Thematic Evaluation
Of National Programmes and UNFPA Experience in the Campaign to End Fistula
Draft Report Nigeria Country Assessment

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Special thanks also go to the participants of the debriefing meeting in Abuja on 5 June 2009 and the conference call on 16 June 2009, in which valuable comments were received for fine-tuning this report.

The Review Team

Reet, July 2009
## List of abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BEmOC</td>
<td>Basic Emergency Obstetric Care</td>
</tr>
<tr>
<td>BTS</td>
<td>Blood Transfusion services</td>
</tr>
<tr>
<td>CEmOC</td>
<td>Comprehensive Emergency Obstetric Care</td>
</tr>
<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
</tr>
<tr>
<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<tr>
<td>CP</td>
<td>UNFPA Country Programme</td>
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<tr>
<td>CO</td>
<td>UNFPA Country Office</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FCT</td>
<td>Federal Capital Territory</td>
</tr>
<tr>
<td>FMoH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>FMoWASD</td>
<td>Federal Ministry of Women Affairs and Social Development</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HERA</td>
<td>Health Research for Action</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIV / AIDS</td>
<td>Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HQ</td>
<td>UNFPA Headquarters</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment for Malaria</td>
</tr>
<tr>
<td>ICHR</td>
<td>International Centre for Reproductive Health</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MM</td>
<td>Maternal Mortality</td>
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</table>
Summary

Introduction

Although Nigeria has been taking measures to address reproductive health and maternal health problems, the implemented interventions have not yet reached optimum coverage to obtain the desired impact. For example, the maternal mortality ratio is, as estimated in 2005, 1,100 per 100,000 live births\(^1\); 35% of the births are attended by skilled health personnel; contraceptive prevalence rate is 15%; and coverage of essential obstetric care has been estimated at less than 20%.

Obstetric Fistula is one of the maternal morbidities. By its magnitude, Vesico-vaginal fistula (VVF) is a major public health problem in Nigeria; the situation being more evident in the Northern part of the country. Prevalence estimations range from as low as 100,000 to as much as 1,000,000 cases\(^2\). The incidence is estimated at probably 20,000 new cases a year. With approximately 2,000 - 4,000 fistula repair surgeries being carried out yearly, the problem is aggravating progressively. Nigeria counts for 40% of the worldwide fistula prevalence.

The existence of OF is strongly related to prevention of obstructed labour and access and utilisation of EmOC. Fistula efforts cannot be seen isolated from the efforts to improve RH and maternal health and to reduce maternal morbidity and mortality. There is therefore a need to fully integrate Fistula programming into the overall policies, strategies and interventions related to RH and particularly maternal health.

Key Findings

UNFPA’s involvement in Fistula in Nigeria is very relevant. Not only because OF is an important problem in the country - as indicated by its prevalence and incidence - but also because the presence of OF is linked to issues related to RH (i.e. family planning and EmOC) as well as gender, which are important components of UNFPA’s mandate. In spite of being an important problem in the country, OF is not yet a national priority, as indicated by OF not being integrated or even mentioned in key policy documents related to maternal health such as the Integrated Maternal Newborn and Child Health Strategy (2007), or the fact that in some states OF is not yet recognised as a problem or by the lack of specific budget allocations to fistula activities at Federal or state levels.

The CO made explicit that the Fistula Campaign funds were not going to be used to support activities related to direct prevention of fistula (i.e. EmOC), except where donor funds are explicitly received for that purpose as these activities are part and parcel of UNFPA’s mandate and as the country receives support for its implementation under the RH component of the UNFPA/Nigeria CP. This is a reasonable choice. The present situation in the country indicates that a lot of work still needs to be done in order to effectively prevent OF, therefore a need for UNFPA continued support in this area exists.

The Fistula Campaign has contributed to scaling-up fistula treatment services (though modest number of fistula repairs made) as well as to improving conditions for service provision and to training human resources for the provision of these services. The overall effectiveness of this support is reduced by its ad-hoc nature, its limited coverage and lack of integration in an overall well structured national programme.

Provision of rehabilitation services appears to be a weak link in the fistula management process. The Campaign provided support for pilot testing a community based rehabilitation approach in one LGA with good results. How this modality compares to other existing modalities\(^3\) for provision of rehabilitation services in the country needs further exploration in order to facilitate informed discussions on this issue and recommendations for decision making.

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\(^3\) For example, the facility based modality promoted by the MoWASD or linking the fistula repaired women directly to NGOs providing support to women empowerment.
The most important measure taken by the Fistula Campaign to secure efficiency in the use of resources, has been to work with existing facilities providing fistula treatment or rehabilitation services as well as coordinating with LGA to secure commitment and continuity of the activities after the Campaign support stops.

The advocacy and awareness raising activities supported by the Campaign brought renewed interest in fistula in the country as well as they brought fistula to the attention of high level officials in the country. Considerable investment is required in order to reduce the incidence and prevalence and eventually eliminate OF in the country. Therefore there is a need to continue advocating for adoption of specific policies and implementation of strategies and interventions to address fistula as an important component of reproductive health /maternal health policies and interventions.

The Fistula Campaign also facilitated awareness raising and interest in Fistula within UNFPA CO. For the 6th CP, fistula activities are being integrated in the RH component of the action plans of those states (five out of twelve) that have included fistula activities in their respective plans. Fistula efforts compete for resources with other priorities within RH; the challenge ahead is to secure that an adequate response is provided in those states that have included fistula as a priority.

The sustainability of Fistula Campaign efforts has to be seen in the light of the overall sustainability of the Fistula efforts in the country. A number of factors are currently a threat to sustainable Fistula efforts in the country. The present financial support (federal or state) for fistula activities does not secure the continuous or optimal operation of the existing treatment facilities, newly built or planned new ones. Important barriers for access and utilisation of services are payment for treatment, transport or other costs. Therefore there is a need to secure policies and actions to effectively remove these barriers. Securing the availability of human resources in quantity and skills to provide care (prevention, treatment and social support) is also a challenge. Of great importance is to make sure that those members of staff that have been trained (surgeons, nurses) are engaged in provision of services. Equally important is to secure that in-country training can continue to be performed in the country, most likely with the formation of a Master training. The strengthening of institutional capacities at federal and state level for planning fistula care as well as monitoring and follow-up of the progress made with the implementation of strategies and interventions is also critical to sustainability.

The evaluation team recommends:

A. Opportunities for Strengthening the UNFPA’s CO engagement on Fistula in Nigeria

1. Move from ad-hoc support to a more systematic and programmatic approach. Important issues to address as part of this approach include the review and approval of the draft National Strategic Framework and Plan for VVF eradication in Nigeria and its corresponding dissemination and implementation plan. Ideally all activities supported by UNFPA should be in line with and complementary to the implementation of this National Strategic Framework.

2. Balance efforts in OF prevention, treatment and rehabilitation. The proper balance between these interventions should be found, but it is necessary to dedicate efforts to all them. In Nigeria, with the existing levels of prevalence and incidence, scaling-up of efforts in both prevention and treatment services is a must.

3. Support for strengthening the national capacities for fistula programming at both federal and state level. The evaluation revealed some of the weaknesses of the existing fistula programming capacities both at federal and state level. Key areas in need of strengthening are planning, availability of evidence for deciding on priorities, proposition of priority interventions and strategies to implement, advocacy for allocation of resources for fistula, monitoring and evaluation of fistula activities, budgeting and costing of fistula interventions, and integration of fistula issues into major RH and maternal health policies and strategies.

4. Address issues that need attention in the short-term. The evaluation team identified three issues that need attention in the short term, where the technical support from UNFPA can be valuable: a) definition and implementation of a human resources development strategy; b) setting in place of information systems and c) support the national authorities in the definition of service level provision for OF. All these issues have immediate implications for on-going and future investments.
5. Support the Federal Government in **advocating for integration of fistula policies, strategies and interventions into major RH and maternal health policy documents as well as in** its effort for **mobilising financial resources for fistula**. Fistula interventions compete for resources with a number of RH and maternal health interventions. There are a number of possible venues in the country, where additional national resources for fistula could be found if it is advocated and if it is part of the maternal health package of interventions, for example the debt relief funds or as part of strengthening the provision of secondary level services.

