. This has always been part of UNFPA core business, and not directly related to the role of UNFPA in the Campaign. In some countries UNFPA supports directly strengthening of emergency obstetric care. For example in **Nigeria**, during the 5th country program, UNFPA assisted in the 15 states by providing equipment as well as by training staff in EmOC. The anticipated improvement of increased visitors and quality of care did not materialise. Embedded socio-cultural factors, beliefs and behaviour are hard to influence and heavily influence the current choices for home deliveries and for more children.

Inadequate number of health facilities offering basic and emergency obstetric care is a constant in all countries. In many cases when the facilities exist, these are not properly staffed or equipped or do not provide 24 hours services. In other cases, the facilities are not accessible to the population, either because they are located far away (particularly for population living in remote rural areas) or because there is no transport (good road all year round or vehicle).

Cost is also a serious barrier to access and utilisation. In half of the 24 countries that responded to the questionnaire (Chad, Eritrea, Ghana, Liberia, Mali, Nepal, Pakistan, Senegal, **Sudan**, **Tanzania**, Uganda, and Zambia) no user fees are charged for EmOC services, while in a third of the countries (Benin[31], Burkina Faso, Cameroon, Ivory Coast, Malawi, Mauritania, Rwanda and Sierra Leone) user fees are charged. Even in situations where official fees are not charged, 'informal payments' may be a barrier to women accessing care. In **Kenya** patients have to pay for comprehensive EmOC services but not for basic EmOC services. In Burundi user fees for EmOC services are charged in private health facilities, not in public health facilities. It is not clear how much the "average" user fee for EmOC is because EmOC services are sometimes defined in a different way: user fees for basic EmOC go up to USD 20 while they vary between USD 35 and USD 500 for comprehensive EmOC. In **Niger**, free ANC and Caesarean section became effective in 2007. About 70 percent of health care costs in the **DRC** are financed through user payments. This proportion also applies to ante-natal care, obstetric care and neo-natal care.

[31] Apart from Caesarean which is provided for free since 1 April 2009.

The cost of a Caesarean section ranges between USD 59 and USD 217, amounts that are unaffordable for a large segment of the population.

There is a great gap in access to emergency obstetric care. In the in-depth study countries Caesarean section rates range from 1%-2.6%, these rates are lower than the recommended rate of 5-15%, as shown in the table below. In **Niger**, the rate of Caesarean sections remains at 1% but it is possible that a significant increase will be recorded in the coming years because of the measures taken for increasing access to basic and comprehensive obstetric care.

TABLE 11 - CAESAREAN SECTION RATES, 4 IN-DEPTH COUNTRY STUDIES

Country	Caesarean sections as % of all births
Bangladesh	1.29% (2008 data from 191 CEmOC facilities)
Democratic Republic of Congo	2.6% (2006, facility based data)
Niger	1% (2006)
Nigeria	2% (2008)

Sources: Bangladesh: Voice of MIS-Health, Newsletter Issue 6, May 2009 MIS-H, DGHS, Dhaka Bangladesh. DR Congo: Rapport d'analyse de la situation de la santé maternelle néonatale et infantile en RDC; Ouedraogo et al. Draft March 2009. Niger: Enquêtes Démographiques et Santé du Niger 2006. Nigeria: Nigerian Demographic Health Survey 2008.

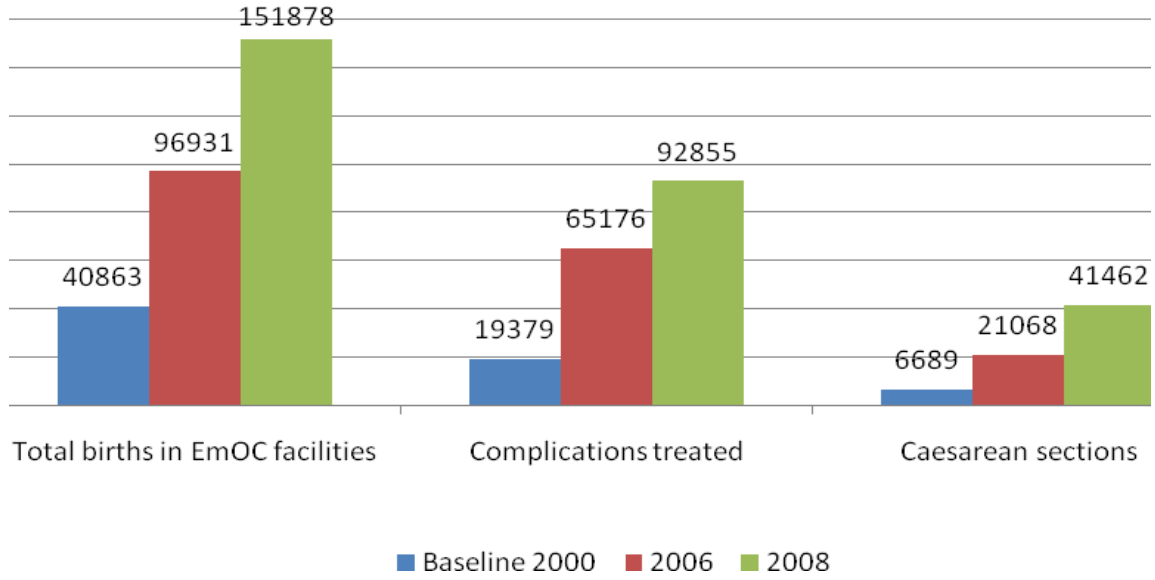
In **Nigeria**, the 2008 Endline/Baseline Survey[32] of the UNFPA CP in 23 states of Nigeria (15 states covered by the 5th CP and eight new states to be covered by the 6th CP) reports that no state had up to a quarter of its health facilities offering full basic emergency obstetric care (BEmOC) and less than 15% of health centres in any of the former states offered all the components of comprehensive emergency obstetric care (CEmOC). These results are calling the attention of the UNFPA CO to identify which adjustments are necessary to reach the expected results.

There have been important improvements in the availability and utilisation of EmOC over the last 10 years in **Bangladesh**. These cannot be attributed to the *Campaign to End Fistula* but the *Campaign* has added another partner to the national effort. Similarly, the many challenges and barriers to maternal health care are health system problems and cannot be directly attributed to the 'failure" of the preventive aspect of the *Campaign*. Figure 1 shows the increase in births in EmOC facilities on the Health Directorate side of the Ministry of Health, an increase in the percent of complications which are treated, and increased Caesarean sections since 2000. This information does not cover the EmOC services in private sector facilities or the Family Planning Directorate of the MoH Bangladesh.

Similarly, the met need for EmOC has increased; again, this only represents the data from the facilities in the Health Directorate of the MoH and refers to a specific project with UNICEF. Out of 59 District hospitals, 56 are providing CEmOC services and 3 are providing BEmOC services. Out of 402 upazila[33] health complexes, 91 are providing CEmOC services and 272 are providing BEmOC services.

[32] Otti, Pauline N., Nigeria/UNFPA, 2008 Endline/Baseline survey of UNFPA Country Programme in 23 States of Nigeria, Technical Report, Key Findings, Zero draft, Abuja, April 2009.
[33] Upazila = subdistrict.

FIGURE 1 - BANGLADESH, TREND OF EMOC PERFORMANCE IN 191 PUBLIC FACILITIES



Source: UNICEF, 2009.

4.1.5 Increased access to and utilisation of quality fistula services (treatment services)

In all countries studied, the main focus of the *Campaign* has been on increasing access to and utilisation of quality fistula treatment services. This has been facilitated through the implementation of several strategies including: advocacy and awareness raising activities; capacity building through training of multidisciplinary teams in obstetric fistula care and management. In some countries it has supported the establishment of training/treatment centres or assisted already established centres or facilities that are providing treatment services for fistula; in others it has supported the mobile teams to provide treatment through surgical outreach services also called fistula fortnights in **Nigeria**; fistula workshops (in **Nigeria**, **Tanzania**, **Kenya**); or fistula campaigns (in **Sudan** and **Pakistan**). In other countries the *Campaign* has supported fistula treatment by expert teams in public or private hospitals.

❖ Advocacy and awareness raising

The advocacy and awareness raising activities have been targeted to different groups. One group is **policy makers**, who are briefed on obstetric fistula through a number of strategies (e.g. presenting needs assessments reports and videos, briefed by fistula survivors) and encouraged them to support the establishment of a fistula programme in the country (**Bangladesh**, **Niger**, **Nigeria**). Some countries have brought policy makers to visit fistula services within the country[34] or outside the country (Ethiopia)[35]. As a result of these advocacy activities, support from the Government of **Bangladesh** (GoB) has been committed for the establishment of the fistula corner in the Dhaka Medical College Hospital

[34] In the DRC e.g., the First Lady attended the opening of a fistula ward established with UNFPA support in a private hospital.
[35] The purpose of the visit to Ethiopia is to get to know the experience of the Addis Ababa Fistula Hospital.

(DMCH) and later on in nine additional college hospitals. In **Nigeria**, the First Lady of Ebonyi State has promoted the Mother and Child Care Initiative, which has a strong component on obstetric fistula activities. In **Niger**, the First Lady established the NGO MAGAMA, as reported to the Niger team.

TABLE 12 - ADVOCACY AND AWARENESS RAISING - EXAMPLES OF STRATEGIES IMPLEMENTED

Target group	Strategies / activities
Policy makers	- Presentation of needs assessment reports - Briefed by fistula survivors - Presentation of videos - Brought them to visit fistula services in the country - Brought them to visit fistula services outside the country
Administrative officers at provincial/regional levels	- Sensitisation Workshops usually previous to or in relation to the organisation of outreach treatment/training campaigns with the purpose of involving them in the identification or referral of obstetric fistula patients.
Service providers at hospitals And district level	- Sensitisation workshops usually previous to or in relation to the organisation of outreach treatment/training campaigns with the purpose of involving them in the identification or referral of obstetric fistula patients.
Communities	- Local CSO and NGOs creating awareness before and during treatment / training campaigns. These organisations establish direct contact with individual women and men, existing women organisations, community leaders, local chiefs, councillors, church leaders. - Radio announcements - Distribution of booklets - Publications in local newspaper, - Flip charts and posters widely distributed - Fistula advocates / fistula survivors spreading the prevention and treatment messages - TV broadcasting of available documentaries

Another important target group for sensitisation has been the **service providers** at hospitals as well as at district level, as well as **administrative officers** at provincial/regional levels with the purpose of increasing their knowledge and understanding of obstetric fistula and encourage them to increase their efforts in the provision of services to prevent obstetric fistula, to actively identify obstetric fistula patients and refer them for treatment at the appropriate level. Usually this sensitisation takes place in relation to the organisation of treatment/training camps in order to involve these facilities in the identification and referral of fistula patients to be treated during the camps.

Communities at large are also another important target group. Creating awareness within communities (individual women and men, existing women organisations, community leaders-local chiefs, councillors, church leaders, women leaders) is carried out by local civil society organisations (CSOs) and NGOs mostly before and during a treatment/training camp. A number of strategies are used for this purpose: radio announcements, distribution of booklets to the local level service providers, articles published in newspapers, flip charts and posters distributed for use at community level. At community level, particular efforts have been made to sensitise religious leaders as well as local leaders. The integration of former fistula patients as Community Fistula Advocates (CFA) or Ambassadors of Hope, in awareness raising and advocacy activities has shown to be an effective mechanism to reach the communities with obstetric fistula prevention and treatment messages. In **Niger**, Cinéma Numérique Ambulant, a NGO specialised in communication and education, is hired to

provide wide scale information on obstetric fistula and prevention. Broadcasting of interviews in TV and radio has also been used. In 2004, the British Broadcasting Corporation (BBC) telecasted a documentary film on maternal mortality reductions in **Bangladesh** which highlighted fistula activities in the country. In **Tanzania**, a film on maternal mortality which integrated comments from community debate on the issue, is used across the country to generate discussion on fistula and maternal health.

Unfortunately, the ET did not come across any evaluation made on the effectiveness of these advocacy and awareness raising activities. However, in interviews with service providers, some of them mentioned that the first time they heard of fistula was when a sensitisation workshop took place and now they were able to look for these cases and refer them for treatment. The fact that women actually show-up for treatment is also an indication that the message to look for treatment came across. We observed the sensitisation work done at community level by fistula advocates and community skilled birth attendants in Bangladesh, and were able to confirm increased awareness on community members on the five messages they are spreading to prevent maternal mortality and fistula.

In **Bangladesh** and **Nigeria**, we observed that in advocacy and awareness raising activities, not enough focus is put on communicating that *prevention of obstructed labour is the most effective mechanism to prevent obstetric fistula.* In the **DRC**, advocacy on fistula services is almost exclusively conducted with a focus on sexual violence. Even senior health officials and senior political figures associated the issue of fistula only with sexual violence and had to be reminded about the link between fistula and obstructed labour.

The coverage of advocacy and awareness raising activities, particularly at community level, has yet to reach an adequate coverage to produce the desired impact (e.g. effective prevention of obstetric fistula, identification of patients that require treatment, and increasing the number of patients referred for treatment as well as the number of fistula repairs being done). Due to the limited resources available, a balance has to be found between the use of mass media vs. direct communication. From the interviews made it seems that direct communication works best, particularly to motivate women to search for treatment. Radio communication is effective to send messages about date/places where outreach campaigns or treatment services are provided (in this case, the messages should be sent not too long before these will take place). Similarly, consideration can be given to the implementation of targeted geographic advocacy and awareness raising activities at community level, with simultaneous coordination with the facilities providing treatment and a referral system, in order to secure that there will be capacity to take care of a potential increase in demand for services.

❖ Capacity building for fistula care and management

Lack of qualified obstetric fistula surgeons and inadequate use of trained ones are among the constraints for the provision of fistula repair services. The *Campaign* has supported the establishment of training programmes in all countries studied. The capacity building activities include: training of Trainers (Master Trainers), training of multidisciplinary teams (doctors, nurses, anaesthetists, physiotherapists), development of training curricula, organisation and implementation of training workshops and/or training camps.

In all countries included in the evaluation, there were health facilities and individuals (doctors) involved in the provision of obstetric fistula repair services, long before the *Campaign* was launched. Almost every country has its own Champion(s) for the provision of obstetric fistula repairs. UNFPA has drawn and built upon the existing knowledge, expertise and infrastructure in each country.

Training of Trainers (Master Trainers) has taken place either by sending interested doctors and nurses for training abroad (to Addis Ababa Hospital in Ethiopia or to the Babbar Ruga Fistula Hospital in **Nigeria)** or the training has been provided in-country facilitated by national and international fistula surgeons. When the training is provided in-country, it takes place in designated training centres or training sites (e.g. **Nigeria**, **Bangladesh**, **Kenya**, **Tanzania**) as well as at hospitals with a high caseload and a trained surgeon (**Tanzania**). In **Bangladesh**, these activities resulted in the country having a group of national experts taking on training activities at the DMCH as well as during the establishment of fistula corners in other medical college hospitals.

Local (national) trainers exist also in **Kenya** and in **Tanzania** (where AMREF has supported the training of Master Trainers). Presently there are some three to five fistula surgeons in **Kenya** who are also involved as Trainers. In **Nigeria**, Engender Health is supporting two doctors to become Master Trainers; however there are a number of doctors that have been trained over the years who also have the potential to become Master Trainers[36]. In **DRC** the Maternité sans Risque in Kindu has organised quite successful training activities.

Having Master Trainers in each country would secure that in-country training can continue beyond UNFPA support. One of the constraints to train Master Trainers is to find suitable candidates, with qualities to become trainers as well as willing to take on this task.

Training of multidisciplinary teams takes place at the designated treatment centres or treatment sites, during special workshops organised for this purpose or during outreach campaigns. Training courses are facilitated by national fistula surgeons sometimes together with international fistula surgeons.

In some of the countries evaluated, a decentralised model for training has been implemented (**Bangladesh**, **DRC**, **Kenya**, **Tanzania**). Ideally, this model requires having resident fistula trainers on each training site. As this has been difficult to achieve, the alternative model of organising training campaigns has been used (bringing the fistula surgeons when the treatment campaigns take place) for training/updating knowledge of in-house staff and training of staff from facilities located in the periphery of the training site (e.g. district hospitals). For this to be effective a careful planning of the training camps (with adequate frequency and duration) at each site is necessary. Among others, key issues to consider include securing that planning training dates are respected and that the corresponding networking, awareness raising and community mobilisation takes place ahead of time to secure adequate number of patients come to demand treatment.

There are many challenges and constraints in the provision of training. One of them is the adequate selection of those to be trained, where interest in continuing to provide obstetric fistula repair services after training seems to play an important role (although not always taken into consideration). In **DRC** e.g., the USAID-funded Axxes project changed its strategy and started to support mobile teams of surgeons because of the experience that five out of eight trained physicians left the service soon after the training. Duration and continuity of the training is also a problem in countries such as **Bangladesh** and **Kenya**, especially when the training does not provide the trainees with enough exposure to carry out obstetric fistula repairs under supervision (therefore not being confident to do it alone when back at their workplaces). It is proposed that a minimum of 10-15 VVF repairs be performed by trainee VVF repair specialists, and that they perform 40-50 repairs annually to retain competence.

[36] According to inquiries of the evaluation team, Nigeria has at least 13 highly experienced fistula surgeons who have performed each between 150-300 interventions, and they could all potentially become master trainers. For the course of Master trainers, Dr. Waaldijk suggests an initial training period of 1 month, followed by another 2-4 weeks training after 6 months and if necessary another 2-4 weeks training after another 6 months. A personal experience of at least 200-300 fistula repairs and willingness to become a full-time fistula surgeon are suggested requirements for future trainers.

Highly experienced fistula surgeons who have performed a minimum of 400-500 repairs could then potentially become Master trainers[37].

Another challenge is to secure that those trained, continue providing obstetric fistula repair services and that they perform enough number of surgeries to maintain their skills. There are several factors contributing to this, among others, lack of interest to provide the service, lack of financial incentives to surgeons, the staff are assigned to places where there are no conditions to carry out the surgery or where fistula repair services are charged to patients (e.g. teaching Hospitals in **Nigeria**, where very few women demand this service due to their impossibility to pay the charged fees for the surgery). There are no policies to secure that those trained will be assigned for a period of time to places where fistula repair services are/should be provided. In some countries the problems related to limited opportunities for doctors to gain experience or to have visibility or recognitions, leading to frustration, demotivation and finally loss of skilled surgeons (e.g. Chad).

A proper system to keep track of those trained is not yet in place, therefore in some countries it is difficult to know exactly how many of those trained over the years are actually providing fistula repair services. Maybe there is room for collaboration with the International Society of Fistula Surgeons (ISOFS) on this area. Given the underlying problem of lack of human resources for health in all countries studied, it is not surprising that doctors trained in fistula repair may well be diverted to other health and administrative demands in their facilities even after fistula training. National commitment for training and securing opportunities to continue providing services to maintain skills is crucial. Training and human resources reinforcement should be planned and decided together with MOH. The National Strategies should quantify the needs for surgeons and plan for their training and capacity strengthening.

The table below presents a summary of staff trained with UNFPA support (except in **Tanzania**) in the eight countries in the period 2004-2008.

TABLE 13 - STAFF TRAINED WITH UNFPA SUPPORT IN COUNTRIES UNDER REVIEW[38]

Country	Doctors*	Other staff**	Total
Bangladesh	137	104	241
Democratic Republic of Congo	44	53	97
Kenya	69	170	239
Niger	7	59	66
Nigeria	12	140	152
Pakistan	55	192	247
Sudan	10	3	13
Tanzania	40	83	123
Total	**374**	**804**	**1,178**

Source: Elaborated by the Evaluation team, based on Annual Reports of *Campaign* activities in each country..
Notes: * Doctors: include general doctors, anaesthetists, OG/GYN, urologist, physical medicine. In Tanzania it also includes medical officers. ** Other staff: include nurses, anaesthetists (not in Bangladesh), physiotherapists, counsellors, social workers. In DRC other staff includes 33 paramedics and 20 social workers. In Nigeria: 40 nurses and 100 are social workers mostly trained to work in the Fistula Fortnight 2005. In Niger includes: nurses, anaesthetists aids, surgical aids, social assistants. In Pakistan includes nurses and operating theatre staff.

[37] Waaldijk, Kees, Obstetric Fistula Surgery, Art and Science, basics, Comprehensive Manual for Trainees, Training Manual, Babar Ruga Fistula Teaching Hospital, Katsina, Nigeria, 2008.
[38] The ET was not given any information on the number of those trained that are still practicing.

❖ Training curricula

Support has also been provided for the development of **training curricula** (**Bangladesh**, **Kenya**) which are used for the training.

In **Bangladesh**, UNFPA supported the development of a VVF training curricula, teaching modules and logbooks including the following guidelines:

- Trainer's manual for doctors on fistula surgery and management
- Participant's handbook for doctors on fistula surgery and management
- Trainer's manual for nurses on fistula management
- Trainer's handbook for nurses on fistula management
- Principles and practices of management of female genital tract fistula.

These materials are excellent and comprehensive. They serve as textbooks and teaching aids to facilitate a more structured training programme. This is certainly a solid backbone to build upon.

In **Nigeria**, there are no national standards or protocols for management and care of fistula. With the experience gained in the National Fistula Project and in the organisation of VVF Centres (mainly in Kano and Katsina), Kees Waaldijk has developed a number of techniques and guidelines described in the publication *Obstetric Fistula Surgery Art and Science* - Training Manual (2008). These are used for the training he carries out. Though not nationally adopted, many of these techniques and guidelines are used in Nigeria, particularly by those that have been trained by him. The *Campaign* supported the Federal Ministry of Health (FMoH) in the organisation of discussions that led to the elaboration of draft clinical standards. This document needs to be approved by the relevant authorities.

In **Tanzania**[39], AMREF provided copies of a quick reference manual "*The Obstetric Fistula*", and bought copies of a practical manual *"Step-by-step surgery of vesico-vaginal fistula"* written by Kees Waaldijk (see above). The two manuals are the main resource materials particularly for the trainees and even trainers in Tanzania. A draft protocol for post-operative fistula nursing care was also completed for use in all participating hospitals. The existing curriculum (adopted from Kenyatta National Hospital) was reviewed in July 2007 and printed.

In 2006, WHO with support from the *Campaign*, the International Federation of Gynaecology and Obstetrics (FIGO) and the Averting Maternal Death and Disability Programme of Columbia University (AMDD), edited the document "Obstetric Fistula : Guiding principles for clinical management and programme development" which is a common reference used in the countries. The *Campaign* also supported the translation of this document into French[40].

The International Obstetric Fistula Working Group (OFWG)[41] has developed a "Competency based training manual for fistula surgeons" as a result of a joint effort of several actors (e.g. FIGO, UNFPA, Fistula Surgeons, ISOFS, and the Pan African Urological Surgeons´ Association (PAUSA). The intention is to pilot test this Manual in the 3-5 training centres. Behind this effort is the goal of securing that training of fistula surgeons takes place following

[39] Training materials such as books and manuals, journals and others on obstetric fistula surgery are not readily available. This is partly because obstetric fistula is no longer a health problem in the developed countries where most literature comes from. Only few doctors and specialists have an interest in doing fistula surgery. This has lead to very few doctors writing about fistula particularly on the technical aspects of the repair.

[40] The document is available at: http://whqlibdoc.who.int/publications/2006/9241593679_eng.pdf.

[41] The OFWG is a partnership of interested actors (organisations, individuals, institutions) working on obstetric fistula established initially by UNFPA and few others partners. It has grown in number of partners over the years. UNFPA is the Secretariat for this partnership.

a certain curricula and standards. Once disseminated to the countries it will fill an important gap in the training activities. ISOFS could play an important role, for example, in identifying qualified trainers and securing the quality of the training,

❖ Provision of obstetric fistula repair services

In all countries studied the *Campaign* has provided support for the provision of obstetric fistula repair services. This has been done by supporting the establishment of treatment centres/treatment sites or as mentioned before through carrying out surgical outreach services (campaigns). In addition to training of staff (as described above), the support to establishment of treatment centres /treatment sites has included support for the renovation of facilities, acquisition of equipment, supplying these centres with medicines, suture materials and emergency medicines. Support for the surgical outreach services includes among others, provision of medical supplies, medicines, covering community mobilisation and awareness raising activities.

Not all supported centres are providing treatment on a regular basis (all year round). Some of the reasons given for not establishing a regular provision of fistula treatment services include: operating theatre time not allocated or if allocated not always respected (as emergencies take priority), surgeons not interested in performing the surgery, trained surgeons express they do not feel competent enough to carry out the surgery on their own, specific beds for fistula patients not available in the wards (not enough beds in the hospital and one fistula patient may uses the bed for a long period of time), patients cannot afford to pay for treatment (in those centres with established user charges), not regular supply of consumables.

It is also a source of concern that only a *small number of surgeries are carried out every year* at each centre (e.g. during 2008 between 5 and 169 fistula repairs were done in each of the ten supported centres in **Bangladesh**). This number of services is not big enough to i) contribute to a significant reduction in the backlog of cases in need of treatment, ii) address the new cases that occur every year and iii) secure that the surgeons will get experience, develop skills and consequently improve the success rate. So even a mix of services at decentralised levels, referral centres, tertiary care facilities, and regional centres of excellence is unable to keep up with the demand. The advantages and disadvantages are further discussed in chapter 6. Tanzania has 30-40 centres and is meeting the needs more effectively, through a government/NGO partnership (Women's Dignity and AMREF, working through government).

A contributing factor to the low volumes of repairs is the low visibility of the service, and the transportation costs which must be borne by the patient to reach care, as well as other attendant costs of hospitalisation. When fistula campaigns have been organised, intense community mobilisation has helped to increase the numbers of women coming for care. As mentioned in table 2 in section 2.2, in all countries included in the evaluation, the annual number of obstetric fistula repairs is still too small when compared to the annual incidence of cases and even less to take care for the backlog of cases.

An important issue to keep in mind is to secure the balance between supply/demand for repair services. When awareness raising activities on treatment availability are carried out before treatment campaigns, in most cases women demanding treatment do in fact receive treatment. The centres that provide treatment services on continuous basis do their best to service all patients that come in search for treatment, either by taking care of them immediately or by having them to go through a waiting time. When an awareness raising activity is carried out in specific communities or geographic area, it is important to establish a system so that those working at the community (an identifying women in need of treatment) are in close coordination with the service providers in order to plan carefully when the

treatment can be provided and provide the corresponding information to the patients. Securing that treatment services are provided not only through campaigns but on routine basis (all year round) in selected centres (properly staffed, equipped, and with guarantee medical supplies) is another important measure towards balancing supply / demand for treatment services. But even if most of the women presenting for treatment receive care, it is often not done in a timely fashion, for example in Bangladesh many women wait in hospital, or the rehabilitation centre, for several months.

Table 14, overleaf presents the number of treatment centres supported by the *Campaign* in each of the countries studied as well as the number of repairs done under the review period.

❖ Fistula follow-up campaigns and quality assurance

Proper quality assurance mechanisms for the provision of treatment services are not in place in the countries studied. There is a need to establish such mechanisms, including among others establishment of protocols and standards of care, supportive supervision, analysis of treatment outcomes, securing availability of proper equipment and medical supplies. This is a problem also seen in the overall health system, where quality assurance is often lacking. In **Bangladesh**, one component of the decentralisation process has been carrying out *fistula follow-up campaigns* where a team of VVF repair surgeons comes to the other Medical College Hospitals (MCHs) to help operate on their difficult cases and to provide on-site training/quality assurance. This has helped to build in a quality assurance component which is not yet fully optimised. The campaigns mask the relatively low volume of repairs performed on a routine basis. With such a low number of interventions, and no established quality assurance mechanism, it is possible that the numbers of repeated repairs are not only due to the relatively complicated cases that arise, but could have been minimised if the obstetrician/gynaecologist or urologist performing the repairs had a higher skill level. The USAID/Engender Health programme contracts a Master Trainer/VVF specialist to visit the facilities they are supporting with the purpose of providing surgery/training in a campaign type situation. This has increased the number of repairs done and has helped also to ensure quality[42]. A model such as this is worth further exploration in public facilities as well, and would require donor support.

A modality that could be explored is to use supervisory visits like in **Tanzania**, where supervisory visits are made by the AMREF fistula surgeons in order to identify problems, challenges and ways of improving fistula services in the participating hospitals and take action to overcome the identified weaknesses. Some of the problems encountered in these visits include: lack of basic surgical instruments and supplies/consumables; fistula surgeons are too busy in some hospitals as they also take up duties of general practitioners because of shortage of doctors; severe shortage of nurses in maternity wards and thus being overworked and therefore unable to provide quality obstetric services; lack of retraining/refresher courses for in-service staff to re-orientate them with current management practices (due to either lack of funds or planning or a combination of the two); some surgeons are not readily willing to teach/pass their skills to resident junior doctors who would like to learn from them; in most of the missionary hospitals (and at least one government hospital), the fistula surgeons are expatriates/foreigners who work on short contract basis such that if they leave, there might be nobody else doing fistula repairs; initiatives for fistula prevention at community level are reported to be under- addressed though posing a big challenge to health providers as well; remote health centres and dispensaries are not well supported in terms of transport, manpower and supplies.

[42] See Vol III - Bangladesh in-depth assessment, for further discussion on this issue.

TABLE 14 - TREATMENT CENTRES AND NUMBER OF FISTULA REPAIRS, 8 COUNTRIES

Country	Fistula treatment centres supported by UNFPA	Fistula repairs performed with UNFPA support	Observations
Bangladesh	10	1,596	13 Centres providing obstetric fistula repairs in the country (10 centres supported by UNFPA). There are plans to build a Regional Fistula Centre in Dhaka (support from IDB). UNFPA support started in 2003
Democratic Republic of Congo	9	1,335	There are 14 centres in the country providing obstetric fistula repair services. The number of fistula repaired with UNFPA support increased from 396 in 2006 to 472 in 2008. UNFPA support started in 2006
Kenya	6	419	The number of obstetric fistula repaired with UNFPA support increased from 41 in 2005 to 143 in 2008. UNFPA support started in 2004
Niger	5	797	One more centre is supported in 2009. The number of reported repairs done in the country has increased from 350 done in the period 1997-2002, to 1551 done in the period 2003-2008 (half of those facilitated by UNFPA support). A "Centre National de Référence des Fistules Obstétricales" with capacity for 100 beds is under construction in Niamey. UNFPA support started in 2004
Nigeria	11	753	In 2009, 20 centres were providing obstetric fistula repairs in the country. The information for repairs done with UNFPA support is incomplete. Most of the repairs reported were done during the 2005 Fistula Fortnight. UNFPA support started in 2004
Pakistan	14	1183 (from 2006-2008)	Seven regional centres and seven referral centres at district level. All regional centres (except one) are in public sector at tertiary units (teaching hospitals). UNFPA support started in 2005
Sudan	4	197	Incomplete data. During fistula camps usually fewer than 100 patients can be treated. Approx. 100 fistula repairs per year are performed at the Dr. Abbo treatment Centre in Khartoum. Nyala and Kassala Fistula Centres will be opened in the near future with support from UNFPA. UNFPA support started in 2008
Tanzania	35-40	Approx. 1000 fistula repairs per year	There has been an increase in the number of annual fistula repairs done from 700 in 2002 to 1000 in 2008. Tanzania does not receive support from UNFPA for fistula activities
Total	**59**	**6280**	**Note: Tanzania not included in total.**

Source: Team elaboration from individual country reports elaborated for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.

❖ Treatment outcomes

Data to assess treatment outcomes is rather scarce, available only at individual hospitals in hospital records (but not consolidated at the hospital or for all centres supported) or not at all available. In **Bangladesh** consolidated information on fistula treatment outcomes for the ten centres supported by UNFPA was not available. The Evaluation Team did receive information from the Sylhet MAG Osmani Medical College Hospital (SMAGOMCH) (Table 15). In this centre a total of 230 fistula cases have been operated from July 2004 to July 2009. According to WHO criteria, 21% of the cases were simple and 79% complex fistula (very much similar to data reported in the literature).

TABLE 15 - BANGLADESH, OUTCOME OF FISTULA REPAIR SURGERIES, 2004-2009

Total operations in SMAGOMCH	230
Successful	185 (80%)
Completely dry	163 (71%)
Urethral incontinence	22 (9%)
Failed repair	40 (17%)
Recently operated	4 (2%)
Death	1 (1%)

Source: Sylhet MAG Osmani Medical College Hospital (SMAGOMCH).

The main quality indicator of obstetric fistula repair is the percentage of women who are completely healed (and without any urinary incontinence) using the WHO classification (simple cases and complicated cases)[43]. In **Niger**, although this indicator is not yet standardised and comparable through fistula repair sites, available data (extracted form a published paper or directly reported by providers) show a success rate between 73-94%. It would be better to use "success rate after the first intervention" as indicator as well (Table 16).

TABLE 16 - NIGER, SUCCESS RATES OF OBSTETRIC FISTULA REPAIR

Hospital	% of women healed after 1st intervention	Average number of interventions per woman	% of women completely healed
Hospital Lamordé			83
National Hospital Niamey		1,36	73-75*
CHR Maradi			
Maternity Tahoua			
Maternity Zinder	70-75		94
Maternity Dosso			

Source: Reports, literature and interviews.

In **Sudan** good attention seems to be paid to the fact that in successful fistula treatment, post-operative nursing care is needed to minimise and promptly treat complications. Based on data from Darfur Campaigns, the following figures show the number of cases treated since 2001 and the rate of success.

[43] There is not an agreed standard definition of what is meant by a "success" of a fistula repair. This is one of the issues being taken up by the OFWG within context of addressing OF Classification, as this has implications for data comparability.

TABLE 17 - SUDAN, OBSTETRIC FISTULA CASES TREATED, 2001-2008

Year	Cases Treated	Success rate
2001	34	88.2 %
2002	53	88.7 %
2003	54	87.0 %
2004	34	97.0 %
2005	38	97.3 %
2006	42	92.8 %
2007	43	90.6 %
2008	40	97.5 %

Source: Data from Darfur campaigns.

In 2008 the success rate of over 97.5 % is very good and compares well with previous years. In the Darfur Campaigns contributing factors for these high success rates include that only very experienced surgeons do most of the repairs, application of selection criteria for surgery, the rigorous surgical techniques observed and the high-level post-operative nursing care. Surgery on fresh cases should be postponed for two to three months to allow for sloughing of necrotic tissue; complex cases involving calculi should be operated in two steps. Recto-vaginal fistula surgery may have a higher success rate if a colostomy is done some time before the fistula repair.

Following a training/fistula repair fortnight in Juba, a number of quality of care decisions were made: cases must be evaluated by the trained personnel and classified as simple or complicated using the set criteria discussed during the training: simple fistula will be those of not more than two cm in diameter, freely accessible, mid vagina or juxta-cervical in position, without involvement of the bladder sphincter mechanism, urethral loss and devoid of fibrosis. Newly trained physicians should jointly repair selected simple cases in turn until such a time they are individually able to repair simple cases with other people assisting. Where there is doubt, the case should be deferred even if the compelling challenge was discovered in theatre prior to commencement of surgery. Other cases can be pooled and appointed for planned repair or referred. It might be advisable to establish as a regular practice the evaluation of quality of care issues after a treatment campaign and adjust/improve practices accordingly.

❖ Establishment of referral system

A specific referral system for obstetric fistula would not be necessary if functional referral systems would be operating in the countries. It is recognised that in most countries health referral systems are not operating properly. A functional referral system is another missing link in the overall efforts to secure access and utilisation of EmOC. In Bankilare district, **Niger**, the NGO Health and Development International, developed a well functional referral system with early referral of obstetric fistula patients to the hospital, where an indwelling Foley catheter results in early closure of the fistula without surgical intervention. **Tanzania** (see box. 2) worked towards the establishment of a referral system linking lower and higher level facilities (i.e. health centre, hospitals) to each other, as well as connecting NGOs, community-based organisations and others to hospitals to facilitate referrals of patients with obstetric fistula, particularly those in remote areas of the country. In the other countries no formal attempt to establish a referral system has been made. However, an informal referral system is operating between facilities that are providing fistula repair services and lower level facilities as these are aware of where to refer patients when necessary. This informal system has been built up somewhat through the training activities and surgical outreach campaigns. The ad-hoc mobilisation and organisation for identification and referral of

obstetric fistula patients from communities to the treatment facilities is always done before a treatment/training campaign will take place (see section 4.1.3).

BOX 3 - REFERRAL SYSTEM FOR OF PATIENTS IN TANZANIA

The establishment of a functional referral system was one of the recommendations from the Fistula Survey carried out in 2001 as it was considered a key element to enable girls and women to access obstetric fistula repair services. Key partners for implementation of the referral system included hospitals providing fistula repairs, NGO and faith based organisations (FBO) organisations working in underserved areas, Women's Dignity (WD) partner-NGOs and WD. The establishment of the system was piloted in 10 districts in 2007 and 13 more districts were added in 2008. For the organisation of the referral systems meetings were convened in all districts and attended by a variety of stakeholders. Each district made an action plan for instituting and monitoring the system, including plans for community sensitisation, identification of girls and women with fistula, referral mechanisms to hospitals providing repairs, data collection, and follow up (no funds were provided by WD or the National Fistula Programme (NFP) to the districts for this work). As a result of this collaboration, four of the ten pilot districts included fistula activities in their 2007 district plans (CCHP); and the remaining districts were planning to do so in 2008. In some districts, district medical officers took an active role of transporting women using health facility transport.

An increase in the number of OF patients referred to hospitals in the pilot districts has been observed. Although it is not possible to determine whether this is due to the referral system alone or in combination with the other public education and information activities carried out as part of the fistula media campaign of the NFP (through radio and TV, the population is informed on which hospitals are providing OF repairs and when outreach visits for OF treatment will take place). In any case, the results are positive, for example Sokoine Hospital (Lindi) received nine patients from Ruangwa district in 2007, which had never referred women before. In Rukwa, fistula attendance has doubled since 2006; and in Ruvuma, 52 new fistula patients were identified and referred for repair.

❖ Cost of treatment

At the individual, family and community level, poverty, is not only a contributing factor for obstetric fistula development, it is also an important factor determining the ability of girls/women to have access to fistula repair and treatment. All countries in the evaluation mentioned that most women affected by obstetric fistula are poor and have great difficulties in paying for fistula repairs. In all countries studied, obstetric fistula repair services were provided free of charge to patients in the hospitals/camps receiving UNFPA support. UNFPA provides surgical equipment, medicines and medical supplies, and training of doctors and nurses[44], although patients often pay for medicines or other supplies when not available at the centres or for the cost for supplementing the food provided (except in Niger). Additional expenses are incurred to cover the costs of the accompanying family members. The hospitals cover the salaries of staff, food, and accommodation.

In **Bangladesh**, patients do not have to pay for the cost of fistula surgical treatment at the medical college hospitals. It is estimated that each surgical repair costs the facility over 1,000 USD[45]. UNFPA and USAID/Engender Health have helped to subsidise the costs of the

[44] In the DRC UNFPA paid the full hospital bills for surgery at designated hospitals.
[45] Information provided by the UNFPA National Professional Project Personnel for Fistula. The cost calculation includes costs for accommodation, food, surgeon fees, dressing charges, anaesthesia charges, pre and post operative investigations, supportive staff, medication, consultation fees for doctors.

repairs by the provision of surgical equipment, medicines, medical and surgical requisites, and training of doctors and nurses. In **Nigeria**, patients pay for obstetric fistula surgical repairs in Teaching Hospitals[46]. According to enquiries of the evaluation team, the cost charged to patients for a fistula repair varies between Naira 300 to Naira 45,000 (approximately USD 2-300 at exchange rate of 1 USD = Naira 150 in June 2009); in other facilities patients are not charged and the treatment is subsidised by UNFPA, NGOs, FBOs. It has not been possible to make explanations for the cost differences between countries. The country reports makes some estimates per patient and the ET refers readers to those volumes. The ET was not able to get information on how countries are using the costing tool developed by UNFPA, this could be an issue for UNFPA to further follow up.

In **Kenya** and **Tanzania**, the African Medical Research Foundation (AMREF) receives donor funds to reimburse hospitals USD 200 for each obstetric fistula repair done (including payment to reimburse patients for transport cost). In Kenya, UNFPA also reimburses this amount to hospitals; and USAID/Engender Health does so in Bangladesh.

The majority (n=18 out of 24; 75%) of the countries that responded to the mail questionnaire, **do not charge user fees for obstetric fistula surgical repair services** because these services are provided for free by the government, UNFPA and/or other donors and NGOs. In five countries (Burkina Faso, Cameroon, Ghana, Nepal and Senegal[47]) user fees for obstetric fistula exist. The average user fee for fistula surgery (charged in the 5 countries by public/NGO sector) is 250 USD[48]. In addition to the user fee for fistula treatment, the patient pays an average transport price between 5 and 30 USD (depending on the distance).

More than half of the countries (n=13; 54%) have no **government subsidies for obstetric fistula repairs**. In nine countries (Benin, Eritrea, Ivory Coast, Kenya, Malawi, Mauritania, **Pakistan**, **Sudan** and **Tanzania**) there are government subsidies for obstetric fistula services including treatment, social reintegration, food and accommodation. Three countries (Chad, Senegal and Uganda) mention other subsidies coming from CSOs or NGOs. Only two countries specifically refer to UNFPA subsidies. Most countries respond that subsidies should preferably be available for fistula repair services. These subsidies should cover the costs of the treatment (medicines, surgery), transport costs, accommodation and food during pre- and post-surgery. Some countries state that the subsidies should also be available for the social reintegration services.

*More than half of the countries that responded to the questionnaire (n=15; 63%) expressed that **money generated by the Fistula Campaign** should be used for paying for subsidies for OF services. Most of them see this as a temporary measure, until the (public) health facilities can take over the fistula treatment.*

❖ Information systems and research

Information on fistula related activities including health facilities, trained doctors and nurses, repairs, treatment outcomes, backlog and new cases is scarce, scattered, incomplete and hard to obtain. For management purposes, a functioning health information system is required in order to make appropriate decisions in designing, planning, implementing projects and activities, in allocation of resources in the most cost-effective way. Support for the strengthening of the national health information systems is certainly an area where UNFPA and other stakeholders working on fistula could join efforts. In **Nigeria**, in the VVF

[46] These hospitals do not have a high demand for fistula services.
[47] In Senegal, in 2007, the President decided the gratuity of Obstetric Fistula treatment and Caesarean. The recently approved Strategy (August 2009) also refer to the implementation of the gratuity of Obstetric Fistula treatment
[48] Costs have been estimated by the respondent to the questionnaire.

facilities visited, records were kept, but there was no system in place to ensure that information would be analysed or used for planning purposes or support decision making[49]. The ET was informed that in Ghana cases of obstetric fistula are reported through the Reproductive and Child Health database. The integration of obstetric fistula into national health information system is discussed in Malawi. The Johns Hopkins University (JHU) study will help countries involved in standardizing data collection. In Benin, 'near-miss' audits are carried out to assess the extent of fistula.

Apart from the support provided to carry out the country needs assessment, no specific research activities have been supported in the countries studied. However, in **Tanzania**, several studies were carried out and their results used for advocacy and citizen's mobilisation. Additionally, a data collection system for obstetric fistula at three levels (community, health facility and hospitals) providing fistula repairs is now being used in ten districts. According to the Campaign Annual Reports, some of the non-study countries have conducted national/community studies with support from UNFPA.

As part of the global efforts, the *Campaign* is supporting the roll out of a multi-country research study with JHU as implementing partner, and in collaboration with WHO. The research will examine the clinical and quality of life outcomes for women following fistula treatment. The study includes a capacity building component on research methods, mainly directed to the principal investigator and the local research team in each country. The research was originally planned to be carried out in eight countries. Due to financial constraints, the number of countries has for the time being been reduced to two (until additional funding can be secured). The research activities have recently started in Bangladesh. It is expected that the JHU study will help countries involved in standardizing data collection during treatment and follow up.

There is a need for a functioning routine information system as well as specific research or studies that will provide an in-depth analysis of specific issues related to obstetric fistula.

4.1.6 Increased availability of services to assist women with repaired fistula to reintegrate into their community

Provision of rehabilitation services appears to be a weak link in the fistula management process. Two main types of social reintegration services for fistula patients exist in the countries included in the review[50] (i) fistula rehabilitation centres or facilities, and (ii) community-based initiatives. In the countries included in the review these services are initiated by the government or by local NGOs, with or without support from UNFPA. The centres visited by the ET in Nigeria and Bangladesh were exclusively open to obstetric fistula patients. However, in Bangladesh the fistula programme was exploring the possibility of referring obstetric fistula patients to centres that are receiving women victims of gender based violence. The centres offer different levels of pre- and post-operation support, including health education, training in life skills and competencies for smooth reintegration in their communities and for income-generating purposes. The proportion of women who access these services remains small (as compared to the number of women who had a surgery). Overall the availability and accessibility of rehabilitation services is insufficient. The quality of rehabilitation services provided with support from the *Campaign* is variable but often poor. The ET saw some good rehabilitation in Bangladesh, but on a very small scale. More efforts are necessary to really empower women – this will need closer linkages with other community, government, and NGO partners.

[49] Dr Kees Waaldijk keeps personally meticulously record of each intervention he performs, including over 250 indicators.

[50] The team was informed that in Mali, incurable women, tend to stay in the hospital/rehabilitation centre OASIS in the hope of receiving new services

The needs for social reintegration support among women who have undergone fistula surgery vary greatly. As experience has shown, together with the Pope et al. study in Mwanza[51], that a woman can probably reintegrate well on her own if she is healed of her fistula (and she has had it for a relatively short time). It is often said that in order to prevent discrimination and exclusion from the community, a maximum of 6 months should be the period of time from the onset of the obstetric fistula to the provision of treatment services.

In the country questionnaires, most respondents pointed out that the social reintegration services - no matter the type (rehabilitation centre or project-like activities) - are best provided by involving (community-based) NGOs and beneficiaries in the development of income-generating activities. Some reply that advocacy by NGOs is important as well for obtaining better acceptance of the obstetric fistula patients and to reduce stigma and social rejection by their families and communities. *Community advocacy on reintegrating women with fistula is directly linked to - and reinforces – general messages about fistula and stigma reduction.*

UNFPA is considered to be the organisation for **partnering and supporting** - technically and/or financially - the NGOs and CSOs that focus on social reintegration of fistula patients (e.g. through income-generating activities, by addressing stigma and discrimination) and to advocate on OF for social acceptance and reintegration at the level of governments and political actors.

The following table presents a summary of social integration services supported by the *Campaign* in the countries reviewed.

TABLE 18 - SOCIAL REINTEGRATION SERVICES FOR FISTULA PATIENTS IN COUNTRIES UNDER REVIEW

Social Reintegration Services			
Country	**No. of centres supported**	**Number of women who benefited**	**Observations**
Bangladesh	1	236	One Centre funded by UNFPA as pilot initiative, managed by Bangladesh Women's Health Coalition. Costly model. Potential to build upon community fistula advocates for community-based rehabilitation.
Democratic Republic of Congo	None	10-15% of women access post-surgery social support services. Total: 127/939	Partnerships with NGO established at 4 sites to provide social support. Two variations: through community volunteers, through NGO staff. Community volunteer (before, during, after surgery). NGO staff: list presented.
Kenya	None	n.a.	No clear mechanism in place. In West Pokot alliances with NGO Sentinelles who provides some social reintegration support. Potential for building up on Ambassadors of Hope (group of former OF patients).
Niger	4	567	Focal point is the Ministère de la Promotion de la Femme. Delegated to two NGOs: DIMOL and Solidarité. Three areas: reproductive health education, income-generating activities, initiating fund for IGA (50.000 FCFA).

[51] Pope, Rachel J., Social Reintegration after Repair of Obstetric Fistula in Tanzania, Women's Dignity Project, 15/06/2007

Social Reintegration Services			
Country	**No. of centres supported**	**Number of women who benefited**	**Observations**
Nigeria	2 (not UNFPA support)	35	Centres administered and owned by the State Ministries of Women Affairs and Social Development/UNFPA community-based rehabilitation pilot project.
Pakistan	1	n.a.	Rehabilitation Centre in Koohi Goth Women Hospital (one of the regional fistula centres), supported technically and financially by UNFPA.
Sudan	None	110 women participated in 3 days' workshop on RH, nutrition and psychosocial support and counselling.	One centre being established in Khartoum and similar ones will be established in Darfur States. During campaigns (treatment camps) NGO supported by UNFPA empower patients (income-generating skills, sewing, knitting) training before/after surgery.
Tanzania	2 (not UNFPA supported)	n.a.	Research done. A rehabilitation centre is attached to CCBRT Disability Hospital which is providing OF repair services.

Sources: Team elaboration from individual country reports elaborated for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.
Note: n.a. = not available.

❖ Fistula rehabilitation centres

Development of fistula rehabilitation centres is of recent introduction in the countries reviewed (except for DRC) and countries are still testing ways and means for the operation of these centres. The experiences in **Bangladesh** and **Nigeria** are described below as illustration. In **Bangladesh** there is one rehabilitation centre funded by UNFPA, managed by the national NGO Bangladesh Women's Health Coalition, and linked to the Dhaka Medical College Hospital Fistula Centre. The centre can host 30 women, many staying both while waiting for surgery and during the post-operation period. Stays are sometimes long – as there are many delays waiting for surgery and for medical pre-op tests. This lengthy stay adds to the cost of the services. Women provide peer support and receive training in tailoring, baking, animal husbandry etc. as well as functional literacy and health education (e.g. family planning, nutrition, how to take care of themselves during post-operative period, sexual relations). Some rehabilitated patients are now employed by the centre. Follow-up is provided to women once they return to their communities to facilitate their reintegration into their families and communities. The centre has also developed a special programme for community fistula advocates. These are fistula treated patients who are trained to carry out sensitisation and health education in their communities. They have also acquired skills and have been given a small starting capital or goods to initiate an income generation activity. The model is well developed but costly and relatively few women have been served, and not replicable at a larger scale. However it could develop lessons learned to help guide less costly community-based models. It is unsure how the project will be sustained after the end of 2009. Options such as stronger linkages with organisations/institutions already working with women, socio-economic empowerment, the creation of a revolving fund and further involvement of fistula advocates as rehabilitation/reintegration agents based at the community were discussed with the CO (see community based rehabilitation activities below).

The State Ministries of Women Affairs and Social Development (SMoWASD) in **Nigeria** are mostly involved in the provision of rehabilitation and reintegration services, either by running specific centres dedicated to receiving fistula patients in their post-operative period or

through facilitating the linkages with their "skill acquisition centres" located at the state capital or in the local government area. The *Campaign*'s direct work and support to SMoWASD has been very limited and ad-hoc. It has consisted in coordinating activities with these centres during the fistula fortnight and for the pilot community based project. Sometimes the centres are used more as a hostel than as a centre to receive rehabilitation support. Most fistula patients who decide to stay some weeks in the rehabilitation centre for post-operation and follow-up examination period choose this option because of geographic accessibility problems and because accommodation is free. Because of lack of resources and materials, the variety of skills and competencies provided in the rehabilitation centres is usually limited and not the most appropriate for the individual preferences and socio-economic situation of the fistula patients. Training provided in the rehabilitation centres is related to functional literacy and numeracy, knitting and sewing or income generation activities, and sometimes women can receive grants.

❖ Community-based rehabilitation initiatives

Several community-based rehabilitation initiatives are implemented in the countries. The experiences are different from country to country. A common feature is the link with existing organisation working on programmes aiming at socio-economic empowerment of women. A brief description of the situation in Bangladesh, Niger, DRC, Nigeria, Sudan and Kenya follows. Some women who stayed at the rehabilitation centre in **Bangladesh** have received additional support as Community Fistula Advocates (CFA) and do IEC on prevention, treatment, and also some limited patient referrals. In the future, there is a potential to build upon the CFAs to help them become the community-based trainers of newly repaired women to teach tailoring, sewing themselves and to model how they have created their own livelihood.

In **Niger,** the focal point for the organisation of the social reintegration is the Ministry of Promotion of the Woman (Ministère de la Promotion de la Femme), but in practice it has delegated this to the NGOs DIMOL and Solidarité (through the national network to end fistula). Three main components of the social reintegration programme are: information on reproductive health (need for ANC, prophylactic Caesarean section); training in income generation activities (IGA) and provision of 50,000 FCFA to start the IGA. A total of 567 women have benefited from the programme in the period 2005-2008.

In **DRC**, in the four major sites for fistula repair supported under the *Campaign,* UNFPA has established partnerships with local NGOs and associations to provide social support to women following fistula repair. This component of the programme is implemented differently in Kindu and in Kinshasa:

- In Kindu, the community volunteers providing social support are closely associated with the medical services at the Maternité Sans Risque. They provide public education and awareness building about fistula, they identify women living with fistula and help them contact the clinic, and they then provide support to the woman after her surgery.
- In Kinshasa, Bas Congo and Equateur, local NGOs receive lists of women who have undergone surgery containing very limited information. They then contact the woman and determine if and what type of support she requires. This initiative is managed and coordinated by the Ministry of Gender, Family and Children.

The proportion of women who access these services remains small (as compared to the number of women who had a surgery). It is not clear whether those not benefiting from the programme did not require the services or whether they could not access them for a variety of reasons. The needs for social reintegration support among women who have undergone fistula surgery vary greatly. The approach used in Kindu is able to take these differences into consideration. The community volunteers are in a good position to assess the needs for

reintegration when the fistula patient leaves medical treatment. In Kinshasa and Bas Congo, however, the participating NGOs are presented with a list of women after their hospital discharge. It seems that the main criterion for entering into a post-surgery training or income-generation programme was not needed, but rather proximity to the NGO training site. In the past, UNFPA has contracted NGOs directly to provide these services. Now UNFPA provides a lump sum to the Ministry for Gender, Family and Children who are selecting, training, and financing NGOs with the UNFPA grant. This applies to Kinshasa and Bas Congo. In Maniema, the Community Organisations working on reintegration are directly supported by the clinical facility (Maternité sans Risque) that in turn is supported by UNFPA.

During fistula treatment campaigns in **Sudan** some NGOs (International Red Cross, LABINA and Zakiya Centre for Women and Children), with support from UNFPA, have agreed to empower the patients with income-generation skills like soap and macaroni making, sewing, knitting etc. The routine followed in the fortnightly campaigns is that after a successful repair of the fistula, the patient needs to be advised before discharge on her sexual life, and be provided with family planning/child spacing counselling and methods as requested. She should be offered the possibility of training on a self-reliant activity (income generating activity) to facilitate integration back into the community, especially where she has been rejected before.

Follow-up of women after the obstetric fistula surgery and assisting them in reintegration to their communities has been a challenge and it is an area that has not received enough attention by the *Campaign* in **Kenya**. Up to now there are no clear mechanisms in place to secure this follow-up and assist women with repaired fistula to reintegrate to their community (when required). The weak linkages between the community and local hospitals mainly caused by the absence of social workers has been mentioned as one reason for this. Other reasons mentioned are the absence of CSOs and NGOs working in the localities where the training/referral sites are operating or that the hospitals are not well suited to liaise with existing organisations that could provide these services. In West Pokot the hospital has established partnerships with Sentinelles, a local NGO in order to provide social support to women following fistula repair. Sentinelles carries out awareness raising activities, identifies women for treatment, secures transport back and forth for the patients, provides social support for their reintegration at the community. This is a small NGO only able to reach out to a limited number of communities.

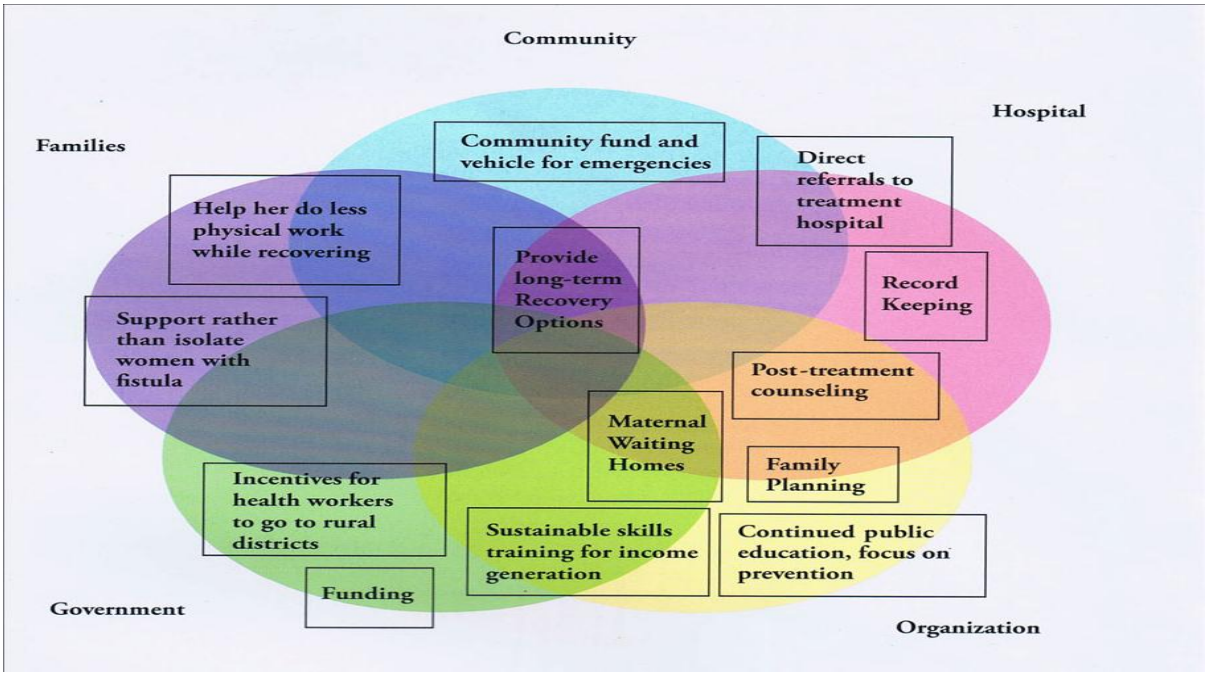
In **Nigeria** (as part of a pilot project done in Kankara local government area) women received goats, or sewing machines or noodles makers. Some of these women did start a small business out of this. Some of these women and their husbands were also trained to become advocates in their community. Coordination was established with the local government authorities.

Maybe the recently created Network of African NGOs Working on Fistula could play a role in facilitating an exchange of experiences on issues related to their involvement on social reintegration of obstetric fistula patients.

The two modalities observed suggest that social support and reintegration of fistula patients back to their communities work well when fistula patients are integrated into existing activities or programmes directed to empowering women (e.g. education, skills training, income generation, self-esteem). Women need support to liaise with and have access to these opportunities. *Opportunities to facilitate greater involvement of former fistula patients in social reintegration services could be promoted. The main role suggested for UNFPA is to provide technical and financial support to civil society organisations that focus on the social reintegration of fistula survivors. UNFPA could also document information and lessons-learned from reintegration projects in order to provide examples of different kinds of efforts.*

The following graph represents the actors that could be involved in assisting women to reintegrate into their communities and their respective tasks, as suggested in a study carried out in **Tanzania** in 2007 on reintegration of women after fistula repair.

FIGURE 2 - POSSIBLE ACTORS INVOLVED IN SOCIAL REINTEGRATION ACTIVITIES



Source: Pope, Rachel J., Social Reintegration after Repair of Obstetric Fistula in Tanzania, Women's Dignity Project, 15/06/2007

4.2 Fistula indicator framework

The definition and consensus on indicators for the *Campaign* in general and/or fistula programmes in particular (e.g. their relevance, added value, how realistic is it to measure them) is still a work in progress. The OFWG has been working on the elaboration of an Indicator Compendium that could be used by countries for monitoring of obstetric fistula programmes. The idea behind this work is to provide countries with a menu of indicators that could help them to decide on which one to use for monitoring progress of their respective programmes. This list is made of 59 indicators, and they are classified as core, additional or extended indicators. The list includes also the six agreed indicators proposed in 2006 for countries to report on, with the purpose of monitoring the progress of the *Campaign*. Based on the Indicator Compendium list the ET elaborated an Indicator Framework for the evaluation. During the presentation of the Inception report for the evaluation, there was a recognition that the list was ambitious and most likely the information on many of the indicators was not going to be available. It was agreed that the evaluation should make an attempt to test the availability of this information in the countries. The national consultants in the ET assisted the UNFPA CO to provide the information on the indicator framework for the in-depth study countries.

Obtaining data to fill out the Indicator Framework for Fistula Evaluation proved to be a difficult task due to the weaknesses of the data recording and reporting systems in the countries in general and in particular for data on obstetric fistula. As a result of the wide scope of issues covered by the indicator framework, a number of sources needed to be consulted, and sometimes it was not easy to find out where to look for information. For a

number of indicators no routine data collection exists and information on them is presently available only as a result of specific studies or publications. For many indicators there was no data available. The following are key findings from this exercise:

- The DHS provides information on key indicators regarding the overall context, particularly those related to unmet family planning needs; contraceptive prevalence rate; skilled attendance at birth; Caesarean section rates by rural/urban place of residence, educational level of mother, and socio-economic quintile of mother; female literacy and median age at first birth.
- For indicators of a more qualitative nature (i.e. integration of fistula interventions into ongoing safe motherhood and reproductive health policies) the main sources of information are interviews with people working on these areas and consultation of the specific documents[52].
- Information on treatment services is available at each facility, but not consolidated nationally; it is therefore difficult to assess national indicators. It is unclear how many of the various people trained, are actually practising and how many have been transferred to other duties, thereby not using / losing their skills.
- It seems that specific data on obstructed labour (management, protocols, referrals, existence of EmOC services) is very scarce. In some countries specific studies on EmOC have been carried out and data on EmOC was taken from these studies. It is difficult to find out these documents as there is no such a database at hand and often the search starts asking to senior government officials or UNFPA staff if they know of studies done in this area.
- There are no mechanisms in place to collect and report data on the overall human resources situation for fistula treatment. Specific projects providing support on this area have their respective data and should be contacted separately in order to obtain it. Information on training was basically related to the training carried out within the framework of support provided by UNFPA. The same situation exists with regard to data on social integration services. It was not possible to obtain a clear picture of the overall human resources situation for fistula.
- There are few reliable data on health available in the **DRC**.

It would be unreasonable to expect country programmes to report against all 59 global indicators. Participating countries have the option to choose the most relevant and feasible indicators to monitor their own performance. It is, however, also evident that presently countries fall to a great extent short of providing a clear picture of the evolving outcomes and impact of the national campaigns. Nor do they include information that can be readily used for global campaign monitoring framework. Like health information systems overall, the key to data collection on fistula indicators is to make the data collection useful to – and used by – the fistula stakeholders. There is also a rational balance required between data that are interesting to have and those that are essential to have, in order not to overload already stressed routine national health information systems.

There is an urgent need to streamline the key information required to monitor fistula progress and to establish the necessary mechanisms for this to operate effectively. The Indicator Compendium has been proposed when most of the national Strategies/policies/programmes were already approved and in which the monitoring and evaluation (M&E) framework is very weak. A pending task in the countries is to develop a M&E framework for fistula programming. All possible efforts should be made to limit the amount of information requested (including the number indicators to be selected for monitoring progress). The need to establish baseline data should also be taken into consideration.

[52] Section 4.1.2 presents a discussion on integration of fistula care in national programmes and policies in the countries studied.

4.3 National commitment and coordination

The role of the Ministries of Health in fistula management should be the development of policies, guidelines and standards and the coordination of fistula activities in the country. A few countries have drafted a national fistula programme or policy and even fewer are implementing it. For example, only two of the eight countries included in the review have integrated obstetric fistula in their reproductive and safe motherhood programmes (see section 4.1.2). This is often because fistula is not considered to be a major public health problem both by the health authorities as well as by the health care providers.

Leadership and commitment at the national level varies. In some countries the political will and commitment seems to be strong (**Bangladesh**, **Niger**) while in others it is still weak (**Nigeria**, **Kenya**, the **DRC**). The lack of a national policy to end fistula, the government's inertia to implement a specific obstetric fistula policy or programme, and/or the weak coordination in fistula prevention and management are some of the bottlenecks for scaling up the national efforts to eliminate fistula. Countries that specifically refer to these factors in their responses to the questionnaire are: Burundi, Congo, Guinea, Nepal, North Sudan, and Sierra Leone.

The transition from individual obstetric fistula projects to national fistula programmes remains a pending task in most countries. However, progress has been made in some countries. For example, the National Strategic VVF framework 2010-2021 is in the draft stage in **Bangladesh** and a national programme is emerging from individual projects funded by different donors.

TABLE 19 - NATIONAL COORDINATION MECHANISM FOR FISTULA CARE IN COUNTRIES UNDER REVIEW

Existing and functional	Existing but not functional
Bangladesh National Task Force	**DR Congo** Coordination supposed to be done by National Reproductive Health Programme (MoH)
Niger National network to end fistula (Réseau national d'éradication de la fistule - REF)	**Kenya** Weak coordination by Division of Reproductive Health (MoH)
Pakistan National Fistula Working Groups (in Karachi, Peshawar, Multan and Lahore)	**Nigeria** National Fistula Task Force (1990-1997); VVF Foundation
Sudan Fistula Task Forces	
Tanzania National Fistula Programme coordinated by Department of Hospital Services (MoH&SW); NFP Secretariat (WD); NFP Steering Committee; NFP Stakeholders meetings	

Sources: Team elaboration from individual country reports elaborated for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula.

National coordination mechanisms for management of the fistula activities have been established in many countries (see Table 18). In **Bangladesh** a National Task Force has been created which is dealing among others with issues of consolidation vs. expansion of activities, how to improve coordination and joint planning among stakeholders, and how to make more resources available at the bottom. In **Niger** a national network of national and international organisations (in total 41) is created. This « network to eliminate fistula (REF) » is formalised by a Ministerial Decree in February 2004. National Fistula Working Groups,

consisting of gynaecologists, general surgeons and urologists who have expertise in fistula repair, have been established in **Pakistan**. They discuss how to deal with the complicated OF cases at the regional fistula centres. Several Fistula Task Forces, which include medical doctors, government health personnel, international NGOs, and local Sudanese NGO staff, exist in **Sudan** to ensure good coordination and collaboration between partners involved in fistula management.

In countries where involvement of the government in fistula activities is strong, the implementation of obstetric fistula activities seems to be more timely and successful (e.g. **Bangladesh**, **Niger** and **Pakistan**).

4.4 Management of the Fistula Campaign activities at UNFPA CO

The integration of the *Campaign* in the UNFPA Country Programme was discussed in section 3.2. Some CO have contracted a National Programme Officer (Obstetric Fistula) exclusively for the coordination of the *Campaign* activities (**Nigeria**), others have assigned this function in most cases to the RH officer (called also fistula focal point). These persons are responsible for the planning and follow-up of the *Campaign* activities in the country.

UNFPA usually works with **implementing partners** who are responsible for the implementation of activities. In most countries the Ministry of Health is the implementing partner for the Fistula *Campaign* activities. Sometimes NGOs or CSOs are also implementing partners for specific components.

Monitoring and follow-up of *Fistula Campaign* activities is done by the National Programme Officer for Obstetric Fistula or by the focal point, and not always as part of the regular monitoring and follow-up system of the CO (e.g. **Nigeria**). The *Fistula Campaign* has its own **reporting** system (e.g. own reporting format for annual reports) to keep track of the implementation of activities. Fistula indicators are not always included as part of the indicators for tracking progress in the implementation of the CP nor are they included in the Country Office Annual Report. The ET has been informed that recently key obstetric fistula indicators have been included in the country office annual report.

The **supply of equipment** and consumables procured by the *Fistula Campaign* follows the CO procedures for this purpose. The team was informed that equipment was not always of good quality or appropriate for its intended purpose (i.e. **DRC**, **Nigeria**, **Bangladesh**) but this situation has been corrected.

Within UNFPA, the *Campaign* activities could benefit from a more effective integration with the overall CP activities and more specifically with the RH activities. In this integration, there is a risk that fistula activities may not receive enough attention or priority. It will be necessary to monitor carefully that integration does not result in less visibility or less support to fistula activities.

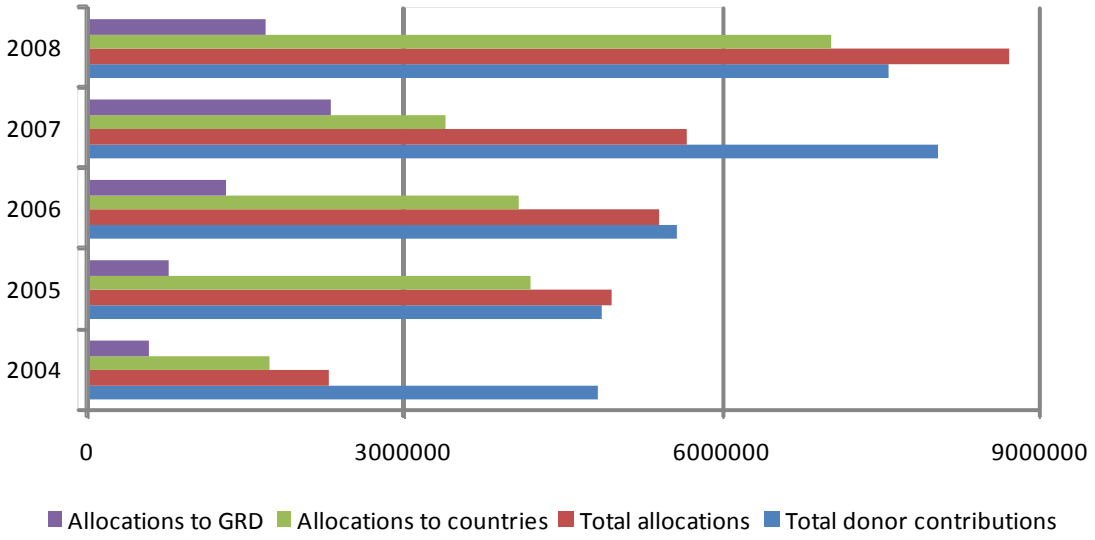
4.5 Financial aspects

4.5.1 Financial contributions and allocations

A total amount of almost USD 31 million has been **contributed by donors** (through UNFPA) for the *Campaign to End Fistula* in the period 2004-2008, with an annual sum of USD 6.2 million on average[53].

Eighty-eight per cent of the total donor contributions during 2004-2008, or an amount of USD 27 million, has been **allocated to the *Campaign*** over the five-year period 2004-2008. On average, seventy-five per cent of this sum (USD 20.2 million) is allocated directly to countries while the other quarter (USD 6.7 million) is available for global and regional purposes (see Figure 3). The money not yet allocated at the end of 2009 will be rolled out into future country allocations.

FIGURE 3 - CONTRIBUTIONS AND ALLOCATIONS TO THE CAMPAIGN TO END FISTULA 2004-2008 (IN USD)



Source: UNFPA Headquarters
Note: GRD: Global/Regional Divisions

4.5.2 Expenditure rate by the beneficiaries

Eighty-one per cent of the amount of allocations for the whole period 2005[54]-2008 is spent as of September 2009. The expenditure rate of the combined group of countries is 75% while this rate is 105% for the group of global and regional divisions for the 4-year period. The annual rates of expenditure are presented in Table 20.

[53] It is not clear to the Evaluation Team whether the 2004-2008 data received on annual contributions include recommitments from donors (which would mean a double counting of some of the contributions).
[54] Because no detailed expenditure data are available for the financial year 2004, the analysis of allocations versus expenditure has been conducted for the period 2005-2008.

TABLE 20 - EXPENDITURE RATES FOR THE CAMPAIGN TO END FISTULA 2005-2008, PER BENEFICIARY (IN %)

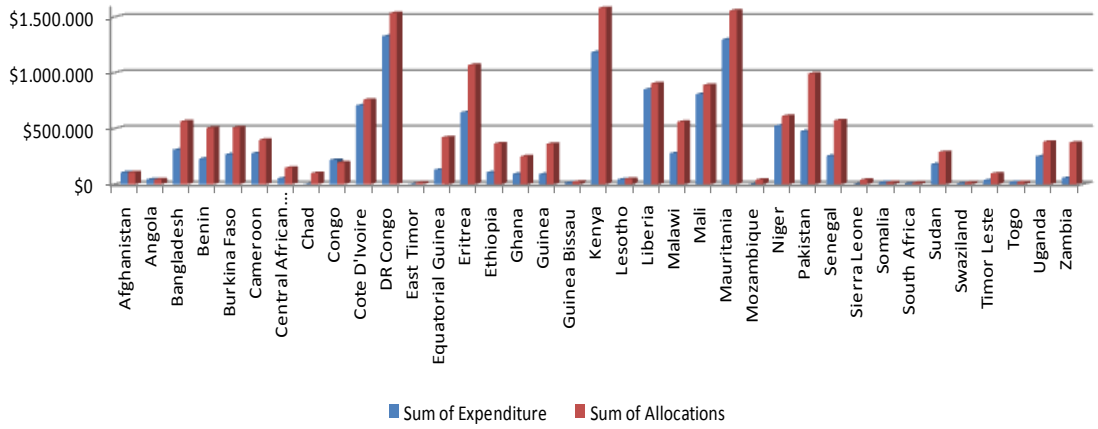
Beneficiary	2005	2006	2007	2008	Average 2005-2008
Country	66%	82%	84%	71%	75%
Global/Regional division	104%	76%	162%[55]	68%	105%
Total	**72%**	**81%**	**107%**	**70%**	**81%**

Source: UNFPA Headquarters.

❖ Expenditure by the countries

Figure 4 shows that the allocations to the beneficiary countries for the *Campaign* mostly exceed the money spent by the countries during the period 2005-2008.

FIGURE 4 - ALLOCATIONS TO AND EXPENDITURE FOR THE CAMPAIGN TO END FISTULA 2005-2008, PER COUNTRY (IN USD) – EXCLUDING NIGERIA



Source: UNFPA Headquarters.
Note: Nigeria has been excluded from this graph because its allocation (4 million USD) exceeded more than 5 times the expenditure (726,000 USD) for the period 2004-2008. Half of this allocation corresponds to contribution from the UN HSTF fund for building of a fistula centre in Abuja (being done through Federal MOH).

The expenditure rate differs over the years and per country but the general trend is that less than allocated is spent. This could indicate that countries lack absorption capacity or that implementation of planned activities is delayed year after year. It may also reflect the level of priority given to obstetric fistula by a specific country. It could also indicate that plans were over budgeted, or that maybe some activities were financially covered by the CP. Due to limitations in the information provided it was not possible for the evaluation team to carry out a more in-depth analysis of expenditures.

[55] Due to the difficulties of getting financial information fro the campaign, the ET was not able to ascertain the reasons why this is such an outlier.

TABLE 21 - EXPENDITURE RATE BY COUNTRIES FOR THE CAMPAIGN TO END FISTULA 2005-2008 (IN % OF ALLOCATION RECEIVED) [56]

Expenditure rate < 50 %		Expenditure rate ≥ 50% and < 100%		Expenditure rate ≥ 100%	
Malawi	49%	Mali	99%	Ethiopia	219%[57]
Pakistan	47%	Somalia	98%	Eritrea	127%
Ghana	46%	Liberia	92%	Congo	111%
Equatorial Guinea	42%	Lesotho	91%	Niger**	103%
East Timor	38%	DR Congo	85%	Angola	102%
Zambia	35%	Uganda	85%	Afghanistan	100%
Nigeria**	27%	Mauritania	84%	Togo	100%
Sierra Leone*	0%	Benin	76%		
East Timor*	0%	Kenya	75%		
Chad*	0%	Central African Rep.	74%		
		Sudan	73%		
		Senegal	72%		
		Guinea Bissau	72%		
		Cameroon	71%		
		Cote D'Ivoire	70%		
		Burkina Faso	63%		
		Bangladesh**	62%		
		Swaziland	54%		
		South Africa	54%		
		Guinea	52%		

Source: UNFPA Headquarters.
Note: * The zero expenditure rate is due to the fact that no money was allocated to the countries while all three have had some expenditure (all under 100.000 USD for the whole period). ** Data from UNFPA CO show a different expenditure rate: Bangladesh (100%), Niger (92%), and Nigeria (37%).

The **Bangladesh** CO reports a financial expenditures rate of 100%. The main contributing factors to this performance include careful planning and regular monitoring of activities and expenditures. According to data from UNFPA CO in **Nigeria** the financial execution rate was 70% without including the construction of the Abuja centre (37% with the construction included). The construction has been delayed for various reasons including delays in legalising the construction site and delays in the tender process.

Some of the reasons mentioned for low levels of expenditure are: receiving allocations late into the year (e.g. the Bangladesh CO reported that it takes approximately 3-4 months for the CO to receive funds from the Fistula Trust Fund after funds being allocated)[58], discordance between the national accounting year and the UNFPA accounting year, delays by the national implementer (central level MoH) in making funds available to the operational levels.

The evaluation team recognised in the inception report that it is difficult within the context of this thematic evaluation to link investments to outputs in view of the multiple strategic inputs required to achieve the *Campaign* goals and the fact that reaching those goals depend on many factors outside of the control of the *Campaign*. However, it would have been desirable to make an analysis of expenditures by activity or type of expenditure. Information on

[56] This table shows the difficulty of using ATLAS as the only source of data for tracking implementation rates.
[57] The ET was not provided with information for detailed analysis of expenditures. With the Hamelin Hospital based in Ethiopia, it is possible there are considerable additional training activities there.
[58] This process is affected by the AWP approval process at HQ. Consideration could be given to better aligned this process with the corresponding CO process.

expenditures by activity or by type of expenditure was requested both to HQ as well as to the eight countries included in the evaluation. The information received did not allow for a detailed comparative analysis. Only a few countries provided relevant or useful information for carrying some rough assessment by category of expenditures (see the specific country reports of **Bangladesh** and **Pakistan**), but still the information is not detailed enough to draw conclusions. UNFPA needs to strengthen its financial tracking system. This would allow among others, timely identification of delays in expenditure, carry out cost-analysis of interventions, and the development of criteria for allocation of resources.

The move at HQ from the thematic Fistula Fund to the one Maternal Health Thematic Fund will most likely affect the future allocation and disbursements of funds for fistula activities to the countries. The evaluation team was informed that due in part to the financial crisis, the funds available for fistula activities in 2009 are more constrained than in previous years. The *Fistula Campaign* is working closely with the Resource Mobilisation unit and with the Maternal Health Thematic Fund to ensure adequate fund availability for 2010. However, as the financial crisis continues to evolve, there is a need to be realistic and cautious regarding potential funds availability. A careful transition planning is required in order not to bring activities to a standstill and lose the momentum gained. UNFPA HQ will be exploring with countries the possibility of increasingly including fistula prevention/treatment activities within their overall country programme. There are also opportunities for the CO to mobilise resources locally. For example, the **Bangladesh** UNFPA Country Representative stated that the CO will secure funding for fistula activities for the next year. The ET was informed that Burkina Faso has mobilised significant amount of resources at country level from Luxembourg. The Coordination of the Campaign is also working closely with the Resource Mobilisation Branch to develop a clear and concise guidance for national resource mobilisation by COs.

4.6 Role / assistance from UNFPA's regional and HQ levels

Within the Campaign there are three possible ways for countries to request technical assistance (TA): request directly to SRO, request directly to RO or request directly to HQ. For the SRO/RO/HQ planning of TA is not always possible or efficient. Often requests from countries come in at the last minute, during a process that has already been initiated often long before, and without the participation of the other levels; making it sometimes impossible (when not too late) for adequate responses from SRO/RO/HQ. In order for a TA to be provided by SRO/RO/HQ a request for it has to come from the countries. Therefore even if the SRO/RO/HQ have identified a need for TA in a country, SRO/HQ staff cannot provide it until a request have been made by the CO.

The regional/sub-regional support is key for the coordination and (sometimes) implementation of activities related to capacity development, research and documentation that might originate at global level but involves the participation of countries in the corresponding regions or that are initiated at the regional level in response to identified needs or suggestions from countries. The regional level is also key for the facilitation of south-south cooperation

Countries have demanded assistance to UNFPA HQ or RO/SRO for issues related to formulation or elaboration of project proposals, submission of budget request, organisation and implementation of the (first) fistula repair camp(s), for formulation or review of proposals for national strategies to end obstetric fistula or for carrying out the country needs assessment on obstetric fistula. Some countries have also received support from RO/SRO when taking initiatives to include a data collection and analysis model on fistula in their Demographic and Health Survey. Countries also receive feedback from RO/SRO/HQ both to their annual reports as well as to their annual requests for funding. The feedback for annual

reports is provided on a summary sheet for all national campaigns in African, Arab and Asian countries. The feedback provided asks pertinent questions on both the report of activities and the proposed annual work plan. Many of the comments and questions are related to indicators and monitoring activities which are clearly weak points of the programme. Most of the follow-up is done by email. There seems to be limited capacity (time and resources) to provide on-site technical support to overcome perceived weaknesses at the national level.

There has been good interaction and careful communication and planning between CO/SRO/HQ for coordination of participation of national fistula advocates in global level advocacy efforts. It seems that in most cases where technical assistance is requested from HQ or Sub-Regional Office this assistance is provided. In the responses to the mail questionnaire twenty-one countries (out of 24) responded that they have never experienced a situation when requested technical assistance was not provided. Only Pakistan and Sierra Leone responded affirmative, but this was due to special circumstances.

In the African Region, there are two persons at regional level providing support to countries: one overall regional focal point for Fistula (also responsible for programmatic aspects) and one Technical Specialist[59] (responsible for technical aspects). This set-up may have hindered them to provide timely and sufficient assistance and support (none of them having the overall picture of what was taking place in the countries). According to staff placed in the African Region, the possibilities for RO/SRO to provide assistance to the CO are limited by the financial resources available[60] as well as by the time availability of the RO/SRO focal points. In some cases the CO/RO either do not have budget allocations for TA for fistula or the allocations are insufficient. In other cases each person has under his/her responsibility a large number of countries to look after or in addition to responsibilities for fistula, the staff is also responsible for other regional programmes[61].

A better communication[62] between all levels has been suggested, with the purpose to avoid overlapping of activities (i.e. the **Nigeria** National Programme Officer (Obstetric Fistula) has not been able to participate in Regional activities due to overlapping of activities organised simultaneously by the SRO and by HQ) but also to secure that institutional knowledge is shared and preserved. This communication is also necessary to secure that activities supported by HQ and taking place in the country, do establish proper linkages with the CO.

The evaluation team was informed that the country offices are increasing their own technical capacity on maternal health with international maternal health advisors, being placed on a country by country basis, particularly in the countries with highest maternal mortality. It might be advisable that these advisors are fully aware of obstetric fistula issues. This might reduce the need for technical assistance from SRO. However, as several countries are entering into a consolidation phase for their fistula programmes, it is the opinion of the evaluation team that in the near future countries might be requiring support from HQ/SRO in areas related to formulation of national strategies, establishing monitoring mechanisms, integration of fistula activities within national reproductive health and maternal health programmes, strengthening of their training programmes as well as their service delivery models.

As a result of the UNFPA reorganisation, there will be a shift towards technical assistance being provided through existing institutions or consultants (nationally or regionally) and not by UNFPA RO/SRO staff any longer. The SRO level should help identifying the

[59] In the Atlas system (financial and admin system) this position is reflected as Programme Officer.
[60] Countries do contribute to the cost of SRO assistance when needed. In addition, some funds are available at SRO level for supporting missions within the countries. In addition lots of assistance can be delivered without involving mission cost.
[61] Personal interview with Y. K.
[62] The communication lines are not always clear. With the Regionalization, the SRO are now the first port of call for countries. Unfortunately, this is not always respected.

consultants/institutions and should manage the provision and the quality of the technical assistance provided. Of course, this has an increased cost for the CO.

Provision of TA is a joint venture between SRO/HQ and Country Offices. Until there is a real partnership, the TA will remain limited with or without funding. It has been suggested by some of those interviewed that one of the best way to identify and plan TA is a monitoring visit. Unfortunately very few countries have had their programmes monitored after years of implementation. It would be advisable that every year a few countries should agree to be monitored and focus should then be given to these countries for the implementation of the recommendations provided.

4.7 South-south collaboration

Among the countries responding to the questionnaire, the majority (n = 18; 75%) have experienced south-south collaboration within the framework of the *Campaign*. Only five countries reported not having experience in south-south collaboration at all (Sierra Leone, Sudan and Zambia), but two of them have plans (Kenya and Rwanda). The main results of the collaboration are the **exchange of experiences and capacity strengthening of staff** through training sessions, study tours or outside exposure during the fistula fortnights in other countries (see Table 22 for some examples).

Especially the collaboration with the Addis Ababa Fistula Hospital in Ethiopia and with the Babbar Ruga Fistula Hospital in Katsina (**Nigeria**) have been a vehicle for sharing experiences as well as for capacity building. For example, when the Fistula *Campaign* activities were initiated, selected senior obstetricians/gynaecologists from **Bangladesh** went to the Addis Ababa Fistula Hospital in Ethiopia for training and returned to establish VVF services in Bangladesh. Many other countries (e.g. Burkina Faso, Malawi, Sudan, and Uganda) have made an effort to send health care providers for training to both Ethiopia and **Nigeria**. These trainings had a multiplier effect because the trained staff was now able to perform fistula repairs in their own country and to train local staff. For example, VVF repair specialists from East Timor, Pakistan, Nepal and Afghanistan went to the DMCH Fistula Centre in **Bangladesh** for training. It seems that the Addis Ababa Fistula Hospital as well as Babbar Ruga Fistula Hospital in Katsina (Nigeria) function as reference fistula centres in the East African region and the Dhaka Medical College Hospital Fistula Centre would like to become a referral Centre in Asia.

TABLE 22 - EXAMPLES OF SOUTH-SOUTH COLLABORATION WITHIN THE FRAME OF THE CAMPAIGN TO END FISTULA, 2004-2009

Exchange of experiences and training in fistula repair	
Bangladesh	▪ Surgeons sent to Ethiopia for training. ▪ Surgeons and patients from other countries in the region (Nepal, Pakistan) come to Bangladesh.
Burkina Faso	▪ Study trip to Mali for exchange of experiences and training in fistula repair of one gynaecologist in Bamako. ▪ Training in fistula repair: three urologists, one gynaecologist and five paramedics in Addis Ababa.
Burundi	▪ Two doctors with some experience went to Rwanda for a training of one week in fistula surgery.
Congo	▪ Two gynaecologists and one urologist have visited DRC for exchange of experiences.
Ivory Coast	▪ Capacity building in the Babbar Ruggar centre in Nigeria (Katsina state) in October 2008. ▪ Joint intervention Ivory Coast and Nigeria in Man (Ivory Coast) in July 2008.

Exchange of experiences and training in fistula repair	
	▪ Joint intervention in Mali (Point G hospital in Bamako) in April 2009.
Liberia	▪ The initial project team members were all trained in Nigeria prior to launching of the fistula project in Liberia in 2007. ▪ The Liberia fistula project also established linkage with doctors in Mali who have been visiting Liberia to participate in massive fistula campaigns. ▪ Four Liberian doctors were trained in Fistula management in Mali.
Malawi	▪ The Country Office of UNFPA Malawi visited the Ethiopian OF hospital and lessons were learnt (the trip was specifically to experience the end-of-early marriage campaign and part of it was this visit).
Mauritania	▪ Training in OF repair techniques in Bamako of Mauritanian doctors. ▪ Initial training in Nouakchott of 18 surgeons, gynaecologists and midwives during TA missions by Prof. K. Ouattara.
Nepal	▪ UNFPA Nepal sponsored a fistula operating team of Patan Hospital consisting of a gynaecologist, anaesthetic assistant and a nurse for a 3 days training in Bangladesh in 2008.
Niger	▪ Niger has experienced a sustained and successful south-south collaboration with Katsina, Nigeria.
Senegal	▪ The support provided by Professor Serigne Maguèye Gueye to other countries in the subregion (Rwanda, Benin, Niger) with respect to capacity strengthening for OF repair.
Sudan	▪ In 2004, three gynaecologists went to Addis Ababa Fistula Hospital in Ethiopia for advanced training. ▪ In 2006, a mission made of two staff members from Abbo Fistula centre went to Addis Ababa Fistula Hospital for sharing of experiences.
Uganda	▪ Training was conducted in Addis Ababa. UNFPA has funded training and upgrading of fistula surgeons at the nearest expert centre within the region.
Inter-country collaboration to treat OF patients	
Benin	▪ With the NGO "Sentinelle" from Burkina Faso that traces OF patients and sends them to the Hospital of Tanguiéta for treatment.
Ivory Coast	▪ Collaboration with Mali and Nigeria to treat patients.
Sudan	▪ Many of the cases of VVF treated in Uganda and Kenya in fact originate in southern Sudan. Similarly, many patients from refugee camps in Chad have received care in Darfur Sudan.
OF conferences and workshops	
In West Africa	▪ Annual obstetric fistula conferences in the region (Ghana, Liberia, Mauritania).
In Asia	▪ Workshops with participants from Bangladesh, East Timor, India, Nepal, and Pakistan.
In East Africa	▪ The Tanzania experience of Fistula Prevention, Care and Treatment has been shared in international and regional fora by Women's Dignity programme.

Source: Team elaboration from (1) individual country reports elaborated for the Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula and (2) country responses to questionnaire.

Within the framework of a subregional coordination of obstetric fistula activities by CSOs and with the support from UNFPA, a network of African NGOs working on obstetric fistula has been set-up and has started with its activities. This network includes the national NGO networks of Mauritania, Mali, Niger, Togo and Ivory Coast. NGOs from Tanzania are also participating in this network. In the long term this network could act as well as a framework for sharing experiences and disseminating lessons learnt in the different partner countries.

The obstetric fistula conferences and workshops which are organised regionally (Asia, Africa) are ideal platforms to share experiences and to further strengthen the south-south collaboration. These conferences are costly, therefore their frequency and organisation

should be carefully planned. As much as possible they should be related to discuss critical issues and facilitate decision making / action taken.

The benefits derived from the south-south collaboration (sharing experiences, training in well-known fistula centres or on the job during fortnights, conferences) are highly valued by countries. In the responses to the mail questionnaire it was recommended to organise more joint fistula repair missions and to encourage the practical training of obstetric fistula staff during campaigns to share experiences and to upgrade skills. The CO should become better at documenting their experiences. SRO/HQ should coordinate better south-south cooperation in partnership with CO.

4.8 Perceptions of others stakeholders of UNFPA's role on Fistula in the country

The evaluation team met with stakeholders involved in the implementation of obstetric fistula activities in the in-depth study countries and made telephone interviews with key stakeholders in some of the desk review countries. We encountered unanimous acknowledgment that the *Campaign* has resulted in a major increase in awareness about the issue. The UNFPA efforts for fistula prevention and care were known and acknowledged, however not known in detail (**Nigeria**, **DRC**). UNFPA and other stakeholders in the countries have made attempts to create a national platform for information exchange and coordination, but they have not been successful (**Kenya**, **DRC**, **Nigeria**). Those interviewed agreed that this was due in part to the weak capacities of the national authorities to maintain such a platform as well as lack of resources.

In **Bangladesh** and **Nigeria**, it was also mentioned that due to its relationship and collaboration with national authorities, UNFPA has a comparative advantage to advocate with policy makers. UNFPA has multiple links with different government departments (gender, health and FP, population and development) and has used their comparative advantage relatively effectively. UNFPA has also advocated for fistula with decision makers such as religious and traditional leaders. Others referred to UNFPA as being an important "pillar" for obstetric fistula in the country as well as being an important player with whom to collaborate and coordinate.

There is agreement on the need for better coordination, planning, collaboration and exchange of experiences and information between those working on fistula activities in the countries. Fistula stakeholders in each country, including UNFPA, should collaborate with national authorities in strengthening their leadership and capacities in fistula programming.

5. Conclusions

5.1 Overview

Obstetric fistula is increasingly recognised as a health and human rights issue that needs to be addressed. The *Campaign to End Fistula*, initiated in 2003, has achieved much in terms of awareness building and service development and has been a definite catalyst to mobilise action in the countries towards addressing fistula. The *Campaign* has been instrumental in leveraging additional support and resources, but needs to associate itself more clearly with the need for improved maternal health services. At the same time it needs to move beyond the pilot project mode and be scaled up in a more systematic fashion.

At the level of fistula repairs being done, the backlog of obstetric fistula cases is not nearly being addressed, let alone the new cases. In three out of the eight countries reviewed (Niger, Kenya and Tanzania), the number of fistula repairs done annually cover approximately one third or more of new cases occurring every year. The prevalence of obstetric fistula is still very high in all countries.

Not in all the countries studied, the *Campaign* has provided direct support to **prevention** of obstetric fistula (e.g. through skilled birth attendance or improvement of emergency obstetric care) as these activities are addressed under the reproductive health components of the respective UNFPA CP. The *Campaign* has modestly contributed in mobilising communities to become aware of how obstetric fistula can be prevented, on identification of fistula patients and their referral for treatment. The *Campaign* has certainly created more awareness on the issue of obstetric fistula, not only among health care providers, community workers, and policy makers, but also among the fistula patients themselves and their families. In the countries visited, there is definitely increased visibility, greater government commitment, and higher levels of health workers' and community **knowledge and awareness** on fistula. The awareness raising messages need to stress even more obstructed labour as the main cause of fistula. In some countries this message is sometimes displaced by other *Campaign* messages that are important but deviate from the main focus for prevention of fistula, such as the messages for the prevention of child marriages (in Nigeria and Bangladesh), and for the prevention of sexual violence in the DRC. Family planning, prevention of obstructed labour and timely access to emergency obstetric care are key strategies for the prevention of fistula and for the reduction of maternal mortality, and in all countries there are many players working on these areas. Progress made in the countries on these issues varies greatly and in most cases is rather slow, and with few exceptions not reflected in significant reductions of maternal mortality

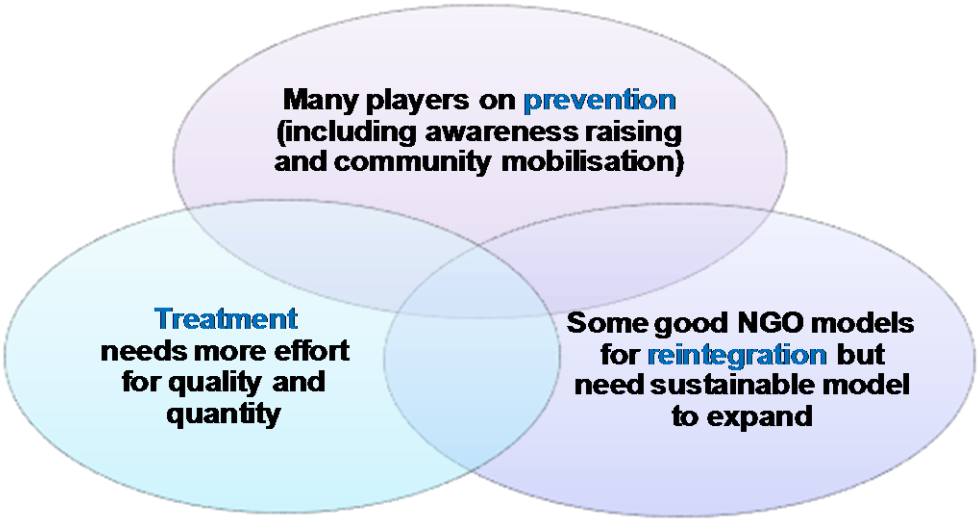
The large focus the *Campaign* has taken towards **treatment** is appropriate since this was a totally neglected area in public health; this has required substantial systems building to become institutionalised and the transition is still far from complete. An important strategic question of the *Campaign* is the service delivery model for fistula treatment. The observed service model for fistula repair in the countries included in the study is a combination of national referral centre(s), services provided at tertiary level facilities, decentralised service provision at lower level facilities and regular fistula campaigns or "fistula fortnights". Each of these modes of delivery responds to a specific demand and country situation, and the appropriate mix should be chosen in each country based on the specific context in each country and the complementarity of services. The level of decentralisation of services for fistula treatment is an important strategic consideration that needs to be evaluated in each country based on a number of local parameters. Issues of quality assurance and

mechanisms for ensuring sufficient volume of skill practice during and after training of fistula surgeons have been reviewed.

Within obstetric fistula programming the aspects related to rehabilitation and social reintegration of patients after fistula treatment are rather new components to be addressed and much more knowledge needs to be gained in order to better understand and address these issues. Follow-up of patients after fistula surgery and support to their reintegration in the community has not been sufficiently addressed by the *Campaign*. Two main types of **social reintegration** services exist: (i) fistula rehabilitation centres or facilities, and (ii) community-based initiatives. In the countries included in the study these types of services are initiated by the government or by local NGOs, with or without support from UNFPA. They offer differing levels of pre- and post-operative support, including skills training and income-generating activities to assist the reintegration of fistula survivors in their families and communities. Overall the availability and accessibility of rehabilitation services is insufficient and the proportion of women accessing this service is small.

Figure 5 presents the overall conclusions for the areas of prevention, treatment and social reintegration.

FIGURE 5 - OVERALL CONCLUSIONS ON THE CAMPAIGN TO END FISTULA



There are a number of significant **challenges** with a *Campaign* which by its nature must be ambitious and sets vision, is time-bound and is primarily for advocacy and awareness. The *Campaign* by setting the goal to 'elimination of obstetric fistula by 2015' from a public health perspective scores high with regards to ambition, though unrealistic from a practical point of view. The pathogenesis of obstetric fistula could be used to construct proximal, intermediate and distal determinants and support this rationale. However, it is very troubling to see the lack of rigor on the basics elements for results based management and within this the absence of monitoring and evaluation elements for the *Campaign*. It is difficult to argue about the benefits and accomplishments of the *Campaign* when we cannot support it with sufficient evidence at any level. Even the advocacy efforts can only be anecdotally measured, which still has shown some strong achievements, but in future more strategic efforts to assess the comparative advantages of different BCC interventions would improve the quantitative data to evaluate interventions.

This *Campaign* was not designed with a logical framework, to establish expected results in quantifiable terms. It is not the task of the ET to distinguish what the Campaign "can

definitely achieve, could probably achieve, and with what level of likelihood." This was the task of the design team. This will now be the task of the follow-on team which will redesign the *Campaign* within the integrated Thematic Fund for Maternal Health. The broader elements of maternal health (increased strategies for skilled attendance, and access to EmOC as well as FP) are the core business of UNFPA and are already part of the general mandate of the RH component of the CP. Training and increased service delivery for treatment services can continue to be delivered, with gradual integration into national programs as obstetric fistula gains recognition as a public health problem. For these, specific results should be determined and measured and evaluated against these criteria – lacking in the current *Campaign.* Rehabilitation should be increasingly contracted to NGOs and other partners at community level, and government ministries such as gender. With UNFPA's strong role in gender activities, the CO is well-positioned to manage those partnerships, which should not need specific *Campaign* leadership.

In the next sections the evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability) will be discussed and synthesised for the eight study countries, with a main focus on the four in-depth country assessments (Bangladesh, DR Congo, Niger and Nigeria).

5.2 Relevance

This criterion determines how much the *Campaign* has contributed to (i) the integration of fistula into national health programmes and to (ii) UNFPA's overall objectives.

UNFPA involvement in fistula activities in the reviewed countries is ***highly relevant***, not only because fistula is an important problem - as indicated by the high prevalence and incidence rates of obstetric fistula - but also because the presence of fistula is linked to issues related to reproductive health (e.g. family planning, skilled attendance and EmOC) as well as gender and poverty, which are important components of the UNFPA mandate. The *Campaign* activities helped to integrate the overall UNFPA objectives of addressing gender, maternal and reproductive health and dealing with factors which contribute to the incidence and prevalence of fistula, such as low education, early marriage, female malnutrition. Poor people have the least access to skilled birth attendance and emergency obstetric care and have benefited from the *Campaign* because services were provided to the poorest and most marginalised women.

TABLE 23 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: RELEVANCE

Prevention, treatment and social reintegration		
Strengths		**Weaknesses**
All 8	Integration of overall UNFPA objectives into fistula strategies	
Niger, Sudan	Integration of OF strategies in national programmes	*Bangladesh, DR Congo, Nigeria*
Bangladesh, Niger	Fistula a national priority	*DR Congo, Nigeria, Kenya*
All 8	Provided services to the poorest and marginalised	
Bangladesh, DR Congo, Kenya, Niger, Nigeria, Pakistan, Sudan	Benefited from Campaign contributions	
Globally, all 8	Leveraged additional support and resources	

In spite of being an important problem in the countries reviewed, fistula care is not yet a national priority in most countries. While being addressed in national programmes in Niger and Sudan, in several other countries fistula management is not incorporated into key

reproductive and safe motherhood programmes or not yet integrated into the sector programme planning (see section 4.1.2). For example in Nigeria, obstetric fistula is not being integrated or even mentioned in key policy documents related to maternal health such as the Integrated Maternal Newborn and Child Health Strategy (2007), in some states obstetric fistula is not yet recognised as a problem and there is no specific budget allocation to fistula activities at federal or state levels. The *Campaign* has contributed only marginally to the effort of improving maternal health care in the DRC. This is, in part, due to the fact that it was launched with a strong link to the issue of sexual violence, and is still being associated with this issue by many national observers. Many senior government leaders in and outside the health sector do not make the link between fistula and poor obstetric services. *This makes the advocacy and awareness raising activities supported by the Campaign very relevant, particularly those directed to policy makers, traditional and religious leaders.*

Between 2004 and 2008[63] UNFPA allocated a total of 27 million US dollars to the *Campaign to End Fistula*: 75% of the money was allocated to the national efforts and 25% to the global/regional efforts. Most countries have limited or no government funds for specific fistula activities or services - apart from the budgets for recurrent costs in the health facilities (salaries, medicines, equipment) - and have therefore benefited significantly from the UNFPA contribution. Apart from Tanzania, none of the eight countries reviewed have a specific budget line for fistula activities. Some countries (e.g. Bangladesh, Pakistan, Tanzania) have received modest financial support from local or international NGOs but securing sustainable funding for future fistula activities – when/if UNFPA support stops - becomes crucial (see section 5.6).

A strong continued focus on fistula is needed by UNFPA and the countries in order to consolidate the momentum gained since 2003 and streamline the obstetric fistula efforts within the broader context of RH and safe motherhood programmes in the countries.

5.3 Effectiveness

This section analyses how much the *Campaign* has achieved the intended objectives in the areas of prevention, treatment and social reintegration. The Global Programme Proposal of "Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010" does not list indicators nor targets for the expected results, which hinders the evaluation of the components of prevention, treatment and social reintegration against the respective objectives.

Data availability is one of the Achilles heels of the *Campaign*. Because national data collection and analysis systems are weak, few data are available if they are not collected by the *Campaign* itself and the data available for monitoring the *Campaign* are insufficient in scope and quality. Introducing project-specific data collection systems would, however, further weaken national efforts for improved health systems data management. *Efforts to improve this situation need to be carefully balanced between meeting the health care systems needs of the countries and the reporting needs of the Campaign*.

In most countries, there is a weak programmatic set-up within the existing health systems structures at all levels.

[63] These allocations are lower than the total funds raised due carry over of funds received at the end of the year 2008. These funds were allocated in the year 2009.

5.3.1 Effectiveness in prevention

Most interventions to address reduction of maternal mortality and morbidity are seen by countries as part of the overall UNFPA mandate and therefore these activities are supported by the respective UNFPA CP in each country. The fact that the *Campaign* is somewhat operating as a vertical project might be contributing to this understanding and the fact that it has a specific focus might be contributing to this somewhat artificial - and counterintuitive - separation, when the reality is that obstetric fistula should be part and parcel of RH and maternal health programmes.

It is not possible to properly assess whether the *Campaign* has had any effect on improving maternal health – e.g. impact on reduction of maternal mortality or reduction of obstructed labour, all countries included in the evaluation have high maternal mortality rates- However, there have been considerable *achievements* in terms of the effectiveness of several fistula **prevention** strategies supported by UNFPA CP and the *Campaign* in the countries reviewed:

- Advocacy and awareness activities have been conducted within UNFPA, in training programmes, and with target audiences such as communities, political leaders, and other maternal health stakeholders.
- In Bangladesh there has been increased availability of EmOC and skilled birth attendance in both the private/NGO sector and government supported skilled birth attendants which contributes to the reduction of complications during labour and delivery. Skilled birth attendance increased slightly in the DR Congo and Nigeria in the recent years. In other countries access to quality emergency obstetric care and midwives availability are still too low: in Sudan efforts are made to increase coverage of rural midwives (currently only 37.7%) and in Pakistan the National Maternal, Newborn and Child Health Programme 2006-2012 introduces community midwives to be trained in home-based deliveries (in order to increase skilled birth attendance which is now 34%). In Niger, motivated midwives practice without official inclusion in the health system and without official payment.
- Good use of partograph was reported in Bangladesh (by the community skilled birth attendants) and in Niger, but there is still insufficient use of the partograph in medical settings (i.e. teaching hospitals) and in the other countries.
- Use of catheterisation for 14 days in cases of obstructed labour to prevent fistula formation was reported in Bangladesh and Niger, but it is not standardised in all settings.

The following *weaknesses* were noted in prevention:

- In some of the countries studied (e.g. Nigeria), the *Campaign* has not provided direct support for the improvement of emergency obstetric care as these activities are covered under the support provided to the country under the RH sub-programme of the CPAP. In most countries the contribution of the *Campaign* to increased access and utilisation of quality basic and emergency obstetric care has been through raising awareness of the need for accessing obstetric care for obstructed labour. It is not fair to expect that the *Campaign* - with limited funding and relatively short period of implementation - can have an impact in improving EmONC at large. Focused and long term investments in the implementation of a number of interventions are required for this purpose. However, due to the importance of this matter in the prevention of fistula, a discussion on this issue has been included.
- There is no use yet being made of mass media. Stronger advocacy is needed with other UN partners to ensure that fistula prevention is integrated in major health policy agendas. In DRC e.g. there have been mass media campaigns but they have largely focused on fistula and sexual violence.
- There appears to be a possible overuse of Caesarean sections (in urban areas) and less use of more timely vacuum assisted deliveries (observed in Bangladesh). Symphysiotomy is sporadically applied in Africa but might be an acceptable alternative

for Caesarean sections in the context of fear and/or rejection of abdominal operations (Nigeria.)This issue may be worth discussing by UNFPA when analysing with countries possible maternal health interventions to advocate for and implement.

- In most countries there is an unmet demand for family planning which requires much more concerted efforts in the countries and (possibly) stronger leadership from UNFPA at all levels.

TABLE 24 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: EFFECTIVENESS IN FISTULA PREVENTION

Prevention			
Strengths		**Weaknesses**	
Advocacy and awareness raising (within UNFPA, target audiences)	*Bangladesh, Niger, Nigeria, Tanzania*	Insufficient/No use of mass media	*Bangladesh, Kenya, Niger, Nigeria, Pakistan, Sudan, Tanzania*
Increased EmOC availability supported by UNFPA and other partners	*Bangladesh*	No direct support for improvement of EmOC	*Bangladesh, Nigeria*
Increased skilled birth attendance	*Bangladesh, DR Congo, Kenya*	Insufficient effort on family planning	*All 8*
Reported use of partograph (e.g. in home births)	*Bangladesh*, DR Congo**, Niger*	Possible overuse of CS and less use of vacuum assisted delivery	*Bangladesh*
Use of catheterisation for 14 days in case of obstructed labour	*Bangladesh*	Midwifery coverage too low	*All 8*

Note: * in home births. ** Only in Maniema and Ituri.

5.3.2 Effectiveness in treatment

All eight countries included in the evaluation focused their *Campaign* activities on increasing access to and utilisation of quality obstetric fistula **treatment** services. Many *strengths* were noted by the ET in terms of treatment:

- Access to treatment of fistula has increased substantially, mainly through the organisation of fistula campaigns, workshops or fortnights. The advocacy and awareness raising activities carried out at community and local level, previous to the a specific treatment campaign have shown to be successful in identifying obstetric fistula patients and motivating them to search for treatment.
- Capacity has been built through training of multidisciplinary teams in obstetric fistula care and management, establishment of training/treatment centres or supporting already established centres or facilities that are providing fistula treatment services. In Niger e.g. the capacity strengthening of the national support is a real achievement, with available evidence showing a success rate of fistula repairs varying between 73% and 94%.
- Training of Trainers (Master Trainers) has taken place by sending interested health care providers for training abroad to the Hamlin Hospital in Ethiopia or the Babbar Ruga Fistula Hospital in Nigeria or by in-country training facilitated by national and international fistula surgeons in designated training centres or training sites (Bangladesh, DRC, Kenya, Tanzania).
- Standards and protocols have been developed (Bangladesh, Kenya and Sudan). This is not the case in all countries as in Niger e.g. where no consensus yet exists on a standard protocol for surgical interventions.

- The decentralisation of the fistula services involved the establishment of treatment sites in hospitals outside the capital city, national referral hospitals or teaching hospitals[64]. In some cases this has facilitated the organisation of outreach camps to reach population from remote areas in their respective catchment areas, and has contributed as well to address some of the backlog of patients (Bangladesh, Pakistan, Sudan, Tanzania, Kenya, and Nigeria). In Niger a decentralisation was ensured to some extent by adding a number of fistula repair sites outside the capital city and in secondary hospitals.
- Improved equipment, infrastructure and consumables have been realised by the *Campaign* in most countries. However, in the DRC, the *Campaign* has provided major support to a private hospital in Kinshasa (construction, equipment, service payment). Once UNFPA stopped paying for services, the hospital stopped treating fistula, because it is a commercial enterprise and a hospital for the very rich, and nowadays nobody with a fistula can actually afford to go there.

TABLE 25 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: EFFECTIVENESS IN FISTULA TREATMENT

Treatment			
Strengths		**Weaknesses**	
Increased access to fistula treatment	*All 8*	Low case volume (although camps help to mask the low clinical volume)	*All, except Niger (at least in 3 health facilities)*
Campaigns helped to build awareness and bring in outside quality assurance	*Bangladesh, Kenya, Nigeria, Pakistan, Sudan, Tanzania*	Quality assurance mechanism not in place	*All 8*
Treatment standards, protocols developed	*Bangladesh, Kenya, Sudan*	Low retention of trained staff	*All 8*
Capacity building in fistula treatment	*All 8*	Quality of surgery variable	*Bangladesh, Pakistan*
Training of trainers conducted	*Bangladesh, Kenya, Pakistan, Tanzania*	High costs for interventions for the facilities	*Bangladesh, DR Congo*
Decentralisation of the health service delivery	*Bangladesh, Kenya, Pakistan, Sudan, Tanzania*	Nurses underutilised (operating theatre, anaesthesia)	*Bangladesh*
No user fees for fistula treatment in UNFPA and other donor supported sites	*All 8*	Other intrinsic costs related to fistula treatment for patients (e.g. transport cost, accommodation)	*All (except DRC)*
Improved equipment, infrastructure, consumables available	*Bangladesh, DRC, Kenya, Niger, Nigeria*		

The *weaknesses* in terms of treatment are:

- Despite the numerous fistula outreach/treatment campaigns or fortnights carried out, which have resulted in an increase in the number of fistula repairs conducted, the volume of fistula patients treated is too low and the quality of surgery is still variable. It has to be acknowledged that some countries had almost no provision or only very limited

[64] For example in Nigeria, there is no centre in the capital city, but the fistula centre in Katsina is somehow acting as a national referral centre for difficult fistula cases.

provision of obstetric fistula treatment services before the support from the Campaign started.
- In most supported centres, there are no quality assurance mechanisms in place except for informal supervision.
- There is low retention of staff trained in fistula repair and care.
- Although obstetric fistula treatment services are provided free of charge to patients in the UNFPA or other donor supported sites, the patients often incur other costs for food, accommodation and transport costs, and the inability to pay for these costs is a barrier to access services.
- The cost of interventions is relatively high for the facilities. In DRC e.g. the treatment costs per patient claimed and reimbursed by the *Campaign* appear to be very high and there are large differences in costs claimed by different institutions.
- Nurses are extremely underutilised in the operating room and in potential new roles as nurse anaesthetists. In Bangladesh, the inverse ratio of nurse to doctors (22,000:40,000) evidently does not support effective service delivery, and has been a persistent problem in spite of substantial efforts to overcome this by many stakeholders.

5.3.3 Effectiveness in social reintegration

In general, social reintegration of fistula patients into their community is the least prioritised intervention of the *Campaign* and the effect of the *Campaign*'s support is still weak. But there are some *positive elements* to be mentioned in the area of social reintegration and rehabilitation:
- In some countries local NGOs have initiated social reintegration activities either in fistula rehabilitation centres/facilities or through community-based initiatives. In Bangladesh, it is positive to see a strong NGO such as the Bangladesh Women's Health Coalition being used for this aspect of fistula care. In Nigeria, the support provided for rehabilitation services through the Community-Based Reintegration pilot project in Kankara and Nasarawa LGA had good results[65] and those were highly appreciated by the fistula clients, as they are in the Bankilare area covered by the HDI NGO in Niger. In Niger two NGOs were already doing social reintegration work before the *Campaign* was launched and were strengthened by the latter.
- Excellent use has been made of Community Fistula Advocates for prevention and referral: in Bangladesh both social and economic rehabilitation have been supported, as well as psychological support and health education.
- Former obstetric fistula clients are effectively used as communicators, ambassadors, peer educators, to identify and refer women-sisters still suffering and hiding, not willing or able to reveal themselves as fistula patients.
- Income-generating activities are very effective for the fistula patients, both because of the skills training which is often included and the economic value added (Bangladesh, Pakistan). In Niger the effectiveness of the current income-generating activities for fistula survivors is not clear and those activities are being revisited.

[65] Over 80% of the women who received rehabilitation support in Kankara LGA had multiplied the input received after twelve months. (source: Nigeria UNFPA Fistula Campaign Annual Reports 2008; V. Lessons Learnt)

TABLE 26 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: EFFECTIVENESS IN SOCIAL REINTEGRATION OF FISTULA PATIENTS

Social reintegration			
Strengths		**Weaknesses**	
Good use of (local) NGOs	*Bangladesh, Niger, Pakistan*	Least prioritised intervention	*All 8*
Some use of Community Fistula Advocates (CFA) for prevention, treatment and referral	*Bangladesh, Kenya, Nigeria*	Incomplete linkages yet with existing NGOs and government services (other Ministries)	*Bangladesh, Kenya, Pakistan*
Social and economic rehabilitation through income-generating activities	*Bangladesh, DR Congo, Niger*	Only available in few sites (with UNFPA support) and/or not replicable	*All 8*
Psychological support and health education	*Bangladesh, Niger, Nigeria, Pakistan*	Few beneficiaries as compared to patients undergoing repairs and selection of beneficiaries unclear	*Bangladesh, DR Congo, Nigeria*

W*eaknesses* observed in the area of social reintegration are:

- Some of the good examples (e.g. Bangladesh) are not replicable (expensive, no resources available), although with adjustments could have the potential for replication and for others to follow, both in a facility-based and in a community-based context.
- Linkages with the local NGOs/CSOs to offer social reintegration and rehabilitation services to the fistula patients are incomplete or not fully exploited. The limited coverage of social support services by NGOs in e.g. the DR Congo raises questions about the organisation of these services in the most effective and efficient manner.
- The initiative in the DRC to outsource the organisation of the psychosocial support to the Ministry of Gender is positive, but in general the use of other Ministries (e.g. gender, community development) in the area of social reintegration is incomplete.
- Number of patients having benefited from these services is largely inadequate to have any impact on the rehabilitation component of the fistula programme.
- Criteria for selection of the fistula patients are unclear.
- Data on follow-up might be lacking given the low capacity of NGOs in terms of data management.
- There is no reliable information on the percentage of obstetric fistula patients in need - or not - for rehabilitation.

There are still many questions about the effectiveness of social services for support and reintegration of women following fistula surgery. There are individual accounts of major successes, but there is no systematic record or evaluation that would allow any statements about the overall effectiveness of the programme.

5.4 Efficiency

The criterion of **efficiency** analyses whether the *Campaign* has taken measures during planning and implementation of the activities to ensure that resources are efficiently used.

Positive elements in terms of efficiency are:

- Establishment of national coordination mechanisms for fistula activities, such as the National Task Force in Bangladesh, the network to eliminate fistula (REF) in Niger, the “Comité de Pilotage” in DRC, the National Fistula Working Groups in Pakistan or the several Fistula Task Forces in Sudan. These mechanisms ensure efficient coordination and communication of all obstetric fistula activities among the parterns involved nationally.

- Existing health facilities and infrastructure have been used for fistula treatment and training in all countries or for rehabilitation services in Bangladesh, Niger and Nigeria.
- The current forms of South-South collaboration have contributed to efficient use of available (financial and human) resources.
- The organisation of fistula camps or fortnights generates more patient volume than only having routine services and makes efficient use of the international, national, and local expertise with an inbuilt training component. The camps are conducted by trained and skilled staff in fistula repairs and offer opportunities for on the job training of new surgeons and gynaecologists (Bangladesh, Pakistan, Kenya, and Tanzania).
- Establishment of good Public Private Partnerships which improve coordination and thereby facilitate efficiency by reducing gaps and duplications (Bangladesh).
- The performance contracting in Niger is an interesting way of making efficient use of the available resources and improving performance. During the *Campaign,* UNFPA has "institutionalised" performance contracts with the hospitals and NGOs, who will be reimbursed in function of the number of fistula interventions carried out during the preceding year and according to the action plan. The number of interventions may be increased in the course of the year if performance is higher than predicted, which indicates a certain flexibility and is likely to make the work easier for the health care providers. Also NGOs active in social reintegration have been contracted by the REF on basis of a defined number of cases and according to the action plan.
- Initially many medical surgical requisites and consumables were supply-driven, which led to wastage, but are now ordered on a demand basis.

TABLE 27 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: EFFICIENCY

Prevention, treatment and social reintegration			
Strengths		**Weaknesses**	
Coordination mechanisms established	*Bangladesh, Niger, Pakistan, Sudan*	Waste of training because of too low volumes and redeployment of staff	*All 8*
Existing facilities used for treatment and training	*All 8*	Low level of appropriation of the Campaign by the government	*DR Congo, Kenya, Nigeria, Tanzania*
Camps increase volumes and offer training opportunities	*Bangladesh, Pakistan*	Bottlenecks in fund disbursement	*Bangladesh, Pakistan*
Public Private Partnerships for fistula treatment	*Bangladesh*	Poor quality assurance with many repeated repairs as a result	*Pakistan*
Performance contracting	*Niger*		

Some *concerns* persist with respect to efficiency of the UNFPA *Campaign* activities:

- The (too) low number of fistula repairs and frequent redeployment of staff trained in fistula repair leads to loss of training and hence wastes those training resources, which is not cost-effective. Higher surgical volumes would help surgeons retain their skills and improve the quality of the repairs, hence reducing treatment failures and subsequent repeated operations, which is inefficient. The efficiency of the sensitisation activities and training of "femmes relais" in Niger is not clear.
- The level of appropriation of the *Campaign* by the governments is often too low. In the DR Congo e.g., the National Reproductive Health Programme is not exercising its role as the coordinator of fistula services provided by different international actors.
- Shortage of funds or bottlenecks in the disbursement of funds from the *Campaign* cause interruption or delay of planned activities (recently in Bangladesh and Pakistan). Multiple funding streams from other donors and/or resource mobilisation at local level would allow programme activities to continue uninterrupted.

The resources available in each of the countries (health staff, infrastructure) and the extra financial resources from the Campaign have generally been used in an efficient way but there is certainly room for improvement in the areas of treatment and social reintegration. There is a need to balance the imperative to achieve the widest possible coverage of fistula care with the objective of appropriately targeting the fistula services according to need.

5.5 Impact

This section assesses the effects (positive and negative, primary and secondary, long-term) produced by the *Campaign,* directly or indirectly.

Positive impact generated by the *Campaign* in a **direct** way are:

- At global, regional, national and community levels the *Campaign* has produced more awareness about the causes of maternal mortality and morbidity in general and obstetric fistula in particular. Fistula survivors have been outstanding ambassadors for the mobilisation of political and public support to maternal health services and for raising the profile of the fistula issue within their communities, their countries, in international conferences and the international media.
- The *Campaign* has globally raised (i) more attention to the importance of emergency obstetric care and skilled birth attendance, (ii) access and utilisation of fistula treatment, (iii) more attention for rehabilitation, psychological and social support for women, and (iv) community involvement.
- The *Campaign* has been a catalyst: a major impact of the social reintegration activities is undoubtedly the de-stigmatisation of the fistula issue and the regained self-esteem and dignity of the fistula survivors.

Positive effects produced by the *Campaign* in an **indirect** way are:

- The visibility and awareness of obstetric fistula in UNFPA country offices and in the countries themselves have been increased with targeted IEC to the government, the public, health workers, partners, and other stakeholders. Also the needs assessments have been very useful for the objective of increasing the awareness about obstetric fistula and were used as input to formulate the project proposals for the *Campaign* (i.e. in Bangladesh and Kenya). In Nigeria the advocacy and awareness raising activities supported by the *Campaign* brought renewed interest on fistula in the country as well as it brought fistula to the attention of high level officials in the country.
- The *Campaign* has paved the way for improved collaboration between UNFPA and the US Government and the Fistula Care project, financed by USAID and implemented by Engender Health in twelve countries, was a result of this.
- The *Campaign* has been a lever for additional contributions and support for fistula activities and attracted new players that were not involved in fistula treatment and care before (NGOs, CSOs, and governments).
- The South-South linkages have been strengthened and offer enhanced possibilities in the future for further collaboration and exchange of knowledge and experiences. One potential for further South-South collaboration in training will be the set-up of the regional Fistula Centre in Bangladesh which will be able to provide training to fistula care providers in the region. Similar specialised centres are underway in Abuja (Nigeria) and Niamey (Niger).
- The *Campaign* has increased male involvement and understanding where sensitisation activities were directed specifically to men (e.g. in Bangladesh, Niger - Bankilare district - and Nigeria).

TABLE 28 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: IMPACT

Prevention, treatment and social reintegration			
Positive impact		**Negative impact**	
Visibility and awareness of obstetric fistula in UNFPA CO, countries and communities	*All 8*	Difficult to assess impact as data available is scarce, weak	*All 8*
Leverage for additional resources and support	*All 8*	Link to sexual violence deviated the attention from obstructed labour as main of obstetric fistula	*DR Congo*
More attention for EmOC and skilled attendance	*All 8*		
Increased access and utilisation of treatment (increased number of fistula repairs)	*All 8*		
More attention for rehabilitation, psychological and social support for women	*All 8*		
Male involvement and understanding enhanced	*Bangladesh, Niger, Nigeria*		
South-south collaboration strengthened	*Bangladesh, Niger, Pakistan*		
The *Campaign* has helped to bridge UNFPA and USAID	*Bangladesh, Niger, Nigeria*		

Some *concerns* persist with respect to the impact of the *Campaign* activities:

- The lack of standardised and systematic data collection with regard to evaluation of prevention activities, fistula repair sites and social reintegration makes the impact of the *Campaign* difficult to assess.

In many countries, public communication about the availability of fistula repair services has yet to reach adequate coverage to produce the desired impact: effective prevention of fistula, identification of women requiring surgery, increase in the referral of women for treatment and in the number of fistula repairs performed.

5.6 Sustainability

This section evaluates the sustainability of the *Campaign*: to what extent have planned (and unplanned) benefits been generated, appreciated and utilised by the target group and to what extent has the *Campaign* strengthened local institutional capacity.

Factors that contribute to sustainability of the efforts made so far include*:*

- The *Campaign* has strengthened the institutional capacity of RH/fistula programme managers and government authorities and has - in collaboration with other partners - supported the training of health care providers in fistula care, usually by supporting training programmes conducted by local experts and centres of excellence. In the eight countries studied, a total of 1178 health care workers have been trained with the support of the *Campaign*, 374 of them in fistula surgery techniques. The remainder are nurses, anaesthetists, and social workers.
- The participation of other relevant government Ministries in the provision of social support and reintegration services.

- The South-South linkages and collaborations contribute(d) to the sustainability of the fistula activities. The main results of the collaboration were the exchange of experiences in fistula repair and care and the capacity strengthening of staff through training sessions, study tours or outside exposure during the fistula fortnights in other countries (Bangladesh, Niger, Pakistan, and Sudan).
- Multiple funding streams allow programme activities to continue uninterrupted if bottlenecks in funding disbursement occur from one channel. In Bangladesh, new funds have been mobilised from the Islamic Development Bank and USAID/Engender Health. This investment multiplier effect is a result of the *Campaign* efforts and will contribute to (financial) sustainability of future fistula activities.
- The utilisation of existing infrastructure for provision of treatment services. The utilisation of staff paid by the government.

TABLE 29 - CONCLUSIONS FOR COUNTRIES UNDER REVIEW: SUSTAINABILITY

Prevention, treatment and social reintegration			
Opportunities for sustainability		**Threats to sustainability**	
Strengthened institutional capacity	*Globally*	Vertical nature of the Campaign	*DR Congo, Kenya, Nigeria, Tanzania*
South-South linkages	*Bangladesh, Niger, Pakistan, Sudan*	Weak government commitment and leadership	*DR Congo, Kenya, Nigeria*
Investment multiplier (multiple and new funding)	*Bangladesh*	Weak transition planning in Campaign (to a one maternal health Thematic Fund)	*Bangladesh, Nigeria*
Government contribution (e.g. through use of the public health facilities, equipment, staff)	*Bangladesh, Kenya, Niger, Nigeria, Pakistan, Sudan, Tanzania*	Little local resource mobilisation	*Pakistan Bangladesh*
Example of national fistula programme without UNFPA support	*Tanzania*	Not fully capitalised on the investment	*Bangladesh*

Potential *threats* to the sustainability of the achieved results are:

- While it may have contributed to the improvement of maternal health, the perceived vertical nature of the *Campaign* in some countries (e.g. DRC, Nigeria, Kenya, and Tanzania) - with a number of activities of ad-hoc nature and continuity of efforts not secured - is a missed opportunity and a threat to sustainability. However, in some cases the 'vertical' fistula initiatives have also carved out a much-needed space for programming and policy work on fistula in countries where fistula was historically neglected and ignored.
- Government leadership and commitment are still weak in many countries. The lack of a national policy to end fistula, the government's inertia to implement a specific OF policy or programme, and/or the weak coordination in fistula prevention and management are some of the bottlenecks for sustaining and scaling up the national efforts to end fistula.
- There is an urgent need for transition planning, including more local resource mobilisation as well as increased government financing. Sustainable financing for future fistula activities is crucial and this is one of the current limitations.

- In the in-depth study countries there has been insufficient use and inability to yet fully capitalise on several investments such as the training and the community fistula advocates.

The Campaign has certainly reached the target group and generated benefits for the (limited number of) fistula patients. Key issues that have implications for sustainability (i.e. programme management, increased financial support by all levels of government, coherent and sustained training of providers) are not sufficiently addressed within the framework of implementation of the Campaign.

6. Lessons learnt

Both positive and negative factors have influenced the achievement of the expected results of the national programmes and/or the *Campaign* to eliminate fistula. The stated goal for the *Campaign* was/is ambitious and unrealistic, given the little progress made in countries with regard to prevention of maternal mortality, as discussed in section 2.3. Additionally, the sharp contrast between the incidence and prevalence of obstetric fistula and the number of fistula repairs reported confirms that not all expected results have been achieved. From the previous sections we learn that the *Campaign* in several countries has contributed substantially to raise the focus on fistula - in terms of awareness raising, prevention, treatment and social reintegration - but the lack of knowledge that obstetric fistula can be prevented and treated and the existing backlog in treatment and rehabilitation show that there is room for improvement.

From the responses to the country questionnaires as well as from the in-depth country studies and the desk reviews we learn that the most common **bottlenecks** that hinder(ed) achieving expected results at national level (see Table 30) can be grouped in six categories: political commitment, national context, infrastructure (health infrastructure, roads and transport modalities), financial resources, human resources (available staff, training), and the health system.

TABLE 30 - KEY BOTTLENECKS FOR NOT ACHIEVING EXPECTED RESULTS AT NATIONAL LEVEL

Political commitment	National context	Infrastructure
Lack of national policy to eliminate obstetric fistula Government's inertia to implement obstetric fistula policy or activities Weak leadership or coordination in prevention and management of obstetric fistula	Poor community awareness on availability of prevention and treatment services Unmet needs for family planning Presence of stigma and discrimination against fistula patients Popular myths and false beliefs about fistula, and harmful practices such as child marriage	Difficult access to far-flung areas (no roads/poor roads, lack of transport particularly in remote rural areas)
Financial resources	**Human resources**	**Health services**
Limited or no funds for specific obstetric fistula activities/services Fistula care and management compete with other (health) priorities Women do not have money to cover the cost for EmOC or obstetric fistula services	Insufficient qualified personnel Lack of interest of medical doctors to provide obstetric fistula services Lack of skilled attendants Instability of human resources in the public sector Inequitably allocated personnel	Inadequate capacity to provide maternal or EmOC health services Low utilisation and quality of EmOC services Limited access to treatment for obstetric fistula User fees, costs of transport, and 'unofficial payments' Inadequate equipment or medical supplies in health facilities

Factors that have facilitated the achievement of the expected results of the fistula projects under the *Campaign* are presented in the table below as **prerequisites** for impactful and sustainable implementation of fistula activities in the future.

TABLE 31 - PREREQUISITES FOR FISTULA FOR ACHIEVING EXPECTED RESULTS AT NATIONAL LEVEL

Political commitment	National context	Infrastructure
Concerted action to secure adequate coverage of key prevention strategies (skilled attendant at birth, EmOC, use of partograph) Define service level strategy for provision of fistula care and management	Awareness within communities that obstetric fistula can be treated Demand for treatment is big enough Linkages with relevant actors to provide social support and reintegration services	Commodities and supplies available
Financial resources	**Human resources**	**Health services**
Sustainable funding secured	Adequate midwifery staff Experienced fistula surgeons Adequate nursing staff	Integration of fistula programming within existing reproductive health and maternal health programmes Well established referral system Operations ensured on time Existence of quality assurance Monitoring and reporting mechanisms Removal of user fees Commodities and supplies available Availability and accessibility of services, particularly in under-served areas of a country

An important strategic question facing UNFPA and the *Campaign to End Fistula* is the **service delivery model for fistula treatment**. This was explored in the in-depth country assessments, the desk review studies and the responses to the mail questionnaire. The "average" health service provision model for obstetric fistula services is a combination of national referral centre(s), services provided at tertiary level facilities, decentralised service provision at lower level facilities and regular surgical outreach services (i.e. fistula fortnights, camps). This mix is chosen by many countries because of the complementarity of the different models (see table 32).

TABLE 32 - (DIS)ADVANTAGES OF SERVICE DELIVERY MODELS USED IN THE COUNTRIES UNDER REVIEW

Model and countries which have used it	Advantages	Disadvantages
Decentralised model **(services provided outside the capital city, provincial or district hospitals)** *(Bangladesh, Burkina Faso, Cameroon, Chad, DR Congo, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Tanzania and Uganda)*	Closer to patient's home Lower cost Possible to scale up the model Expansion of training opportunities for staff living in exterior?	Limited expertise for repair services Insufficient equipment and supplies
Tertiary care (Teaching Hospitals) *(Bangladesh, Burkina Faso, Congo, Ghana, Ivory Coast, Kenya, Malawi, Mali, Nepal, Nigeria Pakistan, Rwanda, Senegal, Tanzania and Uganda)*	Appropriate surgical set-up Adequate post-surgery follow-up Opportunities for better data collection and research?? Integration of obstetric fistula treatment into young doctors traineeship?? Quality assurance?? Strong training opportunities? Linkages to MH programmes?	Poor accessibility Cost of transport
Fistula fortnights/camps/outreach services *(all countries except Sierra Leone, Nepal and Congo)*	Complementarity of the different models Opportunity to treat many cases and cut down on the backlog Quality assurance for decentralised sites Builds in a training model Support from international and regional experts Financial support for OF repair services	Masks low clinical volume Requires close attention to scheduling (postponements very disruptive) High cost Temporary presence (one to two days/weeks) Inadequate post-op care Non-sustainable strategy Limited follow up of patients?? Poor documentation of experiences??
Referral centres *(at national level: e.g. Bangladesh, Benin, Congo, Eritrea, Guinea, Ivory Coast, Kenya, Malawi, Mauritania, Nigeria, Pakistan, Rwanda, Sudan, Tanzania and Zambia); some also at regional level, like e.g. Benin, Ivory Coast, Kenya and Pakistan)*	Continuous provision of repair services Higher quality of care Concentration of different OB-GYN, urology etc. specialist in one site Opportunities for better data collection and research?? Linkages to MH efforts? Training opportunities?	High cost Difficult access Long waiting times

7. Recommendations

	Issues and Findings	Recommendations	Responsibility and priority
Strengthening UNFPA engagement in fistula prevention, treatment and care at country level			
1	**Integrating the *Campaign* into UNFPA Country Programmes:** In many countries, the *Campaign to End Fistula* is not firmly rooted in the UNFPA Country Programme. It is often perceived to be a vertical project that has limited national penetration, a short time frame and few prospects of sustainability. Integration of the *Campaign* into the Country Programmes, however, carries the risk that the issue will lose priority.	a) UNFPA Country Offices should integrate fistula prevention into their reproductive health and safe motherhood country programmes by linking it directly to the issue of access and quality of obstetric care. The main areas of cooperation with governments should include: • the availability of appropriate and accessible health facilities for obstetric services; • the availability and equitable deployment of qualified human resources with special emphasis on the availability of female personnel and midwives; • the support and improvement of basic training for midwives with standardised curricula; • the support for the procurement of medical equipment and medical supplies.	UNFPA Country Offices **High priority**
		b) As the *Campaign* activities are integrated with other UNFPA programmes and trust funds, dedicated funds raised for fistula prevention should be programmed for the support of relevant activities within the Roadmap for the Reduction of Maternal and Child Mortality.	UNFPA Country Offices **Medium priority**
		c) UNFPA at country, regional and global level should appoint focal points for fistula prevention and treatment to assure that the issue continues to be treated as an important topic within maternal health programmes, and to assure that funds raised for fistula prevention and treatment are appropriately disbursed within maternal health programmes.	UNFPA at all levels **Medium priority**

	Issues and Findings	Recommendations	Responsibility and priority

2	**Increasing national attention to fistula services:**
	The issue of fistula prevention and care is not sufficiently represented in national reproductive health strategies and plans. In some countries, UNFPA is strongly advocating for the inclusion of fistula prevention, treatment and care in these plans and strategies. Where fistula strategies exist, there are often few signs of implementation.
		• UNFPA Country Offices should advocate for the inclusion of fistula prevention, treatment and care in national reproductive health policies, strategies and implementation plans. All possible efforts should be made to include programme targets, adequate resources, and mechanisms to ensure that the issue is taken up in decentralised district health plans. Fistula care should have its own budget line in the national reproductive health budget.
		• UNFPA should advocate for the provision of all year round obstetric fistula treatment services in a number of facilities in each country. There has to be a commitment from Government to secure a certain number of beds for obstetric fistula, allocation of operation theatre time and staff. The main areas of cooperation with government should include:
		  • Training of staff
		  • Establishment of quality assurance mechanisms
		  • Support for the procurement of equipment and medical supplies
			UNFPA Country Offices and Ministries of Health
			Medium priority

3	**Increasing national coordination of fistula prevention and treatment:** The stakeholders met during the evaluation underlined the need for better coordination, planning, collaboration and exchange of experiences and information among those working on fistula activities.	• UNFPA Country Offices should work with Government and with international partners to establish a Government-led national round table of stakeholders in fistula prevention and treatment. The purpose of such an institution should be to coordinate national activities for fistula prevention and treatment within a maternal health framework, and to support national efforts of monitoring fistula services. The round-table should reflect and building upon the strengths of each stakeholder working in-country including government ministries, UNFPA country offices, local NGOs and other partners. • Ensure the participation of obstetric fistula experts within national Maternal Health Committee/Working Groups, as well as in the national round table.	UNFPA Country Offices, Ministries of Health, national stakeholders **High priority**

	Issues and Findings	Recommendations	Responsibility and priority
4	**Improving data availability on maternal health and obstetric fistula:** Programme planning and allocation of resources for fistula prevention and care are severely constrained by large gaps in the availability of information about fistula prevalence, incidence and services.	• UNFPA should work with Ministries of Health and relevant partners (e.g Engender Health/USAID) to ensure that a selected and widely agreed set of routine data on obstructed labour and other major complications of pregnancy, as well as service data on fistula diagnosis and treatment are included in the information collected by the national health information system, and that this data is useful and used. • At the same time, UNFPA should continue its advocacy to have a module on fistula included in the Demographic and Health Surveys and other major population surveys.	UNFPA Country Offices and Ministries of Health **High priority**
5	**Improve monitoring and evaluation of the implementation of fistula programmes.** Monitoring and evaluation of existing national programmes does not take place regularly. A more clear identification of targeted outputs and indicators to achieve is necessary (see also recommendation No.4)	• Further work on fistula will need more measureable criteria to assess impact. TA may be needed to both select these criteria, as well as to assist countries to define / establish relevant indicators such as “obstructed labour” cases. UNFPA should assist with the socio-economic analysis of Caesarean section rates, at lower education and socio-economic levels, this gives helpful information about access to care for obstructed labour. • Future M&E needs can be better structured within the framework of results based management (RBM) which includes M&E as important component of the planning process. • It would be advisable that all countries include in their annual plans an evaluation exercise of the implementation their fistula programmes (ideally, under overall evaluation of national maternal health programmes). When relevant staff from SRO/RO could assist countries in carrying out this evaluation. This participation should be included in the annual plans for the SRO/RO. • UNFPA CO in agreement with MoH can carry out annual monitoring exercised of their fistula programmes. It would be advisable that SRO/RO could contribute to this effort. Guidelines for issues to address as part of these monitoring exercises should be elaborated. • UNFPA could facilitate TA to countries to carry out operations research as a tool to better document, monitor and evaluate their programmes.	UNFPA Country Offices, SRO/RO and Ministries of Health **High priority**

	Issues and Findings	Recommendations	Responsibility and priority
Scaling up services and improving the quality and coverage of fistula prevention, treatment and care services			
6	**Improving the effectiveness of fistula advocacy and prevention:** Advocacy for the prevention of obstetric fistula has to be closely linked to its main cause, namely obstructed labour. In some countries, other important issues such as child marriages or sexual violence have a central role in the advocacy agenda which detracts from the main priority for prevention: the timely skilled management of obstructed labour.	UNFPA at the Global, Regional, and Country level should develop an advocacy agenda for fistula prevention that clearly focuses on obstructed labour as the main cause of obstetric fistula, and that promotes a menu of activities and interventions to prevent it. The focus should be on: • the most proximal activities delivered as closely as possible to the home of the pregnant woman: Access and utilisation of ante-natal services, appropriate risk assessment, skilled birth assistance including the use of partographs, and timely access to emergency obstetric care. • To improve the effectiveness of advocacy efforts, systematic record/clipping of interviews, articles, and broadcast opportunities will create a database on media outreach efforts and results. UNFPA will need to develop applicable indicators of success in these initiatives. • Associated advocacy topics are the abolition of user fees and informal payments, mobilisation of skilled community birth assistance, and financing of transport for emergency obstetric care. Such an agenda overlaps greatly with the agenda for the reduction of maternal and neonatal mortality. In fact, it can be run jointly as long as the topic of fistula is not lost in the process. There are other health and rights agendas that may use fistula as their “hook”, for instance campaigns to end child marriages and for women empowerment or but these should not become the main advocacy focus for fistula prevention.	UNFPA and partners at all levels **Medium priority**

	Issues and Findings	Recommendations	Responsibility and priority
7	**Assuring adequate coverage of quality surgical services for fistula repair:** The annual number of fistula repairs done in the countries included in the study is estimated to be less than one third of the annual incidence. Many trained surgeons are not practicing their skill, or they perform an insufficient number of operations to maintain their skill.	• UNFPA should provide TA to countries in order to analyse and better define the various levels and mix for provision of fistula repair services as well as the options to and requirements for development of these services in the short and medium term (i.e. centralised or decentralised model, referral centers, need for outreach campaigns). • UNFPA should continue supporting countries in the training of the teams to provide fistula repair services. For this purpose, UNFPA should explore options to liaise with ISOFS for the provision of technical assistance to countries in this area. • UNFPA Country Offices should work with national partners and international stakeholders to use as much as possible the Competency Training Manual developed by the OFWG in their training of fistula surgeons. The development of a specific strategy for human resources for fistula care in each country is advisable, defining among others: who should be trained, how many should be trained, by whom, retention strategies, how to secure that they will continue performing surgeries once training is completed. • Training should be provided to teams selected on the basis of location in a facility where fistula surgery can be performed, and where there are potentially a sufficient number of patients to carry out surgeries under supervision during the duration of the training. • To the extent possible, the relative stability of trained staff at the facility should be negotiated with Government or with the non-governmental owner of the health facility. • The retention of staff and the payment of incentives are two major issues affecting the availability of fistula repair services. They can only be addressed within the specific context of each country. • Trained provider teams should be networked with the training centres and receive frequent supportive supervision visits. • UNFPA should advocate for the establishment of a quality assurance team that can travel to countries or to the facilities where treatment services are provided to do supervision and upgrade of skills. If this is not possible, facilitate that surgeons who perform less than 40-50 operations per year should spend some period each year at the training facility or in a fistula treatment campaign to maintain their skills.	UNFPA Country Office and other stakeholders **Medium priority**

	Issues and Findings	Recommendations	Responsibility and priority
8	**Providing appropriate psychological and social support for reintegration:** Reintegration services supported by the *Campaign to End Fistula* reach a very small number of fistula survivors, and there is no assurance that they reach those most in need.	• UNFPA Country Offices should review the different modalities of delivering pre- and post-surgery social and psychological support (this could be strengthened with collaboration with gender experts/ministries/colleagues). This should be done with technical assistance from the Regional Office and UNFPA Headquarters and in collaboration with national partners and major stakeholders in the issue of fistula treatment and care. The most effective approach is likely to differ from country to country, but there are commonalities. They include that (i) the services are best delivered by local civil society organisations; that (ii) identification of need for psychosocial support should be done prior to surgery and the support should start at the latest during the recovery period in hospital; (iii) social and economic empowerment programmes are best provided by organisations that have a history in this type of programming, and that provide the services in a generic fashion, not specifically tailored to fistula survivors; these services should be viable and valuable for the women. • UNFPA Headquarters should collect and review the experiences of individual countries to determine the extent to which a global or regional strategy paper can provide guidance on effective support for reintegration. This has already occurred in the previous Annual Reports. Once the new Fistula team (working in collaboration with the Maternal Health Thematic Fund) is on board and has reviewed this evaluation, they will be better positioned to look for options to do this more effectively.	UNFPA Country Offices and other local stakeholders; UNFPA RO and HQ. **Medium priority**
9	**Addressing issues of immediate concern:** The evaluation has identified priority issues to be addressed by UNFPA Country Offices as soon as possible. Some of these issues are already mentioned in previous recommendations. They are highlighted in order to underline their short term importance.	The issues of most immediate concern to be addressed by UNFPA Country Offices in collaboration with the Ministries of Health are: • The development and implementation of a human resource strategy for maternal health including fistula prevention and treatment (as part of the overall efforts existing in countries to address their human resources for health situation; • The establishment of a system to collect and analyse maternal health and fistula data within the context of the national health information system; • The development of a national policy on services for the prevention and treatment of fistula, including a regulation of costs, fees, and subsidies.	UNFPA Country Offices and Ministries of Health **High priority**

	Issues and Findings	Recommendations	Responsibility and priority

10	**Define vision and focus for the next three years.** There is a need to move from Campaign mode to integration of fistula programming within UNFPA CP and national maternal health programmes	Agree on the vision and focus for fistula activities for the next three years. As a food for thought the following are suggested:
		• Consolidate gains in countries:
		  • Advocacy and awareness raising efforts directed to prevent obstructed labour, identify fistula patients and secure that identified women with OF receive treatment.
		  • Provide TA to countries in defining their mix and level of fistula treatment services to be provided
		  • support countries in the establishment of routine provision of treatment services in selected facilities
		  • Liaise with CSO/NGO for the provision of rehabilitation/reintegration services
		  • Continue training of fistula surgeons and nurses. Secure with national authorities that they continue providing services after training.
		  • support countries in the selection and widely agreed set of routine data on obstructed labour and other major complications of pregnancy, as well as service data on fistula diagnosis and treatment. This data should be included in the information collected by the national health information system, and use for monitoring and evaluation of programme activities.
		  • Expand work with fistula advocates
		• Global/regional efforts directed to:
		  • Ensure technical assistance through regional and national centres as well as through professional associations. For example, liaise with ISOFS for provision of TA on training, establishment of quality assurance mechanisms for treatment.
		  • Establishment of quality assurance mechanisms (regional or national)
		  • Establish monitoring and evaluation mechanisms
		  • Maintain advocacy activities
			UNFUPA at all levels
			High priority

	Issues and Findings	Recommendations	Responsibility and priority
Increasing the support for fistula services by UNFPA Regional Offices and Headquarters			
11	**Providing technical assistance to UNFPA Country Offices.** The evaluation found that UNFPA Country Offices have not requested nor received extensive levels of technical assistance from the Regional or Headquarters level. There was in the Annual Report and AWP format a question about needs of TA. Very few countries responded to that question. In parallel, at CST and now SRO levels, there is mechanism for planning TA request. Unfortunately, most of the TA requests come on an ad-hoc basis. In several countries, however, there were issues that could have benefited from enhanced technical assistance. These were mostly related to monitoring and evaluation and to quality assurance of fistula repair services.	• UNFPA Country Offices should include an assessment of technical assistance needs in their annual work plans. This will be critical at the time of integration of the *Campaign* activities in the larger programme for maternal health. Especially for this time of transition from "fistula projects" to reproductive health strategies that include prevention and treatment of fistula, it is critical that Country Offices receive timely technical support to prevent the issue from falling off the table. If necessary, the RO may assist the countries in identifying their TA needs and estimating the costs implications to cover these needs. • UNFPA Regional Offices should prepare themselves for the new role /function assigned to them as a result of the regionalisation process with regard to provision of TA to countries (a shift from providers of TA to manager of TA). Among others, this will require the identification of a pool of national and regional experts or institutions that could provide TA to countries in various issues (e.g. monitoring and evaluation, quality assurance of fistula repair services). The possibility of contracting an appropriate technical partner by means of a framework technical assistance contract may be worth exploring. • It is very likely that for some time (until proper mechanisms are in place) the RO staff will continue to provide direct TA to countries. The necessary financial provisions for the provision of this TA should be made in the annual plans.	UNFPA Country Offices, ROs, **Medium priority**

	Issues and Findings	Recommendations	Responsibility and priority
Strengthening UNFPA ´s role in the reduction of maternal mortality and morbidity at country level. The elimination of obstetric fistula is strongly linked to securing that women have access to health interventions aiming at reducing maternal mortality and related morbidities. UNFPA has an important role to play in spearheading worldwide efforts to reduce maternal mortality and related morbidities, being UNFPA core business. This may be beyond the scope of the Campaign, but it is perceived by most stakeholders as fundamental.			
12	**Accelerating progress in maternal health services:** The slow progress observed for most maternal health indicators and for the indicators of availability and utilisation of maternal health services underlines the need for more concerted efforts towards increasing access to and coverage of maternal health services.	UNFPA Country Offices should increase the priority accorded to maternal health and fistula prevention in their programmes. Specifically, they should aim for cooperation with Governments to: • improve access to reproductive health and emergency obstetric services; • increase the use of skilled birth attendants; (consider programmes that bring skilled birth attendance closer to the community such as the community midwives in Kenya and in Bangladesh or the village midwives in Sudan) • remove financial barriers to reproductive health services; (including user fees and transport costs for emergency obstetric care) • increase use of partograph • use preventive catheterisation to prevent fistula • train providers and equip facilities for emergency obstetric care; • target policies and programmes to reach populations that are socially or geographically marginalised • target policies and programmes to adolescent population	UNFPA Country Offices **High priority**

	Issues and Findings	Recommendations	Responsibility and priority
13	**Enhancing the political and social environment for the reduction of maternal morbidity and mortality:** Countries with high fistula incidence and prevalence have also seen plateaus or weak progress in contraceptive prevalence rates, with unmet needs rising in several countries. Family planning (core business of UNFPA) remains the most cost-effective intervention to reduce maternal mortality. Strengthening health systems to improve Reproductive Health Commodity Supplies (RHCS) is needed to help reduce the exposure of women to risky pregnancies and subsequent morbidity (including fistula) and mortality.	UNFPA Country Offices should strategically explore what funding and technical assistance is required to consolidate efforts to improve national capacity in RHCS and reducing unmet need. This cooperation with government needs to: • identify which components of this support can be funded through the core budgets of RH in the Country Programme • prioritise specific areas which should be packaged as proposals to the RHCS component of the integrated maternal health fund • assess how subsidisation of FP services can be enhanced (e.g. in essential services packages and national health insurance schemes) • ensure high-risk groups including fistula survivors, women with previous Caesarean sections, and all adolescents receive services, especially in populations which are socially or geographically marginalised. • identify and resource non-governmental partners which can assist in reaching these groups	UNFPA Country Offices, Ministries of Health and other in-country partners RHCS component of the Maternal Health Thematic Fund **High priority**
14	**Increasing financial resources for maternal health:** The low level of funding for health care in general and for maternal health in particular is an important constraint towards achieving the *Campaign* goals	• UNFPA Country Offices should work with Ministries of Health to increase funding for maternal health care. UNFPA should support national partners who are advocating for increased budget allocations for health, and use its position in the Committees for Maternal and Newborn Health and in the Global Fund Country Coordinating Mechanisms to assist Government in obtaining international financial support for maternal health	UNFPA Country Offices and Ministries of Health **High priority**

ANNEXES

Annex 1. Terms of Reference

Thematic Evaluation of

National Programmes and UNFPA experience in

The Campaign to End Fistula

A. ABOUT UNFPA[66]

UNFPA, the United Nations Population Fund, is the world's largest international source of funding for population and reproductive health programmes. Since we began operations in 1969, the Fund has provided nearly $US 6 billion in assistance to developing countries.

UNFPA works with governments and non-governmental organisations in over 140 countries, at their request, and with the support of the international community. We support programmes that help women, men and young people:

- plan their families and avoid unwanted pregnancies
- undergo pregnancy and childbirth safely
- avoid sexually transmitted infections - including HIV/AIDS
- combat violence against women.

Together, these elements promote reproductive health- a state of complete physical, mental and social well being in all matters related to the reproductive system. Reproductive health is recognised as a human right, part of the right to health.

UNFPA also helps governments in the world's poorest countries, and in other countries in need, to formulate population policies and strategies in support of sustainable development. All UNFPA-funded programmes promote women's equality.

UNFPA works to raise awareness of these needs among people everywhere. We advocate for close attention to population problems and help to mobilize resources to solve them.

UNFPA assistance works. Since 1969, access to voluntary family planning programmes in developing countries has increased and fertility has fallen by half, from six children per woman to three. Nearly 60 per cent of married women in developing countries have chosen to practice contraception, compared with 10-15 per cent when UNFPA started its work.

BACKGROUND

Obstetric Fistula

The vast majority of gynaecologic fistula is caused by prolonged, obstructed labour. This type of fistula is typically referred to as an 'obstetric fistula.' It is estimated that obstructed labour occurs in approximately 4.6 per cent of deliveries worldwide.[67] When the obstructed labour is unrelieved by medical intervention, the pressure of the baby's head against the woman's pelvis can cause extensive tissue damage. If a woman survives such a labour, she may be left with a fistula between her vagina and bladder and/or vagina and rectum,

[66] http://www.unfpa.org/about/index.htm
[67] Abou Zahr, C. Global Burden of Maternal Death and Disability. British Medical Bulletin 2003; 67 (1).

resulting in incontinence of urine and/or faeces. Women that experience an obstetric fistula have typically survived an average of three to four days of labour and some longer than a week[68]. In as many as 90 per cent of cases the baby is stillborn or dies within the first week of life[69].

Women living with fistula experience both medical and social consequences due to their condition. In addition to incontinence, the medical consequences of obstetric fistula include frequent bladder infections, painful genital ulcerations, kidney failure and infertility. The prolonged, obstructed labour may also cause a variety of health problems, such as stress incontinence, amenorrhea, pelvic inflammatory disease, secondary infertility, vaginal stenosis, and foot-drop.[70] The smell caused by the constant leaking of urine and faeces combined with misperceptions about the causes of birth complications often results in stigma and ostracism by communities and spousal abandonment.

While robust population-based measurements of prevalence and incidence are lacking, it is generally accepted that at least two million women worldwide are suffering from obstetric fistula.[71] The World Health Organisation estimates an annual incidence of approximately 73,000 new cases.[72] Obstetric fistula occurs most often in areas where maternal mortality is high, such as sub-Saharan Africa and South Asia, where 86% of the annual 536,000 maternal deaths occur and maternal mortality ratios often exceed 300 per 100,000 live births.[73]

The Campaign to End Fistula

UNFPA and partners launched the global Campaign to End Fistula in late 2002 and began the Campaign in 2003. The Campaign focuses on interventions to prevent fistula from occurring, treat women who are affected and help women who have undergone treatment reintegrate in society. The Campaign's ultimate goal is to make fistula as rare in developing countries as it is in the industrialised world by 2015, in line with ICPD and MDG targets. The Campaign is a component of UNFPA's overall strategy to improve maternal health.

Beginning with just twelve countries in 2003, the Campaign is now active in more than 40 countries in sub-Saharan Africa, Asia and the Arab region. At the national level, each country undergoes three programmatic phases: 1) rapid needs assessment, 2) collaborative planning of a national fistula elimination strategy and 3) implementation of the national strategy. The Campaign's three strategic intervention points – prevention, treatment and reintegration – are flexible to allow for country context and designed to situate fistula within national maternal health strategies and UNFPA country programmes. The strategy and phases were developed through consensus with national and global partners. Throughout, the Campaign emphasizes political advocacy and capacity development to ensure that fistula elimination is sustainable.

[68] Wall LL, Arrowsmith SD, Briggs ND, Browning A, Lassey A. The Obstetric Vesico-vaginal Fistula in the Developing World. Obstetrical & Gynaecological Survey 2005; 60 (S1): S1-S51.
[69] Wall LL, Karshima JA, Kirschner C, Arrowsmith SD. The obstetric vesico-vaginal fistula: characteristics of 899 patients; American Journal of Obstetrics and Gynaecology 2004; 190(4): 1011-9.
[70] Arrowsmith S, Hamlin EC, Wall LL. Obstructed Labour Injury Complex: Obstetric Fistula Formation and the Multifaceted Morbidity of Maternal Birth Trauma in the Developing World. Obstetrical & Gynaecological Survey 1996; 51 (9): 568-574.
[71] Wall LL. Obstetric vesico-vaginal fistula as an international public-health problem. Lancet 2006; 368: 1201-1209.
[72] Abou Zahr C. 2003.
[73] WHO, UNICEF, UNFPA and World Bank. Maternal Mortality in 2005. Geneva: 2007.

A global thematic proposal was submitted to major donors in Fall 2003 for the period of 2004-2006. With country needs growing at a more rapid rate than anticipated, the initial period was closed in late 2005 and a new proposal submitted to donors for the period 2006-2010. Therefore, the Campaign has now arrived at mid-term of the current period (2006-2010). The main expected results at national level outlined in the proposal are as follows:

- Enhanced political and social environment for the reduction of maternal mortality and morbidity
- Integration of fistula interventions into ongoing safe motherhood and reproductive health policies, services and programmes
- Increased national capacity to reduce maternal mortality and morbidity
- Increased access to and utilisation of quality basic and emergency obstetric care services
- Increased access to and utilisation of quality fistula treatment services
- Increased availability of services to assist women with repaired fistula to reintegrate into their community

Global and regional support is managed by units[74] represented in the internal interdivisional Fistula Working Group (FWG) which is based at UNFPA headquarters. Global and regional approaches to support achievements at national level are centred around four key areas: 1) Capacity Development, Research & Documentation; 2) Measurement, Monitoring and Evaluation; 3) Awareness Raising and Resource Mobilisation; and 4) Partnership Building with the following expected results:

- Increased national capacity for obstetric fistula elimination and improvement of maternal health
- Enhanced decision-making through global monitoring and evaluation of progress in fistula elimination
- Increased visibility and support for obstetric fistula elimination from policy makers, international organisations and donors
- Enhanced collaboration and coordination of global and regional efforts in the elimination of obstetric fistula

Approaches to fistula-related programming

Lack of reliable data on fistula prevalence and incidence has traditionally hampered the ability of the international community to formulate an appropriate and coordinated response to obstetric fistula. Prior to the launch of the Campaign, a number of institutions and individuals had been working to provide services to women living with fistula; however, there was very little documentation or evaluation of fistula-related interventions, both clinical and programmatic, when the Campaign began.[75] For example, in the area of treatment, no aspect, from diagnosis to treatment techniques to assessing outcomes, is standardised or supported by an adequate evidence base.[76] In order to best coordinate global efforts to eliminate obstetric fistula and build consensus on effective strategies, UNFPA established an international alliance, the Obstetric Fistula Working Group (OFWG), soon after it launched the Campaign to End Fistula. The inter-agency OFWG is comprised of approximately 25 members including UN agencies, non-governmental organisations, health professional associations and academic institutions. At the same time an internal coordination

[74] UNFPA Divisions represented in the internal Fistula Working Group include: Africa Division, Asia & Pacific Division, Division for Arab States, Europe and Central Asia, Information, Executive Board and Resource Mobilisation Division and Technical Support Division. Other Divisions participate as needed.
[75] Donnay F, Ramsey K. Eliminating Obstetric Fistula: Progress in Partnerships. International Journal of Gynaecology and Obstetrics 2006; 94(3): 254-61.
[76] Ahmed S, Gendry R, Stanton C, Lalonde, BA. Dead Women Walking: Neglected millions with obstetric fistula. International Journal of Gynaecology and Obstetrics; 2007: 99, S1–S3.

mechanism (FWG) was established to ensure a multi-dimensional and coordinated approach.

In order to begin filling knowledge gaps, national assessments were conducted to determine needs and map existing services for use in both advocacy and initiating actions at country level. These assessments began in 2002[77] and have continued throughout the Campaign. The assessments originally focused only on facility-based data, but expanded in 2004 to include social and cultural dimensions of fistula. The data that has been gathered at country levels has been used in guiding interventions not only in fistula-related programming, but also in maternal health programmes. Partnerships and coordination mechanisms similar to the international OFWG were established at national levels as well.

Countries embarked on programmes, most for the first time ever, utilising the findings from the needs assessments and expert opinion based mostly on programmes running in Ethiopia, Nigeria and East Africa. As new evidence has emerged, many have adjusted their strategies and approaches or incorporated new elements into their programmes. WHO in 2006 issued a manual on obstetric fistula;[78] however the lack of evidence base limited the guidance it could provide in national programming and clinical care for fistula treatment. This knowledge gap has created challenges in programming areas such as training in fistula treatment and service delivery and referral system models. Needs for documentation of programmes, including programme evaluations, and rigorous and comparable scientific data consequently remain great.

Countries have nevertheless risen to the challenge and identified innovative approaches building on existing knowledge in maternal health programming as well as emerging evidence. Measurement of progress remains an area in need of strengthening. While advances have been made in identifying programmatic indicators for monitoring fistula-related programming, still more work is needed to refine the indicators and ensure greater consistency in reporting across countries. Evaluation of all approaches is now needed; to both document promising practices and adjust strategies that may not be optimal in terms of effectiveness or efficiency.

PURPOSE

Evaluation Purpose

The evaluation will contribute to the evidence base to answer critical questions about effectiveness of approaches in fistula-related programming used to date and their role in relation to maternal health programmes. It will also aim to understand whether and how the Campaign approach, with multiple strategies undertaken simultaneously at national, regional and global levels has assisted in advancing the programme. The two main objectives are to:

1) assess the relevance, effectiveness and efficiency of the current strategies and approaches for national fistula programming;
2) assess the coordination, management and support from UNFPA global and regional levels to national level efforts.

[77] UNFPA, EngenderHealth. Needs Assessment Report: Findings from Nine African Countries. New York: 2003.
[78] WHO. Obstetric Fistula: Guiding principles for clinical management and programme development. Geneva: 2006.

Key uses of the evaluation findings and recommendations will be as follows:

- Assist in adjusting strategies/approaches and improving quality of national programmes on obstetric fistula elimination at policy, service and community levels
- Enhance support – technical, programmatic, financial and advocacy – from global and regional levels
- Document lessons learnt to contribute to the knowledge base on obstetric fistula-related programming and approaches for its integration in the national reproductive health strategies as well as in overall health sector planning/budgeting
- Document lessons learnt to contribute to the management and coordination of other UNFPA-wide thematic approaches and campaigns.

Key evaluation users will be:

- National stakeholders involved in maternal health and fistula-related programming
- UNFPA senior management and staff, particularly from Country Offices and those involved in the management of thematic funds
- UNFPA donors
- Partner organisations working in maternal health, particularly obstetric fistula programming

Key Evaluation Questions – National Programmes

The evaluation will make use of the five standard OECD/DAC evaluation criteria namely effectiveness, efficiency, relevance, impact and sustainability. It will look at interventions in the substantive areas of prevention, treatment and reintegration and the programmatic levels of policy, service and community. The evaluation will also be guided and informed by the following broad concerns:

Relevance:

Prevention:

What do stakeholders identify as the role the Campaign to End Fistula has played in leveraging additional support and resources for reproductive health, particularly maternal mortality and morbidity reduction? What approaches have been used? What were the contributing factors?

Treatment & Reintegration:

What role has the Campaign to End Fistula played in terms of increasing access to treatment and reintegration services? What approaches have been used? What were the contributing factors?

Data availability:

What role has the Campaign played in increasing availability of data on obstetric fistula? How were the findings of the needs assessment utilised in programme planning?

Effectiveness

Prevention:

What specific capacity increases for prevention have taken place under the auspices of the Campaign? How have they been linked to ongoing reproductive and maternal health programmes?

Treatment & Reintegration:

How has the number of women receiving treatment and reintegration services changed since the needs assessment? What is the quality of the services? Were approaches adequate and appropriate considering the country context?

Efficiency

Coordination:

What coordination mechanisms are in place to reduce redundancy among partners and promote efficient use of resources – technical, financial, human - at country level? What can be done to increase efficiency of the coordination?

Impact and Sustainability

Results

What results have been accomplished to date? How are progress and results being monitored? To what degree can attribution be measured – e.g. what would have happened in the absence of the Campaign?

Quality of Care

What is the level of quality of care? What are the perceptions of quality from the providers and the women? What is needed to ensure that this is maintained or improved?

National commitment

How well is the fistula integrated in the national health sector plans? What measures have been undertaken to sustain the efforts of the campaign?

Overall recommendations

What are the priority programming areas for the next few years? What are the 'conditions for success' to move national programmes forward? Under what conditions and with what tradeoffs does full mainstreaming of the issue make sense?

Key Evaluation Questions – Global and Regional Support

At the global and regional level, the evaluation will focus on the four main areas of support: 1) Capacity Development, Research & Documentation; 2) Measurement, Monitoring and Evaluation; 3) Awareness Raising and Resource Mobilisation; and 4) Partnership Building. It will aim to assess how these have contributed to progress at national level, in addition to internal management and coordination. Some key questions:

Overall: What would have happened in the absence of the Campaign?

Capacity Development, Research and Documentation:
What is the perception of the usefulness of the guidance that has been developed by UNFPA country office staff and partners? For UNFPA, what would improve the support for capacity development at country level from regional and global levels?

How has the Campaign contributed to expanding the knowledge base at global and regional levels? How has this knowledge been utilised?

Measurement, Monitoring and Evaluation:
How has the Campaign contributed to advancing the monitoring of programmes? How useful is the support provided to countries related to monitoring and evaluation?

Awareness Raising and Resource Mobilisation:
What has been the role of the Campaign in raising awareness of obstetric fistula among policy makers, international organisations, the general public and donors? What has been the contribution of fistula as an entry point to raising awareness of maternal death and disability?

How has the Campaign contributed to increasing resources for obstetric fistula? Within UNFPA? Among other partners?

Partnership Building:
How effective is the coordination among partners at the global and regional level? What role has the OFWG played? How can UNFPA enhance coordination in its role as the secretariat?

Internal coordination and management:
How effective has the management and internal coordination of the Campaign been? What bottlenecks exist and how can they be overcome? What lessons can be drawn for management of other UNFPA thematic funds and approaches?

Evaluation Approach

Sampling approach

The mid-term review will focus on a sample of eight countries with a variety of experiences and at different stages of implementation. The period covered will be from 2004 to 2008, and selected counties will have been involved in the Campaign for no less than one year. A subset of the selected countries will be visited and serve as in-depth case studies.

Given the need to focus on lessons learnt to date, in-depth case studies will focus on countries which have been involved in implementation of fistula programmes starting no later than 2004. By concentrating on the most mature programmes, the evaluation will be able to make informed and credible judgments about the effectiveness of the approaches and lessons learnt.

The following are the selection criteria for in-depth case studies:
- Mature fistula programme with at least 3 years in the implementation phase
- National partners and country office interest and availability for evaluation
- Support provided to more than one treatment facility at country level
- National coordination mechanism exists to ensure stakeholder participation

Four country cases were determined to have met the selection criteria:
- Africa: Niger, Nigeria (selected states)
- Asia: Bangladesh, Pakistan

In addition, the global and regional coordination, management and support mechanisms will be assessed to ensure maximal support to countries. The regions to be evaluated most closely will be Africa and Asia - the location of the majority of Campaign countries. The evaluation will look at efforts in these regions and at the global level as well as the interdivisional efforts.

Methodology

Once selected, the evaluation team will work with UNFPA to develop a methodological inception report which will provide details on the approach to be followed. The Inception report will be presented to the Technical Division/UNFPA for approval prior to the commencement of the research. The Inception Report should among other things provide details on the following:
- An indicator framework for evaluating fistula programme progress to date (see results in global proposal and draft list of priority indicators, note some variations will be needed due to country-level variations)
- Details of methods for collecting data from the selected sample of countries

- Details of how each in-depth country case study will be organised and conducted
- Details of how the regional and global elements will be assessed
- Details of data collection instruments
- Types of data analysis to be conducted
- Proposed schedule of country visits
- A schedule of detailed outputs and dates in line with the work programme of deliverables scheduled below

Key principles for the design of the evaluation approaches are as follows:

- Participatory process to involve and strengthen capacity of stakeholders in design, data collection, analysis and planning for implementation of recommendations utilising national coordination mechanisms
- Approach as a learning process for a relatively new area of intervention; an opportunity to take stock and see how the different approaches are working and assess results to date

The country visits will provide the evaluation team with an opportunity to review with UNFPA staff, Government counterparts and other development partners. The visits will also help facilitate stakeholder involvement in the evaluation process. Country visits will be undertaken to each of the four countries, for duration in each of up to two weeks. In each country, UNFPA will identify and recruit a national consultant to assist in facilitating the process and ensure national participation.

The evaluation team will also use a variety of methods including e-mail surveys, telephone interviews with UNFPA staff and partners, and review and synthesis of secondary sources of data and analysis, such as previous evaluations, project documentation, mission reports and national, regional and global reporting to assess global and regional components of the campaign, to understand national progress in the other selected countries and to complement the in-depth country visits.

Management & Support Arrangements

The evaluation will be managed by UNFPA's Technical Division (TD) in collaboration with the internal interdivisional Fistula Working Group (FWG) and technical advisory services from the Division for Oversight Services (DOS) on the evaluation design**.** The evaluation will follow the UNEG ethical guidelines for evaluation, which require adherence to key principles such as utility and transparency in approach. This requires that the evaluation approach and methodology is guided by intended users' needs and that stakeholders are consulted on the approach.

In order to ensure utility and transparency, TD will establish a Reference Group (RG) to serve in an advisory role to the evaluation team. The role of the RG will be to provide input to the methodological approach which will guide the evaluation as well as to assist with the validation of findings and recommendations. TD will arrange for RG meetings at strategic times during the course of the evaluation. The RG will consist mostly of UNFPA staff, but some partner organisations may also be invited to participate in the RG. The RG is intended to have an advisory role and will not have control over the findings and the methodology.

TD will also provide support to the team throughout the period of the evaluation, assisting with the preparation of data and the provision of background information materials as required.

TD in collaboration with the relevant Regional Offices will assist the evaluation team in arranging country visits. UNFPA Country Offices will provide the necessary logistical and administrative support to the evaluation team whilst they are in the field, including

involvement and participation of national stakeholders and recruitment of a national consultant to join the evaluation team.

Estimated Costs

It is estimated that the cost of the evaluation would range from between USD 250,000 and USD 500,000.

Tentative Schedule and Outputs & Deadlines[79]

Item	*Target Timing*
Preparation and Submission of Inception Report with detailed methodological approach	April 2009
New York Meetings with Reference Group to finalize methodology and country visit details	April 2009
Conduct research including country visits	May-August 2008
Debriefing of Reference Group in New York on key evaluation findings and recommendations	September 2009
First draft of evaluation report due – Reports for each country, global/regional level and synthesis report	Mid October 2009
UNFPA and national stakeholders review draft report and provide feedback and comments	Comments by 31 October 2009
Final Draft of Evaluation Report due	November 2009
Debriefing of UNFPA Senior Management on evaluation results	November or December 2009
Dissemination of results in the in-depth case study countries	December 2009

EVALUATION TEAM COMPOSITION

All evaluation team members will have a relevant background in evaluation, health policy and programme issues in developing countries. All team members must also have the ability to travel to the in-depth case study countries. It is preferred that the same team visits all the countries to ensure consistency. The evaluation team will be supported by a national consultant recruited by UNFPA in each of the case study countries.

The **Team Leader** should possess a background in public health, preferably in reproductive health and have field experience and prior experience leading large-scale thematic evaluations. Prior experience in evaluating maternal health programmes is highly desirable. The team should include a health professional with expertise in obstetric fistula.

- Areas of technical competence
- Language proficiency: English and French
- In-country or regional work experience
- Evaluation methods and data-collection skills
- Analytical skills and frameworks, such as gender analysis
- Process management skills, such as facilitation skills
- Gender mix in team composition.

[79] Schedule adapted as per contract of 25 March 2009.

Annex 2. Questionnaire to countries not included in the in-depth studies

Thank you for briefly responding to this questionnaire on Obstetric Fistula (OF). Please use a short telegram style of response. Details have been provided in the annual reports.

0. **Partners for the Campaign**
    - Who are the main actors working on OF in the country and what are their respective roles?
    - Whom would you say is the actor taking the lead on OF in the country? Why do you say so?

1. **Scaling up efforts**
    - What are the key bottlenecks for scaling up efforts to end OF?

2. **Service provision model**
    - What types of service provision models exist in the country (i.e. national referral centre, services provided at tertiary level facilities (i.e. teaching hospitals), decentralised service provision to lower level facilities (i.e. district hospitals), regular surgical missions (i.e. fistula fortnights)?.
    - What factors have contributed to the decision to implement these models?
    - What are the advantages and disadvantages of each model?

3. **Value added of fistula prevention services**
    - A number of preventive intervention for OF are part of the regular activities supported by UNFPA in the country (i.e. family planning), what is then the value added of the UNFPA Fistula Campaign supporting the implementation of prevention services for fistula.?

4. **Social- reintegration services**
    - What is the appropriate role for UNFPA in the provision of these services?
    - How should social-reintegration services be best provided? By whom and how?

5. **Costs**
    - Are there any user fees charged for fistula services? How much is this fee?
    - What is on average a likely price paid by a patient for transport to a place where OF services are provided?
    - Are there any user fees paid by patients for EmOC? How much is this fee?
    - Are there any government subsidies or other subsidies available for OF?
    - Should there be any subsidies? For which services?
    - Should money generated by the Fistula Campaign be used for paying for subsidies for OF services?

6. **Technical guidance**
    - Have you requested technical assistance/guidance from UNFPA HQ and/or UNFPA RO?
    - What type of technical guidance has been received from UNFPA HQ and/or UNFPA RO? How useful was this guidance? Please provide some examples.
    - Did you request technical assistance that was not provided? Why?

7. South-south collaboration

- Have you had any experience of south-south collaboration within the framework of the Campaign to End Fistula? What was the main result of this linkage? Please provide some examples.
- Do you have any recommendation for further strengthening south-south collaboration?

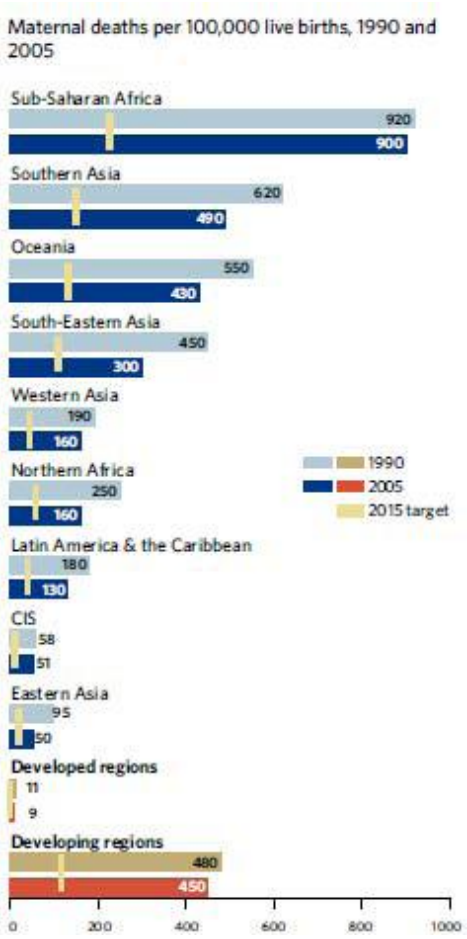
8. Key factors for implementation

- What have been the key factors that have made possible a timely implementation of the OF programming in your country (both financial implementation as well as implementation of activities)?
- What have been the key factors contributing to slowing down or delays in implementation of the OF programming in your country (both financial implementation as well as implementation of activities?

9. Any additional comments?

Annex 3. Maternal mortality ratio by world region

FIGURE 6 - MATERNAL MORTALITY RATIO BY REGION, 1990-2005



Source: United Nations (2008), Millennium Development Goals Report 2008, p. 27, UN.

Annex 4. Year of initiation of Campaign to End Fistula in each country

TABLE 33 - YEAR OF INITIATION OF THE CAMPAIGN AND YEAR OF NEEDS ASSESSMENT STUDY

Year of initiation of UNFPA Campaign support	Country	Year of needs assessment study	Support only for needs assessment study
2003	Bangladesh		Mozambique
	Togo		Rwanda
2004	Benin	2003	
	Burkina Faso		
	Chad	2003	
	Equatorial Guinea		
	Eritrea		
	Kenya		
	Mali	2003	
	Niger	2003	
	Nigeria	2003	
	Senegal		
	Sierra Leone		
	Uganda	2003	
2005	Ghana	2003	
	Malawi	2003	
	Mauritania	2004	
	Pakistan		
	Zambia	2003-2004	
2006	Angola		
	Cameroon	2005	
	DR of Congo		
	Ethiopia		
2007	Afghanistan	2006	
	Congo		
	Ivory Coast	2006 (epi. study)	
	Liberia		
	Nepal	2006	
2008	East Timor	2006	
	Guinea	2006	
	Guinea Bissau		
	India	2006-2007	
	Sudan	2003	
2009	Somalia		
Other countries supported	Central African Republic		
	Djibouti		
	Lesotho		
	Swaziland		
	Yemen		

Source: UNFPA HQ, Annual Country Reports Fistula Campaign.

Annex 5. Main partners involved in obstetric fistula activities in 8 countries under review

TABLE 34 - MAIN PARTNERS INVOLVED IN OF ACTIVITIES IN COUNTRIES UNDER REVIEW

In-depth case studies (including country visits)			
Bangladesh • Ministry of Health and Family Welfare • UNFPA • Obstetrical and Gynaecological Society of Bangladesh • USAID / Engender Health • Bangladesh Women's Health Coalition • Islamic Development Bank (IDB) • NGO service providers • Fistula advocates • 13 hospitals providing OF repair services (10 supported by UNFPA & 3 by Engender Health).	**Democratic Republic of Congo** • National Reproductive Health Programme (Ministry of Health) • WHO • USAID / Axxes • NGO MERLIN • NGO ACDF • Hospital "Maternité Sans Risque" • 22 hospitals providing OF repair services (11 with support from UNFPA).	**Niger** • Ministry of Public Health (Directeur Général de la Santé Publique) • Ministry of Promotion of the Woman and the Child • NGOs DIMOL Solidarité, MAGAMA • USAID / Engender Health • International Organisation for Women & Development • UNFPA • Six hospitals providing OF repairs services with UNFPA support.	**Nigeria** • Federal Ministry of Health • State Ministries of Health • State MoWASD • Office of the First Lady • UNFPA • Engender Health • 20 hospitals providing or with potential to provide OF repair services (include nine dedicated centres for treatment of patients with OF, 12 have received support from UNFPA).
Focused desk reviews			
Kenya • Ministry of Health/UNFPA programme • MoH provides services through 5 provincial general hospitals and one teaching hospital • African Medical Research Foundation (AMREF) • JAMAA Mission Hospital • Kenyatta National Hospital • CSOs (e.g. Catholic Dioceses of Nakuru, Mumias Muslim Community Project, Council of Imams and Preachers of Kenya) • Ambassadors of Hope.	**Pakistan** • Ministry of Health • Pakistan National Forum on Women's Health • Regional fistula centres: (1) Koohu Goth Women Hospital in Karachi; (2) Nister Hospital in Multan; (3) Shaikh Zaid Women Hospital in Larkana; (4) Lady Reading Hospital in Peshawar; (5) Pakistan Institute of Medical Sciences in Islamabad; (6) Lady Wallington Hospital in Lahore; (7) Sandamen Provincial Hospital in Quetta.	**Sudan** • Federal and states' Ministries of Health • Abbo Fistula & Urogynaecology Centre • NGOs • UNFPA • Media • Fistula survivors.	**Tanzania** • Ministry of Health and Social Welfare (MoH&SW) • Women's Dignity (WD) • African Medical Research Foundation (AMREF) • Referral, District and Designated Hospitals.