HERA
HEALTH RESEARCH FOR ACTION

ICRH
INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH

Photo: Marcel Reyners

Thematic Evaluation

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

Assessment of global/regional activities

VOLUME I: Global/Regional Report

Final report – March 2010

Laarstraat 43, B-2840 Reet Belgium
E-mail hera@hera.eu
tel. +32-3-8445930
fax. +32-3-8448221
www.hera.eu

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

Thematic Evaluation

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

Assessment of global/regional activities

VOLUME I: Global/Regional Report

Consultant Team:

Josef Decosas
Thérèse Delvaux
Marcel Reyners
Birgit Kerstens
Thomas Raassen
Els Duysburgh
Shirin Akhter
Victor Muela Difunda
Zubairu Iliyasu
Kadidjatou Maikibi
Mizanur Rahman
Gretchen Roedde (co-team leader)
Marta Medina (team leader)

Table of Contents

Table of Contents ii
List of figures iii
List of tables iii
Acknowledgement iv
List of abbreviations and acronyms v
Summary vii
1. Introduction 1
1.1 The Campaign to End Fistula 1
1.2 Purpose and objectives of the thematic evaluation 2
1.3 Methods 3
1.4 Limitations of the assessment of global/regional efforts 3
1.5 Structure of the report 4
2. Main findings 5
2.1 Background 5
2.2 Internal coordination and management 5
2.3 Role of regional level 7
2.4 Capacity development 8
2.5 Research and documentation 9
2.6 Measurement, monitoring and evaluation 10
2.7 Advocacy and awareness raising 11
2.8 Resource mobilisation 13
2.9 Partnership building 14
2.10 Financial aspects 16
3. Progress towards achievement of expected results 18
3.1 Increased national capacity for obstetric fistula elimination and improvement of maternal health 18
3.2 Enhanced decision-making through global monitoring and evaluation of progress in fistula elimination 18
3.3 Increased visibility and support for obstetric fistula elimination from policy makers, international organisations and donors 18
3.4 Enhanced collaboration and coordination of global and regional efforts in the elimination of obstetric fistula 19
4. Recommendations 20
ANNEXES 1
Annex 1. Terms of Reference 1
Annex 2. List of people met / interviewed by phone 10
Annex 3. List of documents available to the team 12

List of figures

Figure 1 Campaign to End Fistula - Countries 2
Figure 2 - Donor contributions to UNFPA for the Campaign to End Fistula 2004-2008, per year (in USD) 14
Figure 3 - Allocations to and expenditure by the Campaign to End Fistula 2005-2008, per division (in USD) 17

List of tables

Table 1 - Donor contributions to UNFPA for the Campaign to End Fistula 2004-2008, per donor (in usd) 13
Table 2 - Contributions and allocations for the Campaign to End Fistula 2004-2008, per year (in USD) 16
Table 3 - Expenditure Rates for the Campaign to End Fistula 2005-2008, per beneficiary (in %) 16
Table 4 - Allocations to and expenditure by - CAMPAIGN to End Fistula 2005-2008, per division (in USD) 17

Acknowledgement

Thank you to the fistula patients/advocates who are using their own difficult experiences to try to mobilise awareness for better prevention, treatment, and rehabilitation of fistula patients in order to help other women to live in dignity and to try to end the suffering they have experienced.

The Evaluation Team would like to express its gratitude to all officials and individuals who provided information and who graciously gave their time and support to the evaluation process.

Special thanks to the Campaign staff at the UNFPA headquarters, sub-regional offices and country offices for providing relevant documentation and facilitating the necessary coordination at all levels to allow us to carry out our task.

The Evaluation Team

Reet, March 2010

List of abbreviations and acronyms

AMMD	Averting Maternal Mortality and Morbidity Project (Columbia University)
AMREF	African Medical Research Foundation
CDC	Centre for Disease Control (Atlanta)
CO	UNFPA Country Office
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EmOC	Emergency Obstetric Care
FIGO	International Federation of Gynaecology and Obstetrics
FWG	(Interdivisional) Fistula Working Group
HERA	Health Research for Action (Belgium)
HMIS	Health Management Information System
HQ	UNFPA Headquarters
ICPD	International Conference on Population and Development
ICRH	International Centre for Reproductive Health (Belgium)
ISOFS	International Society of Obstetric Fistula Surgeons
JHU	Johns Hopkins University
JIGO	International Journal of Gynaecology and Obstetrics
MDG	Millennium Development Goal
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non Government Organisation
OF	Obstetric Fistula
OFWG	International Obstetric Fistula Working Group
PAUSA	Pan African Urologists Surgeons Association
RHCS	Reproductive Health Commodities Security
RG	Reference Group
RO	UNFPA Regional Office
SRO	UNFPA Sub-Regional Office
TD	Technical Division

TOR	Terms of Reference
UN	United Nations
UNEG	United Nations Evaluation Group
US	United States (of America)
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organisation

Summary

In 2003, the United Nations Population Fund (UNFPA) and partners launched a global *Campaign to End Fistula*[1]. The *Campaign* supports fistula prevention as well as treatment and psychosocial support for women living with fistula[2] in more than 45 countries. At the regional and global level, the *Campaign* provides technical support to national programmes and engages in international advocacy and partnership building for the elimination of fistula. Between 2004 and 2008, the *Campaign* has raised a total of 31 million US dollars. The *Campaign* is currently implementing its second phase (2006-2010).

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 implementation phase of the *Campaign*. The evaluation included an assessment of national programmes as well as an assessment of global/regional efforts in support of national programmes. The findings of the evaluation are presented in ten volumes. **This document, Volume I, presents the assessment of global/regional efforts in support of national programmes**. Volume II presents a synthesis report of the assessment of national programmes and Volumes III to X present specific reports for each one of the countries included in the evaluation. Many of the findings presented below are also discussed in the synthesis report of the assessment of the national programmes (Volume II).

Internal coordination and management

Within UNFPA the internal coordination and management mechanisms for the *Campaign* contributed not only to increased coordination and ownership of the *Campaign* activities but also to greater knowledge and understanding of obstetric fistula. However, these mechanisms have somewhat facilitated a vertical operation of the *Campaign*. This was probably necessary during this period, as obstetric fistula was a new issue to be addressed within the organisation. In 2009, two major transitions have taken place within UNFPA which will most likely affect the way some of these mechanisms operate. On the one hand the ongoing UNFPA reorganisation process might have implications on the way technical support to the countries is provided (e.g. decentralisation of regional offices and dissolving the Country Support Teams) and on the other hand the move at headquarters from various Thematic Funds (including the Fistula Trust Fund) to one Maternal Health Thematic Fund will most likely affect the future allocation and disbursements of funds for fistula activities. A careful transition planning is required in order not to bring activities to a standstill and lose the momentum gained. UNFPA headquarters will be exploring with countries the possibility of increasingly including fistula prevention/treatment/reintegration activities within their overall country programme.

Role of regional level

In the context of the *Campaign* the UNFPA headquarters (HQ) and (sub-)regional offices provide support to countries in several areas, including: the formulation or elaboration of project proposals, the submission of budget requests, the formulation or review of proposals for national strategies to end obstetric fistula, carrying out the country needs assessment on obstetric fistula and the organisation and implementation of the (first) fistula repair camp(s). Here, the Evaluation Team sees two specific issues: a) insufficient resources and b) a need for more focussed follow-up. The (sub-) regional offices have limited capacity (time and resources) to provide on-site technical support to overcome perceived weaknesses at the national level. The feedback they provide to the country offices on both the reporting of activities as well as the proposed annual work plan raises pertinent questions. Many of the comments and questions made are related to indicators and monitoring activities which are clearly perceived as weak points of the country programmes.

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

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

Capacity development

There has been relevant support from the global and regional levels to strengthen capacity for fistula programming in the countries through facilitating south-south linkages, particularly in relation to the training of fistula surgeons, as well as with the purpose of sharing experiences in the organisation of fistula programmes. Regional meetings have been promoted with the purpose of sharing and documenting experiences. Capacity building was done as well through backstopping and monitoring missions for the conduct of needs assessments, the development of national strategies and the formulation of national responses.

The global/regional level has been involved in the development of a number of guidelines/tools that could be used by countries when developing or implementing their fistula programmes. Among others, some of the tools developed include the needs assessment questionnaire, the format for the development of national strategies, a costing tool and templates for presenting proposals and reporting. Tools for documenting lessons learnt and best practices to capture compelling experiences in the field were also developed. The countries have been developing their fistula programmes based on the guidelines and tools produced at the regional/global levels. Some of these tools have been disseminated and others are in the process to be disseminated. A more systematic and structured dissemination plan for these tools would help.

The development of the "Competency-based training manual for fistula surgeons" is one visible product of the global efforts. It has been developed within the framework of the International Obstetric Fistula Working Group (OFWG) and it will contribute to further development of fistula surgeons´ skills as well as the quality of the surgery performed. There are plans to pilot test this manual. Other products of the global/regional efforts include the collaboration between UNFPA and WHO in the elaboration/dissemination of the WHO Obstetric Fistula Guiding Principles for Clinical Management and Programme Development. The Living Testimony publication/toolkit for advocacy activities is another visible product of the global efforts.

Research and documentation

There is a need for increased knowledge and evidence on a number of issues related to fistula. During the country visits the need for research in a number of areas was expressed, particularly related to the clinical management of obstetric fistula and psychosocial integration. Technical assistance to analyse some of the data available at treatment centres (i.e. Kenya, Bangladesh) was also requested. Currently, UNFPA is funding a multi-country study to be carried out by Johns Hopkins University on "Clinical and Quality of Live Outcomes for Women Following Fistula Treatment". The recommendations chapter of the report will discuss how the regional and sub-regional offices of UNFPA will best collaborate with national and regional institutions in research and documentation.

Measurement, monitoring and evaluation

Measurement, monitoring and evaluation are weak areas in all national programmes (see Volume II). Health information systems in most countries are weak and information on fistula is not routinely collected. Information on treatment is most likely to be available in the facilities where these services are provided, but not compiled or analysed on a regular basis nor used to guide decision making. Presently countries fall 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 the global *Campaign* monitoring framework.

Global efforts to support countries in this area include the development and agreement on six global indicators that all countries were going to report on as part of the monitoring of the *Campaign*. The selection of these six indicators was the result of a comprehensive as well as collaborative process with Regions and Countries. Much of the global coordination in monitoring focused on this until recently, when efforts have been directed to the elaboration of an Indicator Compendium for fistula programming. The intention with the elaboration of the Compendium is to provide countries with a tool from which programmers would select a minimum set of appropriate indicators to monitor their respective programmes. The list of indicators in the Compendium is very comprehensive (including 59 indicators). 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 indicators there was no data available. The countries have similar difficulties in reporting on the six global indicators agreed upon in 2006.

Advocacy and awareness raising

The global advocacy and awareness raising activities have contributed to greater visibility and knowledge of the fistula problem at global level. They have also contributed to resource mobilisation for fistula programmes both within and outside of UNFPA. Increasingly, UNFPA has been supporting and relying on former fistula patients (fistula advocates) to convince communities and policy makers of the right to treatment. The fistula advocates are also involved in advocacy and awareness raising on the importance of preventing maternal death and disability (for example when UNFPA facilitated their participation of fistula advocates in the Women Deliver Conference).

Some of those interviewed are of the opinion that as the *Campaign* is focusing on a neglected issue, in order to call attention to this condition, it makes sense for the advocacy and awareness raising activities to highlight treatment to show that the condition can be successfully treated and therefore a particular emphasis on fistula treatment was necessary at this point. This does not necessarily mean that it is at the expense of advocating for prevention or other important dimensions of the problem. Others, particularly some of the members of the OFWG, perceived that global awareness raising activities put (too much) emphasis on fistula repairs and not enough on prevention. The functional linkages (between the *Campaign* and maternal health initiatives) have not been emphasized enough and the idea of fistula as an entry point to mobilize more support for maternal health has not been effectively operationalised especially at the programmes and service delivery levels. It would be helpful to link the awareness raising messages not only to fistula repair but also to prevention issues (i.e. link to maternal health and safe motherhood, advocating for implementation of measures to prevent obstructed labour, access and use of EmOC services, access to skilled attendant at birth, removal of barriers to access these services). It is also perceived by some that the awareness raising activities are more directed to mobilising resources than to advocating for policy changes.

Partnership building

The OFWG is the main platform for collaboration at the global level. UNFPA, through the *Campaign* has been active in fostering this partnership. It has grown from 7 to approximately 25 partner organisations. The OFWG is highly appreciated by its members as a vehicle for sharing information, knowledge and experiences, as well as for networking and discussion on key issues relevant to fistula prevention, treatment and rehabilitation/reintegration services. It is also a space to contribute to ongoing discussions (e.g. on data, indicators, ideas for programming), to identify opportunities for collaboration, to avoid duplication and build a knowledge base. UNFPA's role as Secretariat for the OFWG is highly appreciated for its ability to maintain the links and communication within the group. Those interviewed would like the OFWG to reach out more to the countries and provide additional support to country activities.

Recommendations

Among others, the recommendations of the evaluation team relate to:

- better planning of the technical assistance to be provided by headquarters and (sub-)regional offices to the countries, particularly in the nearby future when efforts will be made for integration of the *Campaign* activities within the UNFPA overall collaboration on maternal health programmes in each country;
- identifying national and regional institutions that could provide, among others, technical assistance to countries in issues related to development of research activities, monitoring and evaluation of programmes, training of fistula surgeons, treatment issues;
- using advocacy and awareness raising activities to promote specific policies as well as introducing a more focused message on prevention of obstructed labour; and

- exploring opportunities for strengthening partnerships with some members of the International Obstetric Fistula Working Group with the purpose of making better use of the comparative advantages of each partner organisation.

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 MDG targets to improve maternal health[3]. A global thematic proposal for the *Campaign to End Fistula* was submitted to major donors in autumn 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 was 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.

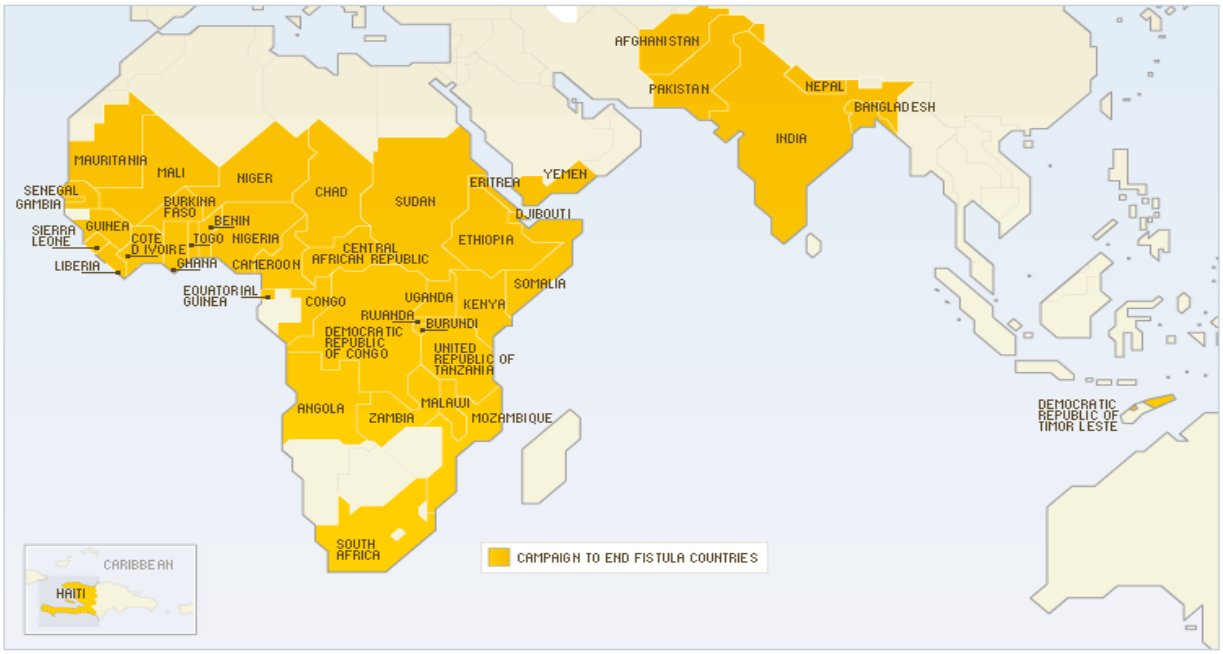
The main expected results at national level (not quantified, nor with specific indicators to determine achievement) as outlined in the 2003 proposal are as follows:
- Enhanced political and social environment for the reduction of maternal mortality and morbidity
- Integration of fistula interventions 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 2003 proposal states that the global and regional approaches to support achievements at national level will be 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. The main expected results for global/regional efforts outlined in the 2003 proposal are as follows:
- 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.

The *Campaign* which started with 12 countries is now working in more than 45[4] 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.

[3] Source: http://www.endfistula.org/campaign_brief.htm (consulted on June 9, 2009).
[4] Vol II, Annex 4 presents a list of countries by year of initiation of Campaign to End Fistula activities.

FIGURE 1 CAMPAIGN TO END FISTULA - COUNTRIES



Source: UNFPA, Coordination Campaign to End Fistula

Globally and regionally, the *Campaign* is working to build the evidence base and capacity for fistula-related interventions, raise awareness, formulate international and regional partnerships, and 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) have been contracted by UNFPA to conduct the Thematic Evaluation of National Programmes and UNFPA's experience in the *Campaign to End Fistula*[5].

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 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:

- 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 efforts in support of national programmes.

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

To evaluate the national programmes component of the *Campaign to End Fistula* the evaluation focussed on a sample of eight countries with a variety of experiences and at different stages of implementation. To enable answering the evaluation questions, four countries having initiated the implementation of a fistula programme no later than 2004 were selected for the in-depth case studies: Nigeria, Bangladesh, Democratic Republic of Congo (DRC) and Niger (including a field visit to each country). Additionally, a focused desk review of another four countries was also performed. Pakistan, Tanzania, Sudan and Kenya were selected as desk review countries.

The global/regional evaluation assessed progress made towards the achievement of the expected results (as stated in the 2003 proposal to donors) for global/regional support to national efforts. In line with the Terms of Reference (TOR), the assessment of UNFPA's global and regional support to national programmes covered the assessment of the following areas:

- Internal coordination and management.
- Capacity development
- Research and documentation
- Measurement, monitoring and evaluation
- Awareness raising and resource mobilisation
- Partnership building

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. **This document, Volume I, presents the assessment of global/regional efforts in support of national programmes**. Volume II presents a synthesis report of the assessment of national programmes and Volumes III to X present specific reports for each one of the countries included in the evaluation.

1.3 Methods

This report is based on review of available documents, reports and data on the *Campaign* and on related issues as well as other information gathered. An open-ended questionnaire was used for phone interviews with selected members of the OFWG. Meetings and interviews with members of the interdivisional fistula working group at UNFPA Headquarters took place during April 2009. Meetings and interviews also included the obstetric fistula staff from both sub-regional offices (SRO) in Africa. The Team Leader of the evaluation team participated as an observer in the annual meeting of the OFWG, held in Dar es Salaam, Tanzania in September 2009.

1.4 Limitations of the assessment of global/regional efforts

As stated in the inception report, it was not always possible for the evaluation team to determine the separate effect of the regional and the global support, as the work of these two levels is very much interlinked. Clear-cut global support activities are for example those related to resource mobilisation, the communication and awareness raising activities that are intended for global outreach, some support to research, the coordination and the overall management of the *Campaign*, and the partnership building efforts at global level. Both levels carry out internal coordination and management activities. The regional focal points for obstetric fistula based at UNFPA regional offices (RO) and SRO have played a role in liaising and coordinating with the countries in order to secure the flow of communication as well as in the provision of direct support to country offices (CO) for the implementation and

follow up of the proposed plans financed by the *Campaign*. As much as possible, the evaluation team made an effort to analyse both levels as separate entities.

1.5 Structure of the report

This document presents the findings and recommendations for the assessment of global/regional efforts in support of national programmes. Chapter 2 presents the main findings of the assessment in each one of the areas requested by the terms of reference. The assessment of progress made towards achieving the expected results for the global/regional efforts (as described in the Global Programme Proposal: Making Safe Motherhood Safer by Addressing Obstetric Fistula 2006-2010) is presented in Chapter 3. The recommendations are presented in Chapter 4.

2. Main findings

2.1 Background

The Global Programme Proposal submitted to donors "Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010" specifies the type of activities that the *Campaign to End Fistula* (spearheaded by UNFPA) was going to support at national as well as global/regional levels. 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 mobilisation, and (4) partnership building. The Proposal also describes the broad expected outcomes at these levels. However the document does not specify 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 ICPD and MDG targets.

The proposal envisages the duration for 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).

The findings of the evaluation team in each of the areas requested by the TOR for the assessment of global/regional activities are presented below.

2.2 Internal coordination and management

The *Campaign* activities are under the supervision of the Chief, Reproductive Health Branch at UNFPA HQ. An overall Coordinator (Technical Specialist) for the *Campaign* was appointed in 2003. In August 2007, a Consultant was contracted to support the coordination function. The Coordination post has been vacant since May 2009, and this function was assumed by the Consultant (whose contract ends in June 2010). She will continue providing support until a replacement is found. Those interviewed, recognise that the work done by the Coordination of the *Campaign* has been carried out with strong commitment, energy, quality and conducive for a good collaboration among all parties.

The global and regional support is managed by several UNFPA Offices/Divisions[6] represented in the internal interdivisional Fistula Working Group (FWG) which was based (until July 2008) at UNFPA HQ when UNFPA regionalisation took place[7]. The interdivisional FWG made of fistula focal points / fistula experts[8] from all the participating Offices/Divisions was constituted with the purpose of securing technical inputs from all involved as well as to facilitate the collaboration and coordination between them. The interdivisional FWG provides overall guidance to the Coordination of the *Campaign.* Additionally, it has been involved in the review and approval of project/programmes proposals submitted by countries to the *Campaign.* It has also been involved in the provision of comments to annual reports,

[6] UNFPA Divisions represented in the internal interdivisional Fistula Working Group include: Africa Regional Office, Asia & Pacific Regional Office, Arab States Regional Office, Internal & External Relations Division and Technical Division. Other Divisions participate as needed.
[7] As a result of the regionalisation, the staff from geographical Offices are now located in the regions.
[8] Within some offices/divisions, there are nominated Focal points but in others (like Africa) there were staff recruited as Fistula experts.

reporting to donors, responding to technical assistance needs of countries, participation / planning of global level advocacy activities and partnership building at global level.

At the regional level *Campaign* staff have been appointed (two in the Africa Region and one in the Asia & Pacific Region) to facilitate the coordination and communication with countries, to provide technical assistance to countries and to implement specific region-wide activities involving participation from several countries.

At national level, each country office appointed/designated a focal point for fistula activities. In some countries, in addition of their on-going responsibilities, the existing reproductive health / maternal health staff was nominated as Fistula Focal Point. In other countries, a staff was specifically recruited for Fistula programming and funded by the Fistula project/programme financed by the *Campaign* (i.e. Nigeria).

This organisational set-up contributed not only to increased coordination and ownership of the *Campaign* activities but also to greater knowledge and understanding of obstetric fistula within UNFPA. However, it has somewhat facilitated a vertical operation of the *Campaign*. A certain degree of verticality was probably necessary during this initial period, as obstetric fistula was a new issue to be addressed within the organisation. The Coordination of the *Campaign* has been encouraging countries to integrate obstetric fistula programming (prevention/treatment/reintegration activities) within current reproductive health activities (within UNFPA overall country programmes as well as within government's programmes). This integration will have important implications at the policy, programme and services levels contributing to greater sustainability and lasting impact of the activities implemented. Some countries are actually doing so, more or less effectively (see Volume II as well as individual country reports).

Two major transitions taking place within UNFPA in 2009 will most likely affect the way some of the above mentioned mechanisms operate. On the one hand the ongoing UNFPA reorganisation process might have implications on the way technical support to the countries is provided (e.g. decentralisation of regional offices and dissolving the Country Support Teams). On the other hand the move at headquarters from various Thematic Funds (including the Fistula Trust Fund) to one Maternal Health Thematic Fund will most likely affect the future allocation and disbursements of funds for fistula activities.

Another change which will affect the role of regional and global support activities is UNFPA's plan to increase the level of in-country technical expertise (starting with the countries with highest maternal mortality rates) on maternal health and other aspects of reproductive health. This will strengthen the capacity of country offices, making them less dependent on regional, sub-regional, or global support levels.

The evaluation team (ET) was informed that, in part due to the financial crisis, the availability of funds in 2009 has been more constrained than in previous years. The Fistula *Campaign* is working closely with the Resource Mobilisation Branch 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. Equally important is that during the present transition it would be possible to secure smooth continuity and preservation of the institutional knowledge at programme delivery, policy and services levels gained through the implementation of the *Campaign* activities.

2.3 Role of regional level

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 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.

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 requests, for formulation or review of proposals for national strategies to end obstetric fistula, for carrying out the country needs assessment on obstetric fistula and for the organisation and implementation of the (first) fistula repair camp(s). Through a collaboration between HQ and RO/SRO some countries have also received support to include a model for data collection and analysis of fistula in their Demographic and Health Survey (DHS). Support was also provided to countries during policy and strategies development. The countries also receive feedback from RO/SRO/HQ to their annual reports and to their annual requests for funding, as well as monitoring and evaluation exercises. The feedback on annual reports is provided on a summary sheet for all the national campaigns in African, Arab and Asian countries. The feedback provided raises 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 obviously weak points of the programme. There seems to be little follow-up on the answers provided, and limited capacity (time and resources) to provide on-site technical support to overcome perceived weaknesses at the national level. There have been coordinated efforts between CO/SRO/HQ in order to secure the participation of national fistula advocates in global level advocacy efforts such as their participation at the Women Deliver Conference (2007) and events in Washington DC and Geneva.

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[9] (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 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[10].

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

[9] In the Atlas system (financial and admin system) this position is reflected as Programme Officer.
[10] Personal interview with Y. K.

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.

2.4 Capacity development

Although important efforts have been invested by the *Campaign*, obstetric fistula has been for (too) long a neglected area and will require substantial systems building to become institutionalised. This transition is yet far from complete, but evidence shows both some important gains in the capacity developed and some gaps still to be completed.

There has been relevant support from the global and regional level to strengthen capacity for fistula programming in the countries through **facilitating both South-South (S-S) [11] as well as North-South (N-S) linkages,** particularly in relation to the training of fistula surgeons and with the purpose of sharing experiences in the organisation of fistula programmes. However, often countries contact directly the surgeons that they want to invite for the training but without involving the Country Office of the expert's country (e.g. Mali). S-S and N-S cooperation need further coordination; because there are sometimes missed opportunities to learn from these experiences as there is little if no technical feedback on these initiatives. The benefits derived from the south-south and north-south collaboration are highly valued by countries. The *Campaign* received an award of excellence from the United Nations Development Programme in recognition for its work in fostering collaboration between countries in the South in order to share knowledge and expertise in the prevention and treatment of obstetric fistula and the rehabilitation of fistula survivors.

Regional meetings have also been promoted with the purpose of sharing experiences, stimulating coordination and collaboration. The participants from the countries found these meetings valuable to increase their knowledge and understanding of the issues discussed. Only a limited number of people can participate in these events because of resource constraints. Examples of these conferences include the 2nd Asia and Pacific Regional Workshop on Strengthening Fistula Elimination in the Context of Maternal Health (Pakistan, 2006) and the Making Motherhood Safer by addressing Obstetric Fistula (South Africa 2005). Some of those interviewed suggested the establishment of mechanisms for sharing the gained knowledge or skills when returning home, as this was perceived as an essential and potentially cost-effective activity. The regional and global level can also help to compare the experiences of different countries as well as to identify best practices so that each country does not have to "reinvent the wheel".

The global/regional level has been involved in the **development of a number of guidelines/tools** that could be used by countries when developing or implementing their fistula programmes. Examples are: The Obstetric Fistula: Prevention and Treatment Resource Requirement Guide; the guidance for the organisation of outreach services (Bringing care closer: Providing Fistula Treatment through Outreach Services: a Guide for Programme Managers); the costing tool for fistula programmes and the Living Testimony Toolkit (a tool for carrying out advocacy activities). Dissemination of these tools started in 2009 and will continue in 2010.

The *Campaign* collaborated with the World Health Organisation (WHO) providing financial support for the printing of the English version as well as for the translation to French of the document "Obstetric Fistula, Guiding Principles for clinical management and programme development", which is used as a reference book for fistula programming. The document is also available on the net at www.fistulanetwork.org. There were significant slow-downs in the delivery of the copies to UNFPA by WHO and this material is yet to reach the countries. Also

[11] More details on south-south collaboration are presented in Volume II, section 4.7

in collaboration with WHO a brief training module based on the above mentioned document was developed and printed. The intention is to roll out a plan for capacity development in fistula programming, identifying opportunities within UNFPA capacity development initiatives related to sexual and reproductive health and maternal health, as well as opportunities within WHO and with others OFWG partners.

The development of the "Competency-based training manual for fistula surgeons" is another visible product of the global efforts. It has been developed within the framework of the International Obstetric Fistula Working Groups as a result of a joint effort of several actors among others, the International Federation of Gynaecology and Obstetrics (FIGO), UNFPA, the International Society of Obstetric Fistula Surgeons (ISOFS), and the Pan African Urology Surgeons Association (PAUSA). The intention is to pilot test this Manual in 3-5 training centres in different countries in 2009-10. Behind this effort is the goal of securing that training of fistula surgeons takes place following an agreed curriculum. This will hopefully result in improved surgery skills as well as improved quality in the surgeries performed. Some centres have already accepted to be part of the pilot testing of the Manual (e.g. Nigeria). UNFPA provided the resources to FIGO in 2009 for piloting the manual.

At best, some countries are managing to treat only one third of the new annual cases of women needing surgery, and together with the significant backlog of cases not being addressed this means that the highly ambitious goal of eliminating fistula by 2015 is far from achievable unless substantial shifts in strategy take place. More technical and financial backstopping will be needed to maximise the return on the investment made by the Campaign in the various countries. This will require more support from the regional and global level. Options for scaling up all models (regional centres of excellence, national referral hospitals, provincial/district hospitals, fistula treatment campaigns, and more decentralised widespread dissemination of skills to prevent fistula such as catheterisation and use of the partograph) need to be critically reviewed and experiences shared between countries. Additionally, the regional and global level is well-positioned to help standardise mechanisms of quality assurance including the use of recognised experts (maybe through collaboration with the International Society of Obstetric Fistula Surgeons (ISOFS)) and ensuring sufficient volume of skill practice during and after training as well as accreditation mechanisms. Strategies to promote policy changes (e.g. promoting retention of trained staff, preventing loss of skills by posting skilled staff to other services) may also require global and regional support as well as strong integration within national maternal and neonatal health (MNH) and other health programmes (i.e. human resources management improvement, health information systems).

2.5 Research and documentation

The *Campaign* supported the publication of a supplement in the peer-reviewed International Journal of Gynaecology and Obstetrics (JIGO) containing 27 articles with the latest evidence on obstetric fistula programming[12].

Research efforts at country level have been mostly related to the elaboration of the country needs assessment or situation analysis. These studies have been useful to provide information on the existing resources for fistula activities available in the country; other studies have provided information to facilitate a better understanding of the dimension of the fistula problem in the countries.

[12] Ahmed, S., Genadry, R., Stanton, C., Guest Editors, Supplement Prevention and Treatment of Obstetric Fistula: Identifying Research Needs and Public Health Priorities, Volume 99, Supplement 1, November 2007, ISSN 0020-7292.

There is a need for increased knowledge and evidence on a number of issues related to fistula. During the country visits the need for research was expressed, particularly related to the clinical management of obstetric fistula as well as to psychosocial integration. Countries also expressed the need for technical assistance to analyse some of the data available at treatment centres (i.e. Kenya, Bangladesh).

As part of the global efforts, the *Campaign* is supporting the roll out of a multi-country research study with John Hopkins University (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. There is a need for the National Fistula Task Force in Bangladesh to be informed on the progress of the research activities. We were informed that this will be done in the near future.

Other organisations, members of the OFWG are also carrying out obstetric fistula related research. For example Engender Health, working in 12 countries through the Fistula Care project (USAID financed) has launched a multi-country study on the determinants of post-operative outcomes in fistula repair surgery.

Fistula surgeons are also doing research, mostly on clinical aspects of the fistula surgery. The possibility of UNFPA collaborating with ISOFS on a common research agenda could be explored.

2.6 Measurement, monitoring and evaluation

Measurement, monitoring and evaluation are weak points in all national programmes (see Volume II). Health information systems in most countries are weak and information on fistula is not routinely collected. Information on treatment is most likely to be available in the facilities where these services are provided, but are not compiled or analysed on a regular basis nor used to guide decision making. The global efforts to support countries in this area from late 2005-2008 were focused on elaboration, consensus and review of **six global** indicators. Later on, the global efforts have been concentrated on the elaboration of an **Indicator Compendium** for fistula programming[13]. The list of indicators included in the Compendium is very comprehensive (including 59 indicators)[14]. The intention is that countries might choose from this list a number of indicators to be used for monitoring and evaluating progress of their fistula programmes. The list is very ambitious for countries to record and report on them. In 2006, the *Campaign* suggested the countries to report on the selected six global indicators, but even this list is sometimes difficult to report on.

Based on the above mentioned lists the evaluation team 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 evaluation team assisted the UNFPA Country Offices (CO) to provide the information on the indicator framework for the in-depth study countries.

[13] This has been one of the activities carried out within the framework of the Data, Indicators and Research Committee of the OFWG, including among others, the Centre for Disease Control (CDC) Atlanta and UNFPA. Engender Health & USAID have also contributed to this work

[14] The Fistula Care Project has defined 15 indicators for the project.

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.

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.

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.

Reliable data on **fistula prevalence and incidence** is scarce or not available. The *Campaign* has been advocating for the introduction of fistula modules in the Demographic Health Surveys (DHS), which was taken up by the following countries: Democratic Republic of Congo (DRC), Ethiopia, Malawi, Mali, Niger, Pakistan, Rwanda, and Uganda. The module varies between countries (including knowledge of and experience of fistula symptoms). Challenges with the data collection and analysis of these modules include that the questionnaires have not yet been validated and also the sensitivity of the issue due to stigma[15]. A standard module developed was included in the recent DHS in Kenya, Burkina Faso & Nigeria.

One potential role of the regional and global level in monitoring and evaluation could be to advocate for detailed socio-economic analysis of Caesarean section rates, which would be one mechanism to assess availability and accessibility of emergency obstetric care (EmOC) for obstructed labour. Currently, Caesarean section rates are the only indicator to assess obstructed labour, yet Caesarean sections are done for other reasons (foetal distress, placenta previa, maternal or physician convenience). Yet if analysed by educational level, socio-economic quintile, and rural/urban location of mother, useful data on access to EmOC could be obtained.

2.7 Advocacy and awareness raising

The global advocacy and awareness raising activities have contributed to greater visibility and knowledge of the obstetric fistula problem at global level. They have also contributed to resource mobilisation for fistula programmes both within UNFPA and outside of UNFPA. For example, USAID reports that the advocacy and awareness raising work done by UNFPA was used by them to respond to Congress when USAID was requested to work on Fistula.

The *Campaign* has used a variety of strategies to bring attention to obstetric fistula such as introducing the topic in UN sessions, media coverage, being present on reproductive health

[15] Interview with Maurice Bucagu (WHO).

conferences as well as on internal UNFPA events, elaboration of brochures and videos, production of advocacy material (Living Testimony), working with fistula advocates and fistula ambassadors. In order to carry out this work a close collaboration with the countries has been necessary, as they are the providers of the primary data required for advocacy and elaborate the story for the advocacy.

The advocacy and awareness raising efforts have been targeted at a variety of audiences in both developed as well as developing countries, including policy makers, health professionals, media, and the general public. Significant interest has arisen from a variety of partners, ranging from donor governments and national and international NGOs to the private sector. Well-known and high profile individuals have become engaged in awareness raising, including Heads of State, First Ladies, and celebrities.

Increasingly, UNFPA has been supporting and relying on the former fistula patients (fistula advocates) to convince communities and policymakers of the right to treatment and the importance of preventing maternal death and disability (for example when UNFPA facilitated the participation of fistula advocates in the Women Deliver Conference). The work with fistula advocates includes an important component of capacity development for the fistula survivors, in order to support them in the development of competences and skills to become more effective advocates.

The advocacy efforts have also reached the United Nations. In 2008, the *Campaign* drafted the report of the Secretary General on Resolution A/63/222 “Supporting Efforts to end obstetric fistula”. A new resolution was adopted which will keep this issue on the policy agenda.

It is perceived by some of the members of the OFWG that global awareness raising activities put (too much) emphasis on fistula repairs. It would be helpful to link the awareness raising messages not only to fistula repair but also to prevention issues (i.e. link to maternal health and safe motherhood, advocating for implementation of measures to prevent obstructed labour – access and use of EmOC services, access to skilled attendant at birth, removal of barriers to access these services). It is also perceived by members of the OFWG that the awareness raising activities are more directed to mobilisation of resources than to advocate for policy changes.

What should be the purpose of awareness raising campaigns in developed countries (e.g. Belgium, UK)? Some suggested mobilisation of resources to implement programmes at country level or advocate for specific policies to be supported by these countries as part of their development agenda. It was considered a missed opportunity that during the time when BBC was transmitting its fistula documentaries (some financed by UNFPA) there was no organised effort in the UK to raise money from individuals to support the implementation of fistula programmes in a specific country in the south. It was suggested, for example, that UNFPA and FIGO could join efforts to mobilise resources in countries in the North where FIGO has local chapters (i.e. UK, Germany).

UNFPA has provided a media guideline for maternal health as countries are looking for guidance on how to work with media on issues related to maternal health. It was not possible for the ET to assess whether or not this guideline is used by countries.

There should be a balance between investing in global awareness raising activities versus investing more in this type of activities at country and community level.

2.8 Resource mobilisation

At global level the *Campaign* has been able to mobilise resources from a variety of donors. Approximately 31 million USD has been contributed by donors through UNFPA to the *Campaign to End Fistula* in the period 2004-2008, with an average annual sum of 5,5 million USD. Donors include countries, UN Funds, private companies and foundations[16]. Donors that have contributed in the 5-year period from 2004 to 2008 are listed in Table 1. Table 1 - Donor contributions to UNFPA for the Campaign to End Fistula 2004-2008, per donor (in usd)

TABLE 1 - DONOR CONTRIBUTIONS TO UNFPA FOR THE CAMPAIGN TO END FISTULA 2004-2008, PER DONOR (IN USD)

Donors	Donor contributions 2004-2008
Australia	$434,279
Austria	$353,435
Canada	$250,000
Catalunya*	$927,988
Engender Health	$749,304
Finland	$73,432
Iceland	$147,026
Ireland	$737,463
Luxembourg	$7,102,479
New Zealand	$621,700
Norway	$3,642,987
Poland	$135,000
Private/Individual contributions	$1,851,307
Republic of Korea	$990,000
Spain	$5,886,122
Sweden	$4,357,759
Switzerland	$24,300
UN Foundation	$180,952
UN Trust Fund for Human Security	$1,773,525
UN Fund for International Partnerships	$30,000
US Committee for UNFPA	$553,211
Total contributions 2004-2008	**$30,822,269**

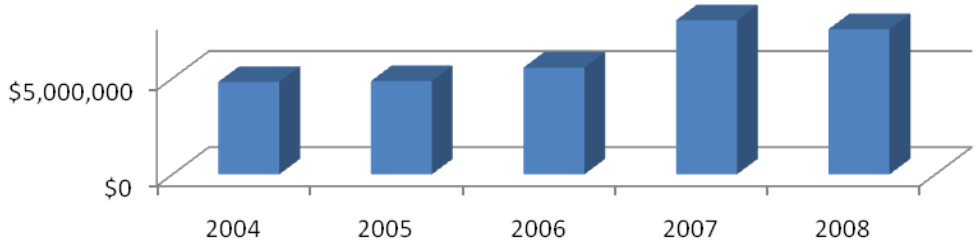
Source: UNFPA Headquarters.
Note: Catalunya contributes as an autonomous community and is therefore separated from Spain's contribution.

The largest donor contributions came from Luxembourg (more than 7 million USD over 5 years), Spain (almost 6 million USD), Sweden and Norway (each around 4 million USD).

Donor contributions were the highest in 2007, mainly due to the single donation of 3,7 million USD from Norway that year. In 2008 the total contributions from countries, private companies and foundations and UN Funds amounted to 7,5 million USD (see Figure 2).

[16] Private contributions include contributions from Americans for UNFPA, European Voice, Johnson and Johnson, One by One, Virgin Unite, Zonta International Foundation and non-specified donors.

FIGURE 2 - DONOR CONTRIBUTIONS TO UNFPA FOR THE CAMPAIGN TO END FISTULA 2004-2008, PER YEAR (IN USD)



Source: UNFPA Headquarters.

Not all countries currently implementing obstetric fistula activities are included in the group of countries to be supported by the joint Maternal Health Trust Fund (or "The Fund" as it is also called sometimes within UNFPA). In this transition period it is critical to secure that support for the programming and implementation of obstetric fistula activities will continue (if countries agree), in order to consolidate and expand on the gains made so far (see Volume II). UNFPA is already approaching donors to explain the operation and functioning of the new joint Maternal Health Trust Fund and it is also encouraging them to provide their support trough this Thematic Trust Fund[17].

Some donors are agreeing to contribute only to the Maternal Health Trust Fund, others have expressed interest in continuing supporting fistula activities through UNFPA but outside the Maternal Health Trust Fund. Some of these donors are not traditional contributors to UNFPA activities and it would be desirable that they continue supporting obstetric fistula activities. UNFPA might need to approach these donors differently from the traditional contributors.

There are also opportunities to mobilise resources for fistula activities at country level. These opportunities have not been yet sufficiently explored by the country offices. They probably need to be discussed as well with the Resource Mobilisation Branch.

2.9 Partnership building

The OFWG is the main platform for collaboration at the global level. UNFPA, through the *Campaign,* has been active in fostering this partnership. It has grown from 7 to approximately 25 partner organisations. The OFWG is highly appreciated by its members as a vehicle to share information, knowledge and experiences, as well as for networking and discussion on key issues relevant to fistula prevention, treatment and rehabilitation services. It is also a space to contribute to issues in progress (data, indicators, review ideas for programming) and to identify opportunities to collaborate and avoid duplication and build a knowledge base.

Among others, members of the OFWG include: Engender Health, FIGO, ISOFS, the African Medical Research Foundation (AMREF), the Averting Maternal Mortality and Morbidity Project (AMDD), the Centre for Disease Control (CDC), WHO, the Johns Hopkins University

[17] The Maternal Health Trust Fund is to scale up activities to reduce maternal mortality in a selected number of countries with the highest mortality rates. Not all countries currently implementing obstetric fistula programming activities are included in this group of countries.

(JHU), Médecins Sans Frontières (MSF), PAUSA, Population Media Centre, Operation Obstetric Fistula, Women's Dignity, Psychology Beyond Borders. It was suggested that within the context of UNFPA participation in the H4 initiative[18], the willingness of UNICEF and The WB to participate in the OFWG should be explored.

Those members of the OFWG interviewed recognised the important role played by UNFPA as a Secretariat for the OFWG. According to them, UNFPA is the organisation most suitable for this role. In its role as a Secretariat, UNFPA has been able to bring together key actors who were working on fistula but were not coordinated. UNFPA is also highly valued for its effort to keep the links and communication within the group. One question raised was if there is a need for more human resources at UNFPA HQ to act as a Secretariat? It was suggested that UNFPA needs to be better in acknowledging the work of others in the OFWG and in emphasising the collective nature of the efforts of the OFWG.

The OFWG has organised itself into various committees: Partnership and Advocacy committee (yet to start); Data, Indicators and Research Committee; Treatment and Training Committee; Reintegration Committee. The training and indicators committees have been the more active ones. A constraint for the functioning of these committees is that little work is done in between the annual meetings of the OFWG. Some of the reasons mentioned, are: the voluntary nature of the work that has to be done next to the respective jobs, and competing agendas. This results in less efficient implementation of the activities.

> ***"The international Obstetric Fistula Working Group (OFWG) is a partnership created in 2003 with the primary purpose of ensuring global coordination and collaboration efforts to eliminate obstetric fistula. The group includes international and regional NGOs, universities, governmental organisations, health facilities and UN Agencies, all of which are working to raise awareness of obstetric fistula in the context of improving maternal and neonatal health. UNFPA serves as the Secretariat and works with all partners to strengthen this coalition for greater coordination of fistula elimination programmes and improved advocacy and resource mobilisation"***
>
> *Meeting Report: Strengthening Partnership and Improving Collaboration, Annual Meeting of the OFWG, Accra, Ghana, April 2008*

The OFWG meets once a year. From our participation at the 2009 annual meeting we conclude that a number of relevant issues are discussed and that up-dated information is presented on various issues related to prevention, treatment and rehabilitation services. The meeting presents good opportunities for networking and establishing contacts with those working in this field. The agenda is tight; overall very little time is left for discussion as well as for discussion on common strategies or how to better coordinate the efforts of the various parties[19].

[18] This is a joint initiative of UNFPA, WHO, UNICEF and the World Bank to provide support for accelerated implementation of reproductive, maternal and newborn core, particularly to the countries with the highest maternal mortality

[19] The one afternoon dedicated to working Committee sessions and reporting back sessions is not sufficient time.

2.10 Financial aspects

❖ Allocations to the beneficiaries of the Campaign

Eighty-eight per cent of the total donor contributions during 2004-2008 or an amount of 27 million USD, has been allocated to the *Campaign* over the five-year period 2004-2008. As the funds in the Obstetric Fistula Trust Fund are not expired at the end of a year - there are often funds "mobilised" within a year and spent/allocated the following year. This explains the difference in mobilised versus allocated funds in table 2 below.

On an annual basis the amount of contributions exceeded or approached the amount of allocations, except for 2008 when the total allocated budget was much higher than that year's amount of donor donations.

TABLE 2 - CONTRIBUTIONS AND ALLOCATIONS FOR THE CAMPAIGN TO END FISTULA 2004-2008, PER YEAR (IN USD)

Year	Sum of contributions	Sum of allocations
2004	$4,816,473	$2,287,025
2005	$4,857,466	$4,941,677
2006	$5,560,670	$5,395,995
2007	$8,027,660	$5,668,734
2008	$7,560,000	$8,704,889
Total	**$30,822,269**	**$26,998,320**

Source: UNFPA Headquarters.

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.

❖ Expenditure rate by the beneficiaries

Eighty-one per cent of the total allocations for the period 2005[20]-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 3.

TABLE 3 - 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%	68%	105%
Total	**72%**	**81%**	**107%**	**70%**	**81%**

Source: UNFPA Headquarters.

❖ Expenditure by the global/regional divisions

A discussion of expenditure by global/regional divisions follows. The expenditures by countries is discussed in Volume II. The global/regional allocations for the *Campaign* for the 4-year period 2005-2008 are almost equally divided between the global (53%) and regional divisions (47%). The global divisions together have spent less than allocated while the three

[20] 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.

regional divisions together have spent a little more than what was allocated (see Table 4). Of the three regional divisions only the Africa Division has spent more than the allocation. We did not have enough information to further analyse the reasons for over or under spending.

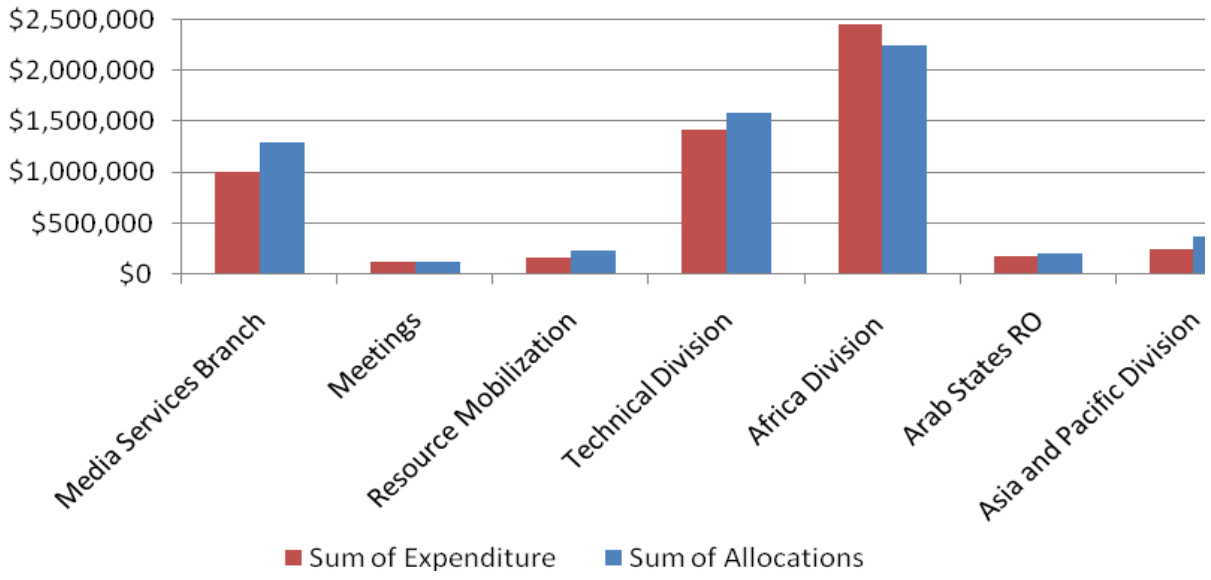
TABLE 4 - ALLOCATIONS TO AND EXPENDITURE BY - CAMPAIGN TO END FISTULA 2005-2008, PER DIVISION (IN USD)

Division	Sum of Expenditure	Sum of Allocations
Global	**$2,713,203**	**$3,234,445**
Media Services Branch	$1,005,585	$1,291,109
Meetings	$120,597	$125,000
Resource Mobilisation	$163,488	$227,928
Technical Division	$1,423,533	$1,590,408
Regional	**$2,886,444**	**$2,812,860**
Africa Division	$2,453,819	$2,240,974
Arab States RO	$179,736	$207,291
Asia and Pacific Division	$252,889	$364,595
Total	**$5,599,647**	**$6,047,305**

Source: UNFPA Headquarters.

The Africa Division takes the largest share (in value and in percentages) of the three regional divisions, in terms of allocations and expenditure. At the level of the global divisions, the largest amount of allocations and expenditure is for the Technical Division and the Media Services Branch (which includes the *Campaign*'s website). No more detailed information was made available to the ET to carry out other analysis of expenditures (e.g. by type of expenditure or by type of activity).

FIGURE 3 - ALLOCATIONS TO AND EXPENDITURE BY THE CAMPAIGN TO END FISTULA 2005-2008, PER DIVISION (IN USD)



Source: UNFPA Headquarters.

3. Progress towards achievement of expected results

3.1 Increased national capacity for obstetric fistula elimination and improvement of maternal health

In the study countries, there has been an increase in the capacity for provision of obstetric fistula repair services (see Vol II as well as country reports Volumes III-X for data among others on number personnel trained, number of fistula repairs carried out, social reintegration services provided). But this capacity is still not large enough to significantly address the new cases occurring every year, nor the existing backlog of cases. The majority of the study countries have made little progress on preventing maternal deaths as indicated by their trends in maternal mortality. The progress made has been the result of the actions of several partners involved in each country and the results cannot therefore be only attributed to the work of UNFPA or to the *Campaign*. The coverage of key maternal health indicators is low. There have been great constraints in human resources, infrastructure, equipment, and in the knowledge of women and men on how to prevent fistula. In particular, there has been limited progress in the countries in early detection and referral of prolonged / obstructed labour which is directly related to prevention of fistula. A great proportion of deliveries are still done by unskilled birth attendants, inadequate EmOC facilities are frequent, with the cost of services and transport costs acting as barriers to access services.

3.2 Enhanced decision-making through global monitoring and evaluation of progress in fistula elimination

The lack of good data has made it impossible to enhance decision-making and to assess properly progress in fistula elimination. The fact that there are no adequate mechanisms to track inputs and compare to outputs limits the potential to make additional analysis. Guidance needs to be provided to COs to enable them to make these comparisons.

It has been difficult to match academic rigour (the substantial number of indicators proposed by the Indicator Compendium) with the availability of data at country levels in a context of weak health management information systems (HMIS).

3.3 Increased visibility and support for obstetric fistula elimination from policy makers, international organisations and donors

The *Campaign* has made an important contribution to increased visibility and support for the elimination of obstetric fistula from policy makers and others. At global, regional, national and community levels the *Campaign* has put a living face on the systems issues causing maternal deaths and morbidities. Fistula survivors have been outstanding ambassadors to mobilise resources. Political achievements such as gaining support from the US Congress and USAID (through Engender Health) in a climate of US opposition to areas of work of UNFPA is remarkable and has paved the way for the improved collaboration under the current American government. The community fistula advocates have helped to raise the profile of the problem of fistula at diverse levels such as in the Women Deliver Conference.

3.4 Enhanced collaboration and coordination of global and regional efforts in the elimination of obstetric fistula

Though not only as a result of the *Campaign* efforts, there is a global (international) platform for collaboration and coordination of global and regional efforts in the elimination of fistula, the OFWG.

The OFWG is yet to become a true partnership, in the sense of having a common plan, jointly implemented, jointly financed, joint goals for the short and medium term. It is not clear to the evaluation team, whether the members of the OFWG are ready for this type of partnership. Presently each member implements its programme(s), somewhat independently of the other. During the interviews with members of the OFWG, it was expressed that the space where coordination should take place is at the country level. The field visits to countries have shown that a lot more could be done to better coordinate and promote synergies at country level. It is the general opinion of those OFWG´s members interviewed that the time has come for the activities and discussions taking place at the OFWG to reach the countries. It has been expressed as, “we need to focus more on the countries”, “we need to help the countries more”.

4. Recommendations

	Issues and Findings	Recommendations	Responsibility and priority
Increasing the support for fistula services by UNFPA Regional Offices and Headquarters			
1	**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 Country Support Team (CST) and now SRO levels, there is a mechanism for planning TA requests. 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 managers 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, training). 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
2	**Transition to one Maternal Health Fund.** The move at HQ from various thematic Funds (including the Fistula Trust Fund) to one Maternal Health Thematic Fund will most likely affect the future allocation and disbursement of funds for fistula activities.	Guidance from the regional and global level should be tapped to help countries look at models for sustaining their efforts, in a potentially more restricted aid environment. • Countries for example can be guided to use their core budgets for reproductive health to support skilled attendance, EmOC and family planning. In addition to the fistula fund, this could be used primarily for treatment services (including training) and at a smaller scale to facilitate linkages with relevant actors for the provision of reintegration services. Many countries are already doing this. • Countries should also be guided on how to better advocate for the adoption of national fistula policies as well as full integration of fistula services within existing services. • The regional and global level could help to showcase the potential of other components of the maternal health fund which could be tapped to bring innovations to scale: community skilled birth attendants, or improving Reproductive Health Commodities Security (RHCS) to strengthen Family Planning - the most cost-effective maternal mortality reduction strategy – and for which UNFPA is the lead technical agency in UN as One.	UNFPA Country Offices, ROs, and HQs **High priority**

	Issues and Findings	Recommendations	Responsibility and priority
3	**Coordination and collaboration of global and regional efforts in the elimination of obstetric fistula.** The OFWG is the existing platform. The intended purpose of the OFWG has been to be a space for sharing knowledge, experiences, networking, discussing issues. It is yet to become a real partnership in the sense of having a common plan and common goals for the short at medium term. It is not clear if all the members are ready for this type of partnership. However there is an agreement on the need to reach out more to the countries and better support them. Less talk and more action.	There are several members of the OFWG with whom UNFPA could establish better synergies and opportunities for closer collaboration could be pursued. For example: • Work together with Engender Health (in countries were both are active) in supporting countries in the strengthening of national leadership for fistula programming and establishing of national coordination mechanisms. Define specific areas of collaboration in each country (i.e. share educational materials, training opportunities, tools and methods). **High priority** • Develop and implement a cooperation agreement with ISOFS on supporting countries for example: ISOFS can be involved in early stages of planning, execution and evaluation of existing and new projects; it can also be involved on issues related to training, quality assurance and clinical research. **High priority** • Establish mechanisms to monitor together with FIGO and relevant Country Offices the pilot testing of the training manual. Document the experience and draw relevant conclusions, lessons learnt and suggestions to improve the manual. If and when relevant prepare a proper dissemination of the experience and work-plan to support countries in adopting the manual and how to use it as their training tool. **Medium priority**. • Establish stronger partnerships with national and regional NGOS with the purpose of liaising with them for the implementation of prevention and more specifically social reintegration activities. Explore further what role the newly established Africa Regional Network for Fistula Elimination could play in facilitating these partnerships. **High priority**	UNFPA HQ, UNFPA CO **Medium to high priority**

	Issues and Findings	Recommendations	Responsibility and priority
4	**Advocacy and awareness raising activities.** The global advocacy and awareness raising activities have facilitated greater visibility and knowledge on obstetric fistula to a variety of audiences. These activities need to focus more towards advocating for specific policies and focus on prevention of preventing obstructed labour. Advocacy and awareness raising activities are also necessary at national level and particularly at community level.	• Direct global and regional advocacy and awareness raising activities to advocate for policy changes that are critical for the achievement of elimination of obstetric fistula. For example, issues related to the prevention of obstructed labour - the need to scale up community skilled birth attendants, free access to EmOC services, subsidies for transport costs when accessing delivery services and issues related to secure access and availability of quality and free fistula repair treatment services. • The above recommendation also applies to national level advocacy and awareness raising activities. Opportunities for peer-evaluation of national advocacy could be explored. • Community level advocacy and awareness raising activities to advocate among others for early identification of and taking measures to prevent obstructed labour, approaching community leaders as well as men to support women in accessing skill birth attendants when obstructed labour appears, support the integration in the community of women with obstetric fistula or successfully treated obstetric fistula, inform the community of where and how to access fistula repair services.	UNFPA HQ, UNFPA CO. **High priority**
5	**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 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. • UNFPA should advocate for detailed socio-economic analysis of Caesarean section rates, which would be one mechanism to assess availability and accessibility of emergency obstetric care (EmOC) for obstructed labour. This data is available in most countries carrying out DHS, but this analysis is not done on a regular basis. • At the same time, UNFPA should continue its advocacy to have a module on fistula included in the DHS and other major population surveys. • UNFPA should support countries in how to better document, monitor and evaluate their programmes through a systematic and planned methodology (i.e. elaboration of a monitoring and evaluation framework and operations research methodology).	UNFPA HQ, UNFPA CO and Ministries of Health **High priority**

	Issues and Findings	Recommendations	Responsibility and priority
6	**Continue efforts for capacity development in countries.** Obstetric fistula has been a neglected area and will require substantial systems building to become institutionalised. Countries could benefit from specific guidance from HQ on key issues related to fistula programming.	• Continue promoting south-south linkages and improve its coordination as a vehicle for capacity building and exchange of experiences. Opportunities for peer-evaluation of country activities could be explored. • Implement the plan for dissemination to countries of the guidelines/tools for fistula programming. Identify which tools each country wants to use and provide necessary TA and monitoring of the use of these tools. When relevant, facilitate exchange of experiences in the application/use of those tools. • Elaborate and disseminate to countries guidelines on quality assurance of fistula treatment services. If necessary and requested by countries, facilitate that countries can have access to specialised technical assistance on this issue. • Elaborate guidelines for countries on options for scaling up efforts towards fistula prevention and treatment (integration of OF-MNH programmes, regional centres of excellence, national referral hospitals, provincial/district hospitals, outreach treatment services, decentralised and wider dissemination of skills to prevent fistula such as catheterisation and use of the partograph).	UNFPA HQ, **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[21]

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 mobilise 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.[22] 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,

[21] http://www.unfpa.org/about/index.htm
[22] 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[23]. In as many as 90 per cent of cases the baby is stillborn or dies within the first week of life[24].

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.[25] 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.[26] The World Health Organisation estimates an annual incidence of approximately 73,000 new cases.[27] 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.[28]

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 emphasises political advocacy and capacity development to ensure that fistula elimination is sustainable.

[23] 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.
[24] 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.
[25] 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.
[26] Wall LL. Obstetric vesico-vaginal fistula as an international public-health problem. Lancet 2006; 368: 1201-1209.
[27] Abou Zahr C. 2003.
[28] 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[29] 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.[30] 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.[31] 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

[29] 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.
[30] Donnay F, Ramsey K. Eliminating Obstetric Fistula: Progress in Partnerships. International Journal of Gynaecology and Obstetrics 2006; 94(3): 254-61.
[31] 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[32] 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;[33] 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.

[32] UNFPA, EngenderHealth. Needs Assessment Report: Findings from Nine African Countries. New York: 2003.
[33] 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[34]

Item	*Target Timing*
Preparation and Submission of Inception Report with detailed methodological approach	April 2009
New York Meetings with Reference Group to finalise 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.

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

Annex 2. List of people met / interviewed by phone

Name	Position	e-mail
Purmina Mane	Deputy Executive Director, Programme, UNFPA	pmane@unfpa.org
Bettina Maas	Chief, Office of the Executive Director, UNFPA	maas@unfpa.org
Werner Haug	Director, Technical Division, UNFPA	haug@unfpa.org
Laura Laski	Chief, Sexual & Reproductive Health Branck, Technical Division, UNFPA	laski@unfpa.org
Kate Ramsey	Former Coordinator Campaign to End Fistula, UNFPA	ramsey@unfpa.org
Katherine Gifford	Coordinator, Campaign to End Fistula, UNFPA	gifford@unfpa.org
Yves Bergevin	Coordinator, Maternal Health, Thematic Fund, UNFPA	bergevin@unfpa.org
Geeta Lal	Coordinator Midwifery, former Regional Focal Point for Fistula in Asia, UNFPA	Lal@unfpa.org
Jagdish Updhyay	Reproductive Health Commodities and Supplies, UNFPA	upadhyay@unfpa.org
Christina Vrachnos	Former Media Officer for the Campaign, UNFPA	vrachnos@unfpa.org
Priya Marwah	Programme Analyst, Humanitarian Response Unit, UNFPA	marwa@unfpa.org
Cecilie Mazzacurati	Programme Analyst, Humanitarian Response Unit, UNFPA	mazzacurati@unfpa.org
Katia Iversen	Media Specialist, Media and Communication Branch, UNFPA	iversen@unfpa.org
Matthew Hodge	Chief Evaluation, Division of Oversight Services, UNFPA	hodge@unfpa.org
Klaus Simoni Pedersen	Resource Mobilisation Adviser, Resource Mobilisation Branch, Fistula Focal Point, UNFPA	simonipedersen@unfpa.org
Aminata Toure	Chief, Gender, Human Rights and Culture Branch, Technical Division UNFPA	toure@unfpa.org
Leyla Sharafi	Technical Specialist, Gender, Human Rights and Culture Branch, Fistula Focal Point, Technical Division, UNFPA	sharafi@unfpa.org
Ann Pettigrew Nunes (*)	Programme Officer, Fistula Focal Point, UNFPA	pettigrew@unfpa.org

Name	Position	e-mail
Magali Romedenne	Technical Specialist, Campaign to End Fistula, Regional Focal Point, UNFPA Dakar, Senegal	romedenne@unfpa.org
Yahya Kane	Regional Coordinator, Campaign to End Fistula, UNFPA, Johannesburg, South Africa	ykane@unfpa.org
Karen Beattie (*)	Coordinator for Fistula Care Project, Engender Health	Kbeattie@engenderhealth.org
Joseph Ruminjo (*)	Clinical Director, Fistula Care Project, Engender Health	JRuminjo@engenderhealth.org
Samantha Lobis (*)	AMMD, Columbia University	Sjl54@columbia.edu
Debra Jones	Communications, Family Care International	
Mario Merialdi (*)	RHR, WHO, Geneva	merialdim@who.int
Maurice Bucagu (*)	Medical Officer, Maternal Health, Dept. Making Pregnancy Safer, Norms and Technical Support Coordination, WHO, Geneva	bucagum@who.int
Saifuddin Ahmed (*)	Associate Professor, Department of Population, Family and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University	SAHMED@jhsph.edu
Mary Ellen Stanton (*)	GH/HIDN/MCH, USAID	MStanton@usaid.gov
Patricia MacDonald (*)	GH/PRH/SDI, USAID	pmacdonald@usaid.gov
Naren Patel (*)	Former Vice- President, Chairman of Fistula Committee, International Federation of Gynaecology and Obstetrics (FIGO)	patel-naren@hotmail.com
Serigne Magueye Gueye (*)	President, Pan African Urological Association (PAUSA)	smgueye@refer.sn

Note: (*)Telephone interview.

Annex 3. List of documents available to the team

Epidemiology

- *Proceedings of the Workshop on Data Methodologies for Estimating Obstetric Fistula*; New Delhi, 30th April to 2nd May 2007; Campaign to end Fistula, UNFPA.

Fistula: General Information

- *Saving mothers' lives the challenge continues*; UNFPA (flyer).
- *Fistule obstétricale; Fin du silence, moins de souffrance; Points essentiels*; INFO Reports, Johns Hopkins Bloomberg School of Public Health; Septembre 2004 - Numéro 2.
- Meeting Report: *Obstetric Fistula as a Catalyst: Exploring Approaches for Safe Motherhood*; Atlanta, Georgia – USA; UNFPA, Health & Development International (HDI), Centres for Disease Control and Prevention (CDC); 3-5 October 2005.
- *Urologie d'ailleurs : Fistules vésico-vaginalesou fistules obstétricales*; Charles-Henry ROCHAT, Fondation Genevoise pour la Formation et la Recherche Médicales; Paris, novembre 2005 (24 slides).
- *Fistula Support Program*; USAID, The ACQUIRE Project (29 slides)
- J Kelly; *Vesico-vaginal and recto-vaginal fistulae*; Journal of the Royal Society of Medicine, Volume 85, May 1992

Maternal Health: General Information

- *Pour une maternité sans risque en Afrique de l'Ouest: L'utilisation des indicateurs pour programmer les résultats*; Adverting Maternal Death and Disability, UNFPA, New York, 2003
- Making safe motherhood a reality in West Africa: Using indicators to programme for results; Adverting Maternal Death and Disability, UNFPA, New York, 2003
- *Soins obstétricaux d'urgence: Liste récapitulative pour les planificateurs*; UNFPA, New York, 2002 (flyer)
- *Emergency Obstetric Care: Checklist for Planners*; UNFPA, New York, 2002 (flyer)
- Prof. dr. Jos van Roosmalen, *De moeder het kind van de rekening*; Vrije Universiteit Amsterdam, april 2008.
- *Mise à jour 2004 sur la mortalité maternelle: accoucher en de bonnes mains*; UNFPA 2004

Psycho-social Background

- *Témoignage vivant: La Fistule Obstétricale et les Inégalités en Santé Maternelle*; 2007 Family Care International, Inc. et UNFPA
- ACQUIRE Report: *Traumatic Gynaecologic Fistula: A Consequence of Sexual Violence in Conflict Settings*; A Report of a Meeting Held in Addis Ababa, Ethiopia, September 6 to 8, 2005; EngenderHealth/The ACQUIRE Project 2006
- Rapport du projet ACQUIRE: *Fistule gynécologique traumatique: une conséquence de la violence sexuelle dans des situations de conflit* ; Septembre 2006 Rapport de la réunion tenue à Addis-Abeba (Ethiopie) du 6 au 8 septembre 2005; EngenderHealth/The ACQUIRE Project 2006
- ACQUIRE Technical update: *Traumatic Gynaecologic Fistula as a Result of Sexual Violence*; The ACQUIRE Project 2008
- *Sally Hartley; Community Based Rehabilitation as part of Community Development: A Poverty Reduction Strategy*; University College London, Centre for International Child Health, 2006
- Katie Tell; *The Hidden Consequence of War*; EngenderHealth 2005.

Prevention and Treatment of Fistula

- *Prévenir le mal et Guérir les Blessures, En finir avec la fistule obstétricale*; UNFPA, Campagne pour éliminer les Fistules; UNFPA 2008.
- *Facility Assessment of Fistula Treatment and Prevention Services: A Tool for Administrators and Fistula Service Providers*; Fistula Care.
- *Report on the Meeting for the Prevention and Treatment of Obstetric Fistula*; UNFPA, Averting Maternal Death and Disability Program Columbia University, International Federation of Obstetrics and Gynaecology; London, July 2001.
- *Preventing Harm and Healing Wounds, Ending Obstetric Fistula*; Campaign to End Fistula, UNFPA 2008.
- Tom J. I. P. Raassen & Emiel G. G. Verdaasdonk & Mark E. Vierhout; *Prospective results after first-time surgery for obstetric fistulas in East African women*; International Urogynaecology Journal 2007.
- C.-H. Rochat, J.-M. Colas; *TVTO après reconstruction cervico-urétrale complexe pour fistule obstétricale: Etude préliminaire*; Fondation Genevoise pour la Formation et la Recherche Médicales, Genève, Septembre 2005 (15 slides).

Indicators

- *Selected Indicators for Obstetric Fistula Programs; Data, Indicators and Research Group*, CDC (27 slides).

Treatment Management

- FISTULA CARE, *Fistula Services Facilitative Supervision and Medical Monitoring for Service Delivery*; EngenderHealth, USAID, Fistula Care, December 2008 (French version also available).
- Prince Pascal Hounnasso, Charles-Henry Rochat, Regina Kulier; *Classification des fistules vésico-vaginales et son importance pour les données de base ;* Fondation Genevoise pour la Formation et la Recherche Médicales, 27 Mars 2008.

Training

- *Obstetric Fistula: Guiding principles for clinical management and programme development*; World Health Organisation 2006.
- *Meeting Report: Training for Fistula Management*: Obstetric Fistula Working Group, Niamey, Niger 19-20 April 2005; Campaign to End Fistula, UNFPA 2005.
- FISTULA CARE, *Fistula Services Facilitative Supervision and Medical Monitoring for Training Sites and Training Follow- up*; EngenderHealth, USAID, Fistula Care, April 2008 (French version also available).
- FISTULA CARE, *Fistula Treatment Training Strategy*; EngenderHealth, USAID, Fistula care, July 2008 (French version also available).

UNFPA Information on the 'Campaign to End Fistula'

- La Campagne Mondiale 'Pour éliminer les fistules'; UNFPA, 16 slides.
- End Fistula Campaign News, Tracking progress in the global Campaign to End Fistula, Issue #7; UNFPA, December 2005.
- *En finir avec la souffrance muette*; UNFPA, Campagne pour éliminer les Fistules (flyer).
- *Dispatch; Tracking progress in the campaign to end fistula*; December 2007.
- *Dispatch; Tracking progress in the campaign to end fistula*; June 2008.
- *Dispatch; Tracking progress in the campaign to end fistula*; December 2008.

UNFPA Reports on the 'Campaign to End Fistula'

- *Rapport de la réunion sur la formation au traitement de la fistule;* Groupe de travail sur la fistule obstétricale Niamey (Niger) 19 et 20 avril 2005; Campagne pour éliminer les Fistules, UNFPA 2005.
- *Rapport de la réunion: Élaboration d'un cadre d'évaluation des résultats de la Campagne*; Groupe de travail chargé de l'évaluation et du suivi, Campagne pour

éliminer les fistules; Niamey (Niger) 21-22 avril 2005; Campagne pour éliminer les Fistules, UNFPA 2005.
- *Meeting Report: Developing a Results Framework for the Campaign*; Monitoring & Evaluation Working Group, 21-22 April 2005, Niamey, Niger; Campaign to End Fistula, UNFPA 2005.
- *Deuxième réunion du groupe de travail pour la prévention et le traitement de la fistule obstétricale*; Addis-Abeba 30 octobre-1 novembre 2002; UNFPA, New York, 2003.
- *The second Meeting of the Working Group for the Prevention and Treatment of Obstetric Fistula*; Addis-Ababa, 30 Oct – 1 Nov 2002; UNFPA, New York, 2003.
- *Report of the Africa Regional Fistula Meeting*; Accra, Ghana 29 June – 1 July 2004; UNFPA Campaign to End Fistula 2004.
- *Report on the 2nd Asian and Pacific Regional Workshop on Strengthening Fistula Elimination in the Context of Maternal Health*; 19-21 April 2006, Islamabad, Pakistan; UNFPA Campaign to End Fistula 2006.
- *The Campaign to End Fistula: Building Prevention and Treatment Capacity in Africa*; Campaign to End Fistula, UNFPA.
- *Global Programme Proposal: Making Motherhood Safer by Addressing Obstetric Fistula 2006 – 2010*; Campaign to End Fistula, UNFPA.
- *The Campaign to End Fistula: 2004 Annual Report*; Campaign to End Fistula, UNFPA.
- *The Campaign to End Fistula: 2005 Annual Report*; Campaign to End Fistula, UNFPA.
- *The Campaign to End Fistula: 2006 Annual Report*; Campaign to End Fistula, UNFPA.
- *The Campaign to End Fistula: 2007 Annual Report*; Campaign to End Fistula, UNFPA.
- *Meeting Report: Strengthening Partnership and Improving Collaboration*; Annual Meeting of the Obstetric Fistula Working Group; 13-14 April 2008 Accra, Ghana; Campaign to End Fistula, UNFPA.
- *The Campaign to End Fistula*: *Global Programme Proposal: Making Motherhood Safe by Addressing Obstetric Fistula*, 2006-2010, UNFPA.
- *The Campaign to End Fistula, Building Prevention and Treatment Capacity in Africa,* UNFPA.

Others

- FISTULA CARE, *Annual Report October 2007 – September 2008, Executive Summary*; EngenderHealth, USAID, Fistula Care, 2008.
- *USAID Fistula Program*, April 2008 (12 slides).
- *Report of Fistula Counselling Experts' Meeting*, March 29-30, 2005, Kampala, Uganda; The ACQUIRE Project/EngenderHealth, 2005.
- *Supporting efforts to end obstetric fistula*, Report of the Secretary-General; United Nations, General Assembly, August 2008.
- La fistule obstétricale; Rapport d'évaluation des besoins: Leçons tirées de neuf pays Africains; UNFPA, EngenderHealth 2003.
- Obstetric Fistula; Needs Assessment Report: Findings from Nine African Countries; UNFPA, EngenderHealth 2003.
- 2nd ISOFs Conference, 25th-27th November 2009, CD