6. **Support and document the experience of Ebonyi State.** A number of conditions are currently present in this State to facilitate the implementation of an integrated approach to fistula care, which could potentially serve as a best practice to share with other states. The State is requesting support from development partners for the implementation of this approach. Potential areas where UNFPA could contribute could be: support to secure that adequate coverage with interventions is reached, strengthening of the information system, assist the State in formulating a plan to secure the continued operation of the newly built Regional South East Treatment Centre as well as its possible operation as a training and research centre. Systematising and documenting this experience is another potential area of work.

**B. General recommendations to UNFPA**

1. **Monitor the integration of Fistula activities into the existing RH component of the UNFPA / Nigeria CP.** For the implementation of the 6th CP, the UNFPA CO intends to put into practice a more integrated approach to implement the RH component. Fistula activities are included as part of this component. As this is a new approach, it is advisable to monitor closely how this integration evolves and to secure that fistula activities are given adequate consideration as well as resources. It is also advisable that fistula activities utilise as much as possible the programme management mechanisms of other components (i.e. planning and reporting).

2. **Improve coordination between the CO - RO and plan for technical assistance from RO.** Up to now the CO has made no use of the potential for technical assistance to be provided by the RO. The CO needs to be informed on how they can best make use of the RO in support of the national efforts. The CO should also be informed on how the UNFPA regionalisation process will affect the provision of assistance from the RO to the CO. Equally important is that a regular flow of information from the CO to the RO is secured, to be able to identify potential areas of support. It is advisable that the required assistance from the RO be included in the annual plans.

The assessment of the Fistula Campaign activities in Nigeria revealed important areas where technical support and guidance from RO and HQ might be necessary. For example, design and implementation of adequate mechanisms for M&E of fistula activities as well as quality control mechanisms for treatment services at country level.
1. Introduction

1.1 The UNFPA 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 industrialized world. The target date for fistula elimination is 2015, in line with MDG targets to improve maternal health. A global thematic proposal for the Campaign to End Fistula was submitted to major donors in autumn 2003 for the period of 2004-2006. Country needs have grown more rapidly than anticipated, so the initial period was closed in late 2005 and a new proposal submitted to donors for the period 2006-2010. Therefore, the Campaign is now at late mid-term of the current period (2006-2010).

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

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

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

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

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

To evaluate the National Programmes component of the Campaign to End Fistula the evaluation will focus 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 (including a field visit to each country). Additionally, a focused desk-review of another four countries will also be performed.

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4 Source: [http://www.endfistula.org/campaign_brief.htm](http://www.endfistula.org/campaign_brief.htm) (consulted on June 9, 2009)
5 In this context, the singular form “fistula” is used to denote the plural as well as the singular.
Nigeria was selected as one of the countries for in-depth assessment. This report presents the results of this assessment.

### 1.2 Purpose and objectives of the thematic evaluation

As indicated in the Terms of Reference (TOR, 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 learned.

### 1.3 Methods

The Nigeria in-depth assessment was carried out over the period May 21st to June 4th 2009. The assessment is based on the review and analysis of available documents, reports and data on the Campaign and on related issues and information gathered during a field visit to the country. While in the country the evaluation team met with UNFPA staff at the country office CO and Africa Regional Office in Dakar. The team had also interviews with Government officials at Federal, State and Local Government Area (LGA) level (Ministry of Health (MoH), Ministry of Women Affairs and Social Development (MoWASD)) and with UN partners as well as with representatives of other agencies involved in fistula management and care (EngenderHealth, Rotary International, Red Cross). The team visited the Federal Capital Territory (FCT) as well as Kano, Katsina and Ebonyi State. In these states and FCT, the team met with service providers, community mobilisers, and fistula clients. Additionally, the team visited fistula treatment facilities, fistula rehabilitation facilities, a maternal and child (MCH) facility, and maternity departments in two specialist hospitals. A site visit was made to the community based fistula project in Kankara LGA. The list of persons met and the work-programme are included as Annex 2 and 3 respectively.

The field visit to the country concluded with a working session with staff from the UNFPA CO to present and discuss the preliminary findings and recommendations of the assessment. These were also discussed in a conference call with staff from UNFPA HQ and ARO.
2. Background

2.1 Country Context

Nigeria has a population of 149 million (July 2009 estimate) and a population growth rate of 1.99%. The life expectancy at birth is for females 47.7 years and for males 46.1 years (2009 estimate). Nigeria is a federation of 36 states and 1 Federal Capital Territory. Below state level there are 774 local government areas.

Nigeria’s economy heavily depends on the oil and gas sector, which contributes 99 percent of export revenues, 85 percent of government revenues, but recently only about 18 percent of gross domestic product (GDP) as oil output has declined due to unrest in the Niger Delta region. The agricultural sector now dominates economic growth, contributing 42 percent of GDP in 2008. With its large reserves of human and natural resources, Nigeria has the potential to build a prosperous economy, reduce poverty significantly, and provide the health, education, and infrastructure services its population needs. Despite the country’s relative oil wealth, GDP per capita is about USD 1,418 (2008), and poverty is widespread. A worsening trend of the poverty situation is observed over the last decade as shown in the table below: percentage of the population living below the poverty line of less than 1 dollar/day.

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
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<th>2006</th>
<th>2007</th>
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<td>%</td>
<td>34.1</td>
<td>45</td>
<td>45</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: [http://indexmundi.com/g/g.aspx?c=ni&v=69](http://indexmundi.com/g/g.aspx?c=ni&v=69), consulted on June 13, 2009

The maternal mortality ratio is very high and is estimated in 2005 at 1,100 per 100,000 live births. Figures based on the results of the 1999 Multiple Indicators Cluster Survey (MICS) show a wide variation in the MMR from 166 per 100,000 live births in the South West to 1,549 per 100,000 live births in the North East, with a national average of 704 maternal deaths per 100,000 live births (2009 estimate). The infant mortality rate is 94.3 deaths per 1,000 live births (2009 estimate). Studies show that Nigeria may have one of the highest fistula prevalence rates in Africa. An estimated 400,000 to 800,000 Nigerian women are living with fistula, with 20,000 new cases added each year. The underlying causes of the foregoing include: early age at first marriage, early child bearing, low contraceptive prevalence rate (13%) and inadequate coverage of maternal health services particularly Emergency Obstetric Care (births attended by skilled health personnel: 35%). See also sections 4.2.3 and 4.2.4 for more details on these issues.


8 [http://indexmundi.com/g/g.aspx?c=ni&v=69](http://indexmundi.com/g/g.aspx?c=ni&v=69); consulted June 13th 2009.


The 1999 Constitution of Nigeria prohibits discrimination on the grounds of gender, but customary and religious laws continue to restrict women’s rights. As Nigeria is a federal republic, each state has the authority to draft its own legislation. The combination of federation and a tripartite system of civil, customary and religious law makes it very difficult to harmonise legislation and remove discriminatory measures. Moreover, certain states in the north follow Islamic Sharia law, which reinforces customs that are unfavourable to women.14

The estimated adult HIV prevalence rate (aged 15-49), 2007 in Nigeria is 3.1%.15

Health service structure and provision

All three levels of government, the Federal, State and Local Government Areas (LGAs), have responsibilities for the provision of health care. The Federal government sets overall policy goals, coordinates activities, ensures quality and training implements sector programmes such as immunization and coordinates the affairs of the university teaching hospitals, while the state government manages the various general hospitals and the local government focus on PHC facilities. The 36 States and 774 LGA are responsible for all financial aspects of Secondary Health Care (SHC) and Primary Health Care (PHC) departments, including personnel costs, consumables, running costs and capital investment. The coordination of activities between the three levels is generally poor. The National Primary Health Care Development Agency provides a source of technical knowledge and expertise on the provision of PHC and monitors PHC delivery on behalf of the Federal Ministry of Health. Capacity to undertake this is limited.

Public PHC services are funded and administered by the state MoHs, which provide technical assistance to the LGAs under the PHC Director in the State MoH. PHC services are the direct responsibility of LGAs whilst SHC services come under the State Hospital Management Board (HMB). However, there are very few links between the two. As a result, the referral system is weak and undeveloped.

Hospitals are providing virtually no support or technical supervision of services provided by PHC facilities, and there are no outreach clinics or visits by hospital staff. In addition, the relative independence of States means that pursuing consistent national policies across the country is problematic.

Many of the health problems that the country faces could be reduced through improvements at the primary care level, but there are many constraints. Inadequate financial resources for the health sector are a major problem resulting in a scarcity of drugs and medical supplies, and the deterioration of facilities.

Each LGA employs a primary care coordinator but communication and coordination between different service levels are poorly developed and data for planning purposes and management are sparse. Available resources are often not employed in a cost-effective manner where they would bring the highest benefit.

In addition, health care is available from private and voluntary/mission sectors. The private sector and the traditional medicine settings are very important and jointly account for 60-80% service provision. There is little regulation and standardisation of services.

14 http://genderindex.org/country/nigeria SIGI Social Institutions & Gender Index (consulted on May 8, 2009)

One of the main reasons for the very low utilisation rates for public sector clinics has been the poor standard of facilities and care. User fees are also perceived as too high. In theory there should be some accountability of public facilities to the community through village development committees, and a range of systems at hospital level. In practice however, these rarely function effectively.\textsuperscript{16}

The Public Health expenditure in Nigeria is 1.4\% of the GDP.\textsuperscript{17}

### 2.2 UNFPA 5\textsuperscript{th} Nigeria Country Programme

Fistula management and care was part of the UNFPA fifth Nigeria Country Programme (CP) 2003-2007\textsuperscript{18}. It was included within the Reproductive Health (RH) sub-programme, as part of the first output “to increase the availability of a minimum package of high quality RH services”

The UNFPA fifth Nigeria Country Programme 2003-2007 was implemented in 240 Local Government Areas in fifteen states of the federation, covering about one-third of the country’s population\textsuperscript{19,20}.

In the area of reproductive health, the 5\textsuperscript{th} CP’s achievements include\textsuperscript{14}:

- facilitated and/or developed critical policies and strategic plans; these included the National Integrated Maternal, Neonatal and Child Health Strategy, National Adolescent Reproductive Health Policy, National Condom Intervention Strategy, Reproductive Health Commodity Security Strategic Framework and operational plan, State Strategic Plans on HIV/AIDS and National Strategic Framework and a Plan for the Eradication of Obstetric Fistula. Several policies and legislation at state level that contribute to the enhancement of the quality of life of the citizenry were also facilitated in the 15 states, in particular the delivery of free maternal health care services in 5 states;
- conducted a Fistula Fortnight in four states of Katsina, Kano, Sokoto and Kebbi, where about 594 fistula clients were repaired. Equally supported Ebonyi State in its conduct of a Fistula Fortnight where about 400 patients were repaired;
- strengthened technical and managerial capacity of 3,149 national partners;
- supplied contraceptive commodities to 5,000 service delivery centres in the public health care sector; and
- provided basic reproductive health equipment to 2,500 primary and 225 secondary health centres in 15 assisted states.

In gender, the achievements were\textsuperscript{14}:

- supported the formulation of the National Gender Policy;
- advocated for and supported the passage of bills on the prohibition of harmful widowhood rites, female genital cutting and violence against women; and


\textsuperscript{18} In order to align the 6\textsuperscript{th} Country Programme with the UNDAF Programme cycle, the 5\textsuperscript{th} CP was extended to 2008 as a bridging period.


\textsuperscript{20} 15 states assisted by UNFPA 5\textsuperscript{th} CP; Abia, Anambra, Bauchi, Borno, Delta, Edo, Gombe, Katsina, Kebbi, Nassarawa, Ogun, Osun, Plateau, Rivers, Sokoto.
established partnerships with stakeholders to build their capacity as Gender equality advocates.

The implementation of the fifth CP had several challenges which include:

- weak programme management procedures and coordination mechanisms;
- ineffective policy implementation and follow up at all levels; and
- weak health system and inadequate health personnel, especially midwives.

### 2.3 UNFPA 6th Nigeria Country Programme

The context of the UNFPA 6th Country Programme is guided by the findings and recommendations of the fifth country programme thematic and final evaluations, the UNFPA priority areas in the Strategic Plan 2008-2011 and the Maputo plan of action. The programme is aligned with ICPD Programme of Action, Millennium Development Goals, the United Nations Development Assistance Framework priority themes for the 2009-2012 programme cycle and national priorities as set in the Federal and State Economic, Empowerment and Development Strategies. The programme will be implemented at the Federal level and in 12 states, selected on the basis of socio-demographic indicators and geographic spread. At the federal level, the focus will be on policies and advocacy, while state programmes will address specific Population, Reproductive Health and Gender needs.

The **reproductive health component** has two outcomes and four outputs. The outcomes are: (a) Federal, and 12 States’ institutions, and sectors able to plan, implement and monitor the delivery of quality Reproductive Health/Family Planning and HIV Prevention services by 2012; and (b) Communities in 12 supported States are able to demand for and use quality reproductive health/FP and HIV prevention services.

Output 3 of the RH component: ‘Increased gender sensitive and culturally appropriate quality maternal health services including Emergency obstetric and neonatal care in 360 public and private facilities in 12 supported States’ is more specified in the CPAP and includes a fistula component. One of the strategies and key activities under this output 3 is described as ‘Strengthening institutional and technical capacity of states/Local Government Areas Health Departments and health facilities to provide a package of quality services’ and includes the following specification:

> The programme will continue to support the prevention, treatment and rehabilitation of obstetric fistula as part of the campaign to eliminate this maternal morbidity in the context of maternal health services. The focus will be on strengthening the national capacity to coordinate the implementation of the national VVF strategic framework at both federal and state levels, as well as support capacity building for providers in the management and rehabilitation of obstetric fistula clients in affected states. Support will also be provided to States to promote the decentralization of treatment and rehabilitation to existing general hospitals, while also supporting social re-integration services.’

The **Population and Development component** has two outcomes and three outputs. The outcomes are: (a) by 2012, federal and 12 supported states’ institutions are able to generate,

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22 The 12 focus states are: Borno, Adamawa, Kebbi, Sokoto, Kaduna, Benue, Abia, Imo, Ebonyi, Akwa Ibom, Lagos, Ogun and the Federal Capital Territory (FCT), Abuja. Six of these twelve States and FCT serve as UNDAF states, in which the entire UN system in Nigeria will deliver interventions as “one”. They are Adamawa, Kaduna, Benue, Imo, Akwa Ibom and Lagos in addition to FCT.
manage, disseminate and use gender disaggregated data on Population, Reproductive Health, and Youth; and (b) by 2012, Population Dynamics, Gender Equality, Sexual and Reproductive Health, HIV/AIDS and Young people issues are incorporated in development policies, poverty reduction plans and expenditure frameworks.

The gender component has one outcome and two outputs. The outcome is: by 2012, an enabling environment for gender equality, equity and women empowerment exists.

The budget for the programme is USD 64.2 millions. USD 29.2 million (45%) from UNFPA regular resources and USD 35 million from other sources (55%). The proposed resources for reproductive health and rights activities represent 57% of the total budget.

3. Obstetric Fistula in Nigeria

The current situation

By its magnitude, Vesico-vaginal fistula (VVF) is a major public health problem in Nigeria, the situation being more evident in the Northern part of the country. Prevalence estimations range from as low as 100,000 to as much as 1,000,000 cases. Most of the authors quote 400,000 - 800,000 whereas Dr. Kees Waaldijk states firmly that the backlog is 200,000 to maximum 250,000 patients. The incidence is estimated at probably 20,000 new cases a year. With approximately 2,000 - 4,000 fistula repair surgeries being carried out yearly, the problem is aggravating progressively. For the first time, the 2008 Nigeria Demographic Health Survey (NDHS) collected data on fistula. It is expected that this survey will provide a clearer picture on the fistula situation in the country. These data were not available at the time of our visit. Nigeria counts for 40% of the worldwide fistula prevalence.

The vast majority of VVF is caused by obstructed labour but also gishiri cut, obstetrical trauma and iatrogenic interventions might result in a VVF. Obstructed labour is a consequence of cephalo-pelvic disproportion and/or malposition of the foetal head and when delivery is postponed and delayed, ischemic necrosis of vagina and adjacent bladder and urethra ends in an opening of bladder into the vagina.

A multitude of inter-linked risk factors acting negatively and simultaneously towards fistula proneness seem to exist, being more pronounced in the Northern part of Nigeria:

- Poor socio-economic environment and abject poverty

24 Gishiri cut is ranged among the harmful traditional practices: cutting the vaginal wall causes bleeding which is supposed to heal gynaecological illness. When the cut goes too deep, the bladder and/or urethra might be opened.
25 The four delays: delayed diagnosis of obstructed labour, delayed decision on referral, delayed transportation to appropriate facility, delayed treatment in facility.
- Low education and literacy, especially of women
- Low status of women
- Harmful traditional believes and practices such as gishiri cut and FGM
- Seclusion and limited access to medical care
- Early marriage, early pregnancy, short stature
- Immature development of pelvic structure and therefore obstructed labour
- Malnutrition
- Weak health system, poor quality of and lack of access to maternal health services: antenatal controls, infrastructure, equipment, drugs and consumables; mal-distribution of trained staff; low caesarean section rate (1%); low presence (18.5% of 4,500 health facilities) and utilization (4.2%) of EmOC; poor inter-personal relations and failure to run shifts; 5.6% of federal budget for health care, insufficient number of skilled birth attendants, delays and late referrals.
- Long distances to health facilities
- Preference of home delivery with TBA performing approximately up to 60% of all deliveries
- Resistance to operative delivery
- Gender inequity in decision making
- Low use of contraceptive methods and high fertility rate (fertility is highly valued and women’s status determined by reproductive capacity)

Indirect factors may also contribute to the phenomenon such as declining economy, a corrupt system and an inefficient political culture.

**Story of one OF patient in Nigeria**

She lives in the Northern part of Nigeria, in a rural area, is poor, illiterate, married at young age, not allowed to leave her home without her husband’s consent, has an early pregnancy without control of a skilled birth attendant, is delivering at home with the TBA, far away of the health centre, pushing for several days and delivers finally a dead newborn. Her family helps her to collect the money for travel and care and it takes several months before she can go to the VVF centre, where she stays for almost 2 months. She has a fair chance to rejoin her husband and family, brings some knowledge and skills with her which guarantee a small income and a little independency. She now dares to dispute issues with husband and mother-in-law when she disagrees about some decisions to make.

**Direct prevention** of OF is achieved by early diagnosis of obstructed labour by trained and skilled birth attendants and universal use of the partograph followed by timely provision of emergency obstetric care and delivery by caesarean section or other obstetric interventions. These are all interventions and services poorly provided in Nigeria. Indirect preventive measures lead to high maternal mortality and morbidity rates, and to social and economic costs. The Abuja Declaration (2001) aim is to spend 15% of the national budget for health.

The Abuja Declaration (2001) aim is to spend 15% of the national budget for health

The pictures is taken and published with explicit consent.
measures for OF cover more the social determinants of health such as alleviation of poverty, better education, improving women status and improving health services delivery by structural changes in the defective health systems.

**OF repair activities in Nigeria**

Nigeria has a long-standing history of fistula repair: Dr. Lawson in Ibadan and Drs. Murphy and Harrison in Zaria. Dr. Sr. Ann Ward was Consultant Obstetrician and Gynaecologist and fistula expert and trainer at St. Luke's Hospital, Anua, Akwa Ibom State. She recently retired after a 40 year career. She also was in charge of the vesico-vaginal fistula treatment at nearby Itam. For a long time, these were a few islands of fistula repair services in an ocean of needs.

The acceleration of interventions and large scale activities started with the arrival in Katsina in 1983 of Dr Kees Waaldijk, a plastic surgeon from the Netherlands. He came primarily to repair the leprosy patients but quickly devoted his energy exclusively to fistula repair and training. In the early nineties the National Foundation on VVF was created with Dr. Kees as the leading surgeon. Finally, with the start of the Campaign to End Fistula, fistula repair in Nigeria came again in a higher gear. An extra boost for advocacy as well as repair was given through an event that still is the referral activity: the organization of the Fistula Fortnight in 4 Northern States in 2005.

Presently there are approximately 20 centres providing VVF treatment on regular basis in the country. According to Dr. Kees Waaldijk, 11 of these centres are part of the National VVF Project. Dr Kees reports in 2008 that the National VVF Project has performed a total 25,000 VVF/RVF repairs and related interventions since its inception. In his Fistula Fortnight report on the other hand, he stipulates that the 14 “VVF master surgeons” totalise roughly 27,800 repairs in 2005, he himself taking 15,000 interventions, all recorded painstakingly in the smallest details with up to 256 indicators and parameters.

The exact number of fistula repairs carried out annually in Nigeria is not known. Most VVF treatment centres collect information on the number of interventions carried out, but recording and reporting is incomplete and non-systematic. A centralised recording and reporting system is not in place either. It is estimated that approximately some 2,000 - 4,000 fistula repairs are done every year. Annex 5 presents a table summarising the findings of the evaluation team on fistula treatments carried out in the period 2004-2008 in 20 facilities. The table below shows that in almost 20 years the number of fistula surgical interventions carried out annually in the country has quadrupled. From one thousand cases treated in 1990 to approximately 4,000 cases treated yearly since 2005.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>1,000</td>
<td>National Foundation on VVF, 2003</td>
</tr>
<tr>
<td>2003</td>
<td>2,500</td>
<td>UNFPA, Nigeria, 2003</td>
</tr>
<tr>
<td>2005</td>
<td>4,146</td>
<td>Training meeting, Niamey, 2005</td>
</tr>
<tr>
<td>2008</td>
<td>4,000</td>
<td>Dr Kees Waaldijk (personal communication)</td>
</tr>
</tbody>
</table>

At the current pace of repairs, fistula will not be eradicated in Nigeria in the near future. On the contrary, every year the backlog increases or, at best, remains as high as it is (see Annex 8, for modelling, scenarios and estimations of OF evolution in Nigeria)\(^{30}\).

Why do the thousands of women not have their fistula repaired? Access to VVF repair services is the key and should increase by 300% from the current level as the Draft National Strategic Framework and Plan for VVF eradication 2005 – 2010 states, or by 500% as suggested in the scenarios calculated by the evaluation team. How to do this is clearly described in the same plan: dedicated VVF centres, well equipped, competent staff and free services. The implementation of this 5 year plan costs 133 million dollars. It has remained as a draft since its elaboration 4 years ago and there has been limited progress in its implementation.

**Functional VVF centres**

The 2002 Nigeria Obstetric Fistula Needs Assessment Report describes in detail 12 health facilities performing fistula surgeries: 7 teaching hospitals and 5 VVF centres. The teaching institutions with tens of trained OB/GYN doctors and even more residents carrying out less than 200 interventions per year whereas a limited number of surgeons in the 5 specialised centres performed 1,365 interventions in 12 months. If the number of interventions is so low (in average 6 repairs/year)\(^{31}\) one can wonder if quality of care can be maintained by the 25 surgeons performing fistula surgeries in teaching hospitals. Patients have to pay for the cost of fistula treatment at teaching hospitals, which reduces significantly the demand for this service.

From visits, reports and phone interviews we learnt that currently at least 20 health facilities (VVF centres, hospitals at Federal or State or LG level or private and faith-based institutions, teaching hospitals) are, or potentially are sites for OF repair (see annex 5). Nine of these are dedicated centres for the treatment of patients with fistula.

Non-availability of and/or inadequate facilities have been identified as a major impediment to provision of effective services for the management and rehabilitation of VVF patients. The evaluation team was informed of two modalities for the organisation of treatment services. One is through VVF Centres dedicated only to the treatment of fistula patients. Usually they are located in the premises of a specialist hospital. The specialist hospital provides the staff, equipment, consumables, drugs and other operational costs (though not regularly and in insufficient quantities). These centres have their own operation theatre, pre-post-operative wards and provide services all year round. In most cases fistula repairs are free and the waiting list for patients is sometimes considerable. This was the case in the centres visited in Kano and Katsina.

The other modality is mostly seen in Teaching Hospitals, where there could be or not a specific fistula ward. If there is no specific fistula ward, the patients are admitted to the gynaecology ward; there is no independent operation theatre. The fistula patients compete with other surgical priorities in order to get access to the theatre. As fistula is not considered an emergency, fistula patients are not a priority. Even if there is a fistula surgeon, fistula treatment is not offered all year round. The demand for services in these facilities is low, mainly due to the charging of hospital fees. This was somewhat the situation in the teaching hospital in Abakaliki before the construction of the new VVF centre. In the teaching hospital of Abakaliki, the tenacity and commitment of Dr. Sunday Adeoye has made possible that fistula repairs have been offered there for years (he has been mobilising additional resources for consumables, drugs, etc). The new facility constructed in Abakaliki with the

\(^{30}\) These scenarios point out the need to substantially increase (500%) the number of fistula repairs done every year if the country will both take care of the backlog of existing cases and of new cases.

support of the Office of the Ebonyi State Governor’s wife provides a new situation. This will be a dedicated fistula Centre. The new Centre is not operating on continuous basis yet, due to lack of staff and possibilities to cover operational cost. Therefore it is operating now with the organisation of tentatively four to five treatment campaigns per year (though resources have to be mobilised for each campaign). Discussions are on-going (between the federal and state government) with regard to securing the necessary funds for a continuous operation of the centre.

It is not clear what the best location is to perform repairs: in existing district hospitals, in teaching hospitals or in specialized centres. Both approaches have advantages and disadvantages. Some experts argue that there is no simple fistula, others advise that simple fistula can be repaired by less experienced surgeons and opt consequently for a technical-hierarchical approach in repair skills and experience. Conditions to be fulfilled include: funding secured, experienced fistula surgeon, the adequate nursing staff, operations assured (time and commodities/supplies). The draft National Strategic Framework and plan for VVF eradication in Nigeria 2005-2010 proposes the following infrastructure development: one teaching hospital per geopolitical zone strengthened to have one dedicated and equipped theatre and ward (6 in total), establishment of one VVF treatment centre per state (36 in total) and one additional centre in each state in North West and North East Zones as well as in Ebonyi and Akwa Ibom States and strengthen 3 VVF centres to serve as referral centres for complicated VVF cases.

There is a tendency in the country to build fistula treatment centres, either just for treatment or for use as treatment and training centres. The linkages with others levels of care and services are not always clear. One centre was recently built in Abakaliki, Ebonyi State (has initiated operations on non-continuous basis due to lack of staff and secure funding to continue operating). Additionally, the federal government is planning to build a brand new national centre for fistula repair and training in Abuja, thanks to a grant provided by the Japanese Human Security Trust Fund through UNFPA. Although the creation of such a centre in Nigeria is very understandable for various reasons, one can wonder whether it would not be more efficient to better support existing well-functioning training centres than to create from scratch a new centre where access, client load and provider’s motivation will remain compromising factors of successful functioning. How these initiatives fit into the overall proposed development is not clear yet. Due to the competing priorities in the country as well as the limited resources available (human and financial) it seems rather urgent that the country defines a service level strategy for the provision of fistula care and management by levels of care (primary, secondary and tertiary level) and its corresponding development.

**Trained staff for fistula surgery**

Dr Ann Ward and Dr Kees Waaldijk, besides their clinical work, spent time and energy in training local physicians and nurses as well as interested staff from abroad. Up to now, the National VVF Project Nigeria has organized 15 Workshops and trained 315 general doctors and consultants, 236 pre- and post-operative nurses, 71 operation theatre nurses, 15 anaesthesia nurses, 23 other persons. The North West Zone centres regularly visited by Dr Kees Waaldijk constitute a conglomerated training centre of world fame, only comparable with the Addis Ababa fistula clinic created by Reginald and Catherine Hamlin. Through the

33 A workshop is a maximum 2-week activity used for both training of a fistula team, treatment of fistula patients, advocacy and publicity for fistula. Approximately 25-30 fistula patients per week are treated. The objectives of a workshop are: to operate a large number of patients within a short time, to demonstrate the state of the art operation techniques, to give high-quality lectures, to tackle specific problems (stress incontinence, urinary diversion), to promote spinal anaesthesia, to initiate doctors with low experience, to further train doctors with experience on an advanced level, to train nurses at all levels, to start a VVF service in a certain area.
implementation of the National VVF fistula project Nigeria, Dr. Waaldijk has been able to
develop training curricula for doctors and nurses as well as training modules for fistula
surgeons. The training is very much individual and advocates for the training of a fistula
management team made of a doctor, an operation theatre nurse, an anaesthesia nurse and
two pre-post-operative nurses. For the training of doctors without or with low experience in
fistula surgery a period of 1.5-2 months is sufficient if there are enough patients to operate
upon during the training (this is why the training is sometimes associated to workshops);
after 50-100 personal repairs, the trainee comes back for an additional 1 month training. For
nurses and other health personnel a period of one month is sufficient if enough patients are
available. For those that will become future trainers, an initial training period of 1 month,
followed by a 2-4 weeks training after 6 months and if necessary another 2-4 weeks training
again after 6 months. A personal experience of at least 200-300 fistula repairs and
willingness to become a full-time fistula surgeon are suggested requirements for future
trainers.

Less known but not less important is the Anua training centre where Dr. Sr. Ann Ward has
successfully treated at Itam VVF Centre in south-east Nigeria more than 3,000 women
suffering from fistula by the year 1997\textsuperscript{34}. Sr. Ann has received universal recognition for her
40 years of work as OB/GYN and fistula surgeon and trainer. In 1997, she received an
Award of Merit by the International Federation of Obstetricians & Gynaecologists. The
following year she was honoured by her peers at University College Dublin who nominated
her for their 1998’s Distinguished Graduate Award.

Unfortunately, only a limited number of the trained local fistula surgeons are still practicing
fistula repair for various reasons. Either they are working in health facilities where admission
fees are a prohibitive barrier for access for the poor women (therefore only very few fistula
surgeries performed if any) or they are working in places where no fistula surgeries are
offered. In other cases, those trained have moved on to administrative posts. Other reasons
include: trained fistula surgeons do not want to dedicate 100\% of their time only to perform
fistula repairs and are not motivated to continue with a career in fistula surgery as it is not as
lucrative as other specialties (fistula patients cannot pay much in their private clinics),
performing fistula surgeries is seen as an additional task and not part of the routine tasks.
Sometimes, doctors trained as fistula surgeons find themselves in other departments of
teaching hospitals, where only gynaecologists are allowed to perform fistula surgeries.

Doctors, especially gynaecologists, trained in OF repair during the residency period are
concentrated in teaching hospitals where the introduction of cost recovery has blocked
almost completely access for the poor. The students have little exposure to patients due to
the limited number of patients that come for fistula repair surgery to teaching hospitals.
Training of more gynaecologists-obstetricians during residency needs to go along with
access enhancing policies in the centres where they practice.

Great challenges for fistula programming in Nigeria are to secure that trained staff continues
working on the provision of fistula treatment and care and to secure that training of the
necessary staff for fistula treatment and care can be done in-country. Up to now most of the
training has been carried out by Dr. Kees and Dr. Ward. She has retired now and Dr. Kees,
although still very active, is not so young anymore. The Fistula Care project is currently
supporting the training of two Master trainers who could eventually undertake responsibility
for training of staff. Nigeria counts at least 13 highly experienced fistula surgeons who have
performed each between 150 and 3,000 interventions (median 1,000). They could all
potentially become also Master trainers.

\textsuperscript{34} Information on Dr. Sr. Ann Ward’s contributions: information consulted July 8\textsuperscript{th}, 2009:
http://www.mmmworldwide.org/index.php?article=International_Award_for_Sister-
doctor_Ann_Ward_in_pioneering_cure_of_Vesico_Vaginal_Fistula
There are no mechanisms in place in the country to maintain quality of skills for fistula surgery and knowledge by continuous medical education sessions, by supervision visits by the expert-trainers, by conferences and meetings or by a recertification and/or re-licensing system.

**Obstetric fistula tourism**

The fistula issue appeals to compassion\(^{35}\). Many doctors abroad are willing to contribute time and money to come and operate fistula, although not experienced in fistula repair as it doesn’t happen anymore in developed countries with universal and timely access to health facilities with skilled staff. That this “fistula tourism” can be harmful is shown by the multiple repair failures during a fistula repair campaign in Sokoto, 1997 (Kees Waaldijk). Regulations, visa entry, work permit are all potential means to limit the non-professional treatment of fistula.

**Organisations involved in fistula activities in Nigeria**

Over the years several organisations have joined the group of OF stakeholders and played a more or less important role in fund raising, organisation, advocacy and policy, treatment and rehabilitation services and other related topics. The following can be mentioned among the most important and visible ones presently active in Nigeria: UNFPA, USAID through ACQUIRE and Fistula Care project, Virgin Unite, Rotary International.

### 4. Main Findings

#### 4.1 UNFPA’s / Nigeria Campaign to End Fistula

The Campaign to End Fistula in Nigeria started with the Country Needs Assessment in 2003\(^ {36} \) and was followed by the initiation of country fistula activities in 2005 (in the middle of the implementation of the 5\(^{th}\) CP). This hindered the integration of fistula activities into the Annual Work Plans (at federal and/or state levels) and resulted in the implementation of fistula activities as a vertical project, in parallel to and not integrated with other UNFPA activities at various levels.

The Campaign supported activities at federal level, as well as in six of the 15 UNFPA’s 5\(^{th}\) CP assisted states and five in non-UNFPA assisted states (see table 3). The Campaign focused its activities primarily in northern Nigeria, although in 2008 activities in Ebonyi State in the South East part of the country were also supported by the Campaign.

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\(^{36}\) Nigeria was one of the nine countries included in the Nine Countries Needs Assessment Study carried out by UNFPA and Engender Health.
Table 3  STATES ASSISTED BY THE UNFPA 5th CP AND BY THE UNFPA CAMPAIGN TO END FISTULA

<table>
<thead>
<tr>
<th>States</th>
<th>15 States supported by the UNFPA 5th Nigeria CP (2003-2007)</th>
<th>States supported by the UNFPA Nigeria Campaign to End Fistula between 2005 and 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abia</td>
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<tr>
<td>Anambra</td>
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<td>Katsina</td>
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<td>Zamfara</td>
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At state level the Campaign has mostly been responding to ad-hoc requests from State Ministries of Health and/or the State MoWASD. At Federal level the main implementing partner has been the Federal Ministry of Health (FMoH). The Campaign also collaborated with the Office of the First Lady.

The following activities have been supported by the UNFPA Campaign to End Fistula in the country:

- Advocacy and awareness raising;
- Purchase equipment and consumables for 12 Fistula Treatment Centres;
- Facilitating and financing access to fistula repair for a number of women;
- Pilot testing of strategies for community sensitisation, awareness raising and community mobilisation and for the reintegration of fistula patients into their communities;
- Implementation of a ‘Fistula Fortnight’ (a two-week advocacy, treatment and training project to address the problem of obstetric fistula in Nigeria) in 2005, covering Kano, Kebbi, Katsina and Sokoto State;
- Mobilisation of resources for the construction of a National Fistula Centre in the Federal Capital Territory, Abuja;
- Collaboration with the Government of Ebonyi State in the implementation of advocacy and sensitization activities, provision of equipment for a VVF Centre, support for the implementation of a fistula fortnight in the state and provision of technical assistance for the development of a framework for the rehabilitation and economic empowerment of the treated fistula patients;
- Supporting at federal level the development of a draft national strategic framework for the eradication of obstetric fistula and the elaboration of a draft document on clinical standards;
- Support to the office of the First Lady Federal Republic of Nigeria as part of the Country Office partnership with this Office on maternal mortality reduction, where Obstetric Fistula programming was integrated as a central component.
The ad-hoc nature of most of the above mentioned activities reduces its effectiveness and efficiency, as most activities are a onetime effort with no continuity on the part of UNFPA and weak programmatic set-up within the existing health systems structures at all levels. Additionally, support to coordinate fistula activities between the different levels of services and the integration of the present activities into reproductive health policies and programmes does not exist. Furthermore, the activities carried out so far are not part of an overall national programme and are not addressing key issues that have implications for sustainability (i.e. programme management, increased financial support by all levels of government, coherent and sustained training of providers).

The Campaign should advocate for the coherent implementation of the national strategic framework for the eradication of obstetric fistula (first draft made in 2005 which has been approved by the National Council on Health but still waiting dissemination by the competent authorities).

The fistula activities as formulated in the 6th CPAP (see above) are part of the RH strategy and are a step in the right direction. However it seems that much more effort is needed to sensitisise authorities and programme managers on the need to make fistula management part of the maternal health policy. Only five of the 12 states where UNFPA is going to support the 6th CP, have included fistula activities in their 2009 annual work plan.

4.2 Progress towards achievement of expected results for national programmes

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

In the country a number of policies and strategic frameworks exist providing a platform for action on reduction of maternal mortality and morbidity. The challenge for the country is the effective enforcement and implementation of these policies and strategies. For example, the MoWASD promoted the passing of several bills that aim to influence a number of factors contributing to maternal mortality and morbidity and to the high prevalence of fistula. One of this is the Child Rights Act, a Federal piece of legislation that, among others, prohibits child marriage for girls under the age of the 18 years. The challenge now is the passing of similar legislation at the State level and setting up the mechanisms for its enforcement. The MoWASD is also promoting a bill that will make it compulsory for boys and girls to have twelve years of education.

Payment for services is one of the most important barriers for access and utilisation of both obstetric as well as fistula treatment services. The Federal Government has stated a policy for the provision of free maternal health services. The enactment of a Federal Policy does not guarantee that the states will adopt that policy. Therefore, not all the states are providing free maternal services (in some cases free maternal services are provided only in a limited number of facilities). Additionally, within the states a bill has to be passed by the State Assembly so that the LGA will also provide free services. This policy has not been accompanied by an increase in resources to cater for the additional demand generated after its declaration.

There is no national policy for free fistula treatment, but some states are providing free fistula treatment services (i.e. in the VVF Centres visited in Kano, Katsina and Ebonyi States, see also Annex 5). In Teaching Hospitals (managed by the Federal Government) fistula treatment services are not free. According to the inquiries of the evaluation team, the cost
charged to patients for a fistula repair varies between N 300 to N 45,000 (at exchange rate of 1 USD = 150 N in June 2009, this is approximately USD 2 – USD 300).

During the implementation of the 5th UNFPA-Nigeria CP, UNFPA facilitated the development and updating of critical policies and strategic plans; these included the National Integrated Maternal, Neonatal and Child Health (IMNCH) Strategy, National Adolescent Reproductive Health Policy, National Condom Intervention Strategy, Reproductive Health Commodity Security (RHCS) Strategic Framework and operational plan, State Strategic Plans (SSPs) on HIV/AIDS and draft National Strategic Framework and Plan for the Eradication of Obstetric Fistula. UNFPA also advocated for and supported the passage of bills on the prohibition of harmful widowhood rites, female genital cutting and violence against women.

The main contribution of the UNFPA Fistula Campaign in Nigeria to an improved political and social environment for the reduction of maternal mortality and morbidity has been done through the advocacy and awareness raising activities with policy makers as well as with religious and traditional leaders - particularly during the planning and organisation of the Fistula Fortnight in 2005 - and later on with the First Lady Federal Republic of Nigeria and State Governor’s Wives. Similarly, the awareness raising and health education activities at community level related to prevention of obstetric fistula contributed also to an improved political and social environment for the reduction of maternal mortality and morbidity. However, these activities have had limited geographic coverage.

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

Integration of the National Fistula Programme in the overall National RH Policy Plan

Fistula management and care is not yet integrated in the national/federal health policy plan but a draft text to be approved exists which integrates fistula policy in the national/federal reproductive health policy plan.

The Integrated Maternal, Newborn and Child Health Strategy (IMNCH, 2007), is the government strategy to address in an integral and comprehensive way the issues regarding maternal, newborn and child health as a continuum. It proposes a scaling up of high impact interventions for maternal, newborn and child health with the goal of reducing maternal, neonatal and child mortality and morbidity in line with the UN Millennium Development Goals 4 and 5. Fistula is not mentioned in this document. A national committee is overseeing the implementation of this strategy. It is at this level that lobby for fistula should be made, so that when the strategy is rolled-out down to the states, the states can also consider fistula activities.

Our observations during the field visit confirm that the Fistula Campaign activities are approached as a vertical system not integrated in the existing safe motherhood and/or RH programmes. Treatment is provided in special dedicated centres or hospital departments, rehabilitation centres and projects focus only on fistula clients and primary prevention/health education is not, as a standard, integrated in general health education on RH and/or safe motherhood. Also the other way around, health education campaigns on fistula seem to include only messages important for the prevention and treatment of fistula.

Integration of the UNFPA Fistula Campaign in the UNFPA RH Strategy

By reviewing the ‘Nigeria UNFPA Fistula Campaign Annual Reports 2005-2008’ reporting on activities conducted between January 2005 and December 2008 and from our observations during the field visit it seems that the UNFPA Fistula Campaign is considered and functions as a separate project with separate activities, not integrated in the UNFPA RH programme.
and strategy. This vertical/not integrated approach decreases the efficiency and the impact of the Campaign activities.

As mentioned in section 2.3 the fistula activities as formulated in the 6th CPAP are part of the RH strategy and this is a step in the right direction. Hopefully this will result in the integration of fistula activities in overall UNFPA RH activities, including health education campaigns.

**4.2.3 Increased national capacity to reduce maternal mortality and morbidity**

VVF is one of the maternal morbidities. A number of interventions required to prevent or reduce maternal mortality and morbidity are also effective for the prevention of fistula. These include: regular antenatal care (WHO: at least 4 visits), early diagnosis of arrested labour by use of the partograph, timely referral to adequate obstetric care (birth preparedness) where adequate interventions can be offered immediately (i.e. vacuum extraction, symphysiotomy, blood transfusion or Caesarean section). Emergency obstetric care provision requires skilled birth attendants, practicing in well equipped health facilities with presence of commodities and drugs.

Unfortunately in Nigeria, use of contraceptive methods, one of the most cost-effective interventions to reduce maternal mortality is low, and particularly among young population (utilisation of modern FP methods, estimated at 4.7 per cent of all currently married female aged 15-19 years)\(^{37}\). The partograph is not widely used in the facilities providing delivery services (we visited two such facilities, in one the partograph was used and in the other one it was not used; the main reason given for this was not sufficient manpower available). Other effective interventions do not reach optimum coverage for the desired impact. For example, a study of the FMoH in 12 states\(^{38}\), found that only 13.9% of annual deliveries took place in a health facility and coverage of essential obstetric care was less than 20%. Coverage reached for other interventions was also low, i.e. coverage for tetanus toxoid injection for pregnant women (TT 40%), intermittent preventive treatment of malaria in pregnant women (IPT 1%), prevention of mother to child transmission of HIV/AIDS (PMTCT 0.1%). One of the major reasons why many people are not utilising available health care services is cost (up to 30% of respondents).

Table 4 presents selected nation-wide indicators, critical for the reduction of maternal mortality and morbidity as well as VVF. It shows that over the last 18 years the progress made towards improvement on these indicators is rather slow.

**Table 4 Selected Health Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>1990</th>
<th>2003</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFR</td>
<td></td>
<td>6.0</td>
<td>5.7</td>
<td>5.7</td>
</tr>
<tr>
<td>CBR</td>
<td></td>
<td>39</td>
<td>41.7</td>
<td>40.6</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>15.1%</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Modern methods</td>
<td></td>
<td>7.5%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Antenatal care</td>
<td></td>
<td>57%</td>
<td>60%</td>
<td>58%</td>
</tr>
<tr>
<td>Delivery care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- skilled professional</td>
<td></td>
<td></td>
<td>35.2%</td>
<td>39%</td>
</tr>
<tr>
<td>- in health centre</td>
<td></td>
<td></td>
<td>32.6%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Source: Nigerian Demographic Health Survey 2008, preliminary report

In Nigeria, the Fistula Campaign has not supported the implementation of activities directed at increasing national capacities to reduce maternal mortality and morbidity, as these

\(^{37}\) NDHS 2003.

activities are covered under the support provided to the country under the RH sub-programme of the CP.

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

In Nigeria, the Fistula Campaign activities have not included direct support towards increased access and utilisation of quality basic and emergency obstetric care, as these activities are covered under the Reproductive Health Sub-programme of the CO. Indirectly the Fistula Campaign activities have contributed to raising awareness on the need for accessing obstetric care particularly when women confront obstructed labour. This has been emphasised during the pilot community project in the two LGA of Kankara and Nassarawa, during the health education messages given to treated fistula patients during the post-operative period. Similarly during the awareness raising activities directed to decision makers and leaders, when the link between fistula and obstructed labour is presented.

In the country, skilled providers are lacking and so are the facilities where emergency obstetric care is provided: less than 25% of the health facilities offer Basic Emergency Obstetric Care (EmOC) and not more than 15%, Comprehensive EmOC.39

UNFPA is one of several partners working with the government in improving maternal health. UNFPA invested importantly during the 5th country program in the 15 states by providing equipment as well as by training staff in EmOC. Unfortunately the anticipated improvement of increased visitors and quality of care could not be materialised. Imbedded socio-cultural factors, beliefs and behaviours are hard to influence and heavily influence the current choices for home deliveries and for more children, thus continuing the negative spiral in health.

The 2008 Endline /Baseline Survey40 of the UNFPA Country Programme in 23 states of Nigeria (15 states covered by the 5th CP and 8 new states to be covered by the 6th CP) reports worrisome trends in certain indicators, for example the percentage of women desiring last pregnancy dropped from 81% in 2004 to 59.2% in 2008 (in the former 15 states where UNFPA worked). Similarly, the percentage of women reported delivering at a health facility decreased from 42.6% in 2004 to 31.5% in 2008. Most states showed a drop in the utilisation level of antenatal care. No state reported up to a quarter of its health facilities offering full BEmOC and less that 15% of health centres in any of the former states offered all the components of CEmOC. Currently use of family planning showed also declining trends in 13 of the 15 former states. These results are calling the attention of the CO in order to identify which are the interventions and strategies that work, and which adjustments are necessary to reach the expected results.

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

A good proportion of the Fistula Campaign activities in Nigeria has been related to contribute to increasing access and utilisation of quality treatment services. The activities have included the organisation of the Fistula Fortnight in 2005, provision of equipment and consumables to treatment facilities, training of personnel and support to the elaboration of draft clinical standards.

The **2005 Fistula Fortnight** was a two-week effort to provide simultaneously fistula treatment in four different fistula treatment centres in four states in Northern Nigeria. It was also an awareness raising and mobilisation effort as well as a demonstration of exemplary collaboration between the different stakeholders, including the Federal Government of Nigeria, the Nigerian States Governments of Kano, Katsina, Kebbi and Sokoto, Americans for UNFPA, UNFPA, Virgin Unite, the Governments of Finland and Sweden, the SK Foundation and the TTT Foundation. A total of 550 women with VVF had surgery (22 of them also having RVF), while other 19 were treated by indwelling catheter. Of the total 591 fistulas treated, 510 were successfully closed, for an overall rate of 87.8%\(^1\). For 40% of the patients this was at least the second repair.

Four deaths occurred at the hospital during post-operative period for a 0.7% mortality rate (causes of death were attributed to malaria, hypoglycaemic coma, hypertension and leukaemia). About 60% of the women returned for the 6-month follow-up visit\(^2\). According to those interviewed, in addition to the number of women treated, important outputs of the Fortnight include significant renovation of the facilities, creating a better environment to provide treatment services both during and after the Fortnight in the participating facilities; provision of new equipment which remained at the sites (operating tables, operating lights, surgical equipment); training of staff (ten physicians received training on fistula management including surgical techniques, 40 nurses were trained on pre- and post-operative care of women with fistula and 60 social workers and Red Cross volunteers were also trained to provide counselling services. Those interviewed also agreed that the main contribution of the Fortnight was to bring new national attention and visibility to the fistula problem in the country. The lack of continuity of UNFPA support to the participating centres in the Fortnight was pointed out as a missed opportunity to continue building up of the fistula programme in the respective states. For future Fortnights a smaller scale and shorter duration was suggested.

If the fistula treatment facilities are owned by the Federal or State Governments, the staff cost as well as operational costs are covered by the respective government. The supply of drugs, consumables, equipment is irregular and not in sufficient quantities to respond to the

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41 While it is difficult to compare this success rate with those published in other studies - owing to variations in classification - it is at the high end of the range of reported success rates for fistula closure.

demand. Therefore, most facilities mobilise additional resources in order to be able to take on additional patients for treatment. This has been the case for example in the Centres visited in Kano, Katsina and Ebonyi States. Hence the support provided by the Fistula Campaign is very important when responding to the specific demands for equipment or supplies or as part of the organisation of specific treatment campaigns (i.e. in Jigawa in 2005, in Abakaliki, Ebonyi State in 2008). Sometimes, the support to specific treatment campaigns includes payment of allowances for fistula surgeons or payment of a certain fee for each repair. The shortcomings of this type of support are its lack of continuity and not being complemented by an overall effort to strengthening the overall service provision. The limited supplies provided by the Campaign can not go very far. The Fistula Campaign estimates that as a result of the direct support provided, a total of 753 fistula repairs have been done (including those repairs made in the 2005 Fistula Fortnight). This might be an underestimate as it does not include the total number of repairs done for example with the new equipment provided.

The Fistula Campaign has provided support for training of surgeons and other staff. This has been in most cases related to the organisation of the Fistula Fortnight or to a specific treatment campaign or in response to requests from the FMoH. Usually the Campaign pays for subsistence, accommodation and transport allowances for the trainees and if necessary for the trainers (when moving from one site to another). The training takes place at the VVF Centres in Katsina and Kano, and is provided by Dr. Waaldijk whose contract with the FMoH includes provision of training.

Lack of protocols and standards hamper good quality of care. On the other hand, excellence of care might be less when protocols and standards are made to respond to both limited skills and financial resources. Presently in Nigeria there are no national standards or protocols for management and care of fistula. With the experience gained in the National Fistula Project and in the organisation of VVF Centres (mainly in Kano and Katsina), Dr. Waaldijk has developed a number of techniques and guidelines described in the publication Obstetric Fistula Surgery Art and Science, Basics (2008). These are used for the training he carries out as well as in its regular practice. Though not nationally adopted, many of these techniques and guidelines are used in Nigeria, particularly by those that have been trained by him.

During the planning of the Fistula Fortnight a first attempt to work on common procedures or guidelines was made. At this time, standardised screenings as well as standardised pre-operative and post-operative care were agreed upon, with surgical techniques left to the discretion of the surgeon according to nature and complexity of the fistula. Later on, the Fistula Campaign supported the FMoH in the organisation of discussions that led to the elaboration of draft clinical standards. This document needs to be approved by the relevant authorities. It was not possible for the team to get access to this draft document.

**Information systems and research**

Information on fistula-related activities, health facilities, trained doctors and nurses, repairs, backlog and new cases is scarce, scattered, incomplete and hard to obtain. In the VVF facilities visited, records were kept, but there was no system in place to ensure that information would be analysed or used for planning purposes or support decision making. In Kano and Katsina, Dr. Waaldijk keeps records of all his interventions. He has been publishing yearly on his work and recently published a book summarising his work over the last 30 years. In the newly built South regional VVF centre in Abakalika, Ebonyi State, an effort is made to keep hard copies of records as well as input some variables into a database (this has been initiated recently and no reports are available yet).

The technical assistance provided by UNFPA for the design of the Fistula module included in the NDHS 2008 has been the only specific activity supported by the Campaign on issues
related to information systems and research. This is certainly an important step in the search for a better knowledge of the fistula situation in the country. This information could be used for further planning and review of the current strategies.

For management purposes, a functioning health information system is required in order to make appropriate decisions in designing, planning, implementing projects and activities, in allocation of resources in the most cost-effective way, starting from the health facilities, LGAs, States and Federation. Support for the strengthening of the national health information systems is certainly an area where UNFPA and other stakeholders working on fistula could join efforts.

Over the years, multiple articles have been published on Nigeria experiences (see annex 4). UNFPA, together with other stakeholders (i.e. EngenderHealth) can be instrumental in providing assistance in further analysis and dissemination of the Nigerian data. For example, the analysis of the data collected around the training centres of the Northern States and comparing these data with the experiences from other countries (i.e. series from the Anua centre).

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

At the individual, family and community level, poverty, not only being the cause of fistula development by lack of services and lack of access, is also the cause of lack of fistula repair and treatment for a huge number of women as they are abandoned by husband and family. The importance of removing financial barriers for access to services is stressed by the fact that most fistula surgeries take place at centres where these services are offered for free (see annex 5). Although patients often pay for drugs or other supplies when not available at the centres or for the cost for supplementing the food provided. Additional expenses are incurred to cover the costs of the accompanying family members. Most fistula patients are very poor and can not afford to pay these costs.

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

While in Nigeria, the evaluation team had the opportunity to observe two different approaches for the provision of rehabilitation/reintegration services:
   o Rehabilitation provided in rehabilitation centres/facilities. The team visited two rehabilitation centres run by the SMoWASD: the Kees Waldijk Rehabilitation Centre in Katsina and the Kwali Rehabilitation Centre in Kano.
   o Rehabilitation provided through community based rehabilitation projects. The team visited the CBR (Community Based Rehabilitation) pilot project funded by Virgin Unite in Kankara LGA, Katsina State.

Fistula Rehabilitation Centres

The evaluation team observed that the Kwali Rehabilitation Centre in Kano was more used as a hostel than as a centre to receive rehabilitation support. Eighty percent of the fistula

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43 With the meticulously updated information collected over more than 20 years and illustrated by thousands of pictures, Dr Kees Waaldijk constituted a wealth of documentation and information on fistula prevalence, incidence, severity and complexity, repair modalities, operation techniques, follow up and demographic information. He has one of the highest success rates, even in difficult-to-operate cases (the severe cases, the stress incontinence repairs, the recurrent fistulas, the repeated interventions for the same fistula).

44 This pilot project was also implemented in the Nassarawa LGA, Kano state.
clients who received fistula repair treatment in the hospital in Kano prefer to go home without receiving rehabilitation support in the rehabilitation centre. Most fistula patients who decide to stay some weeks in the rehabilitation centre choose this option because of geographic accessibility problems; they live too far from the fistula treatment centre to go for regular post-operation follow-up examinations and to be able to attend these post-op examinations they decide to stay in the rehabilitation facility where accommodation is free. In fact they use the rehabilitation centre as a hostel.

The variety of skills and competencies provided in the rehabilitation centres is usually limited by lack of resources and materials. This frequently results in women acquiring skills that might not be the most appropriate for their individual situations and their reintegration in the community back home. Training provided in the rehabilitation centres is e.g. related to functional literacy and numeracy, knitting and sewing or income generation activities, and sometimes women can receive grants.

Community Based Rehabilitation

The evaluation team visited the CBR UNFPA pilot project in Kankara LGA (Katsina State) and interviewed trained community mobilisers and local fistula clients who received rehabilitation support through the CBR project. These fistula clients received support for the initiation of economic empowerment activities taking into account the economic realities of the women’s socio-economic circumstances.

Rehabilitation services provided through the CBR pilot project in Kankara LGA had good results and were highly appreciated by the fistula clients. However, only 35 women received CBR through this UNFPA initiated pilot project; a largely inadequate number to have any impact on the rehabilitation component of the fistula programme in Nigeria.

Overall the availability and accessibility of rehabilitation services remained largely insufficient and the quality of rehabilitation provided remained poor during the implementation of the national UNFPA Fistula Campaign in Nigeria (implemented from 2005 until 2008).

The Hausa praise song “Dan Dunya” (see annex 9) can play an important role in the reintegration and rehabilitation process as it helps strengthening cohesion among fistula patients and decrease suffering by destigmatisation. The use of this song as an instrument for rehabilitation could not be observed during the evaluation visits, neither was it mentioned by any of the interviewees.

A needs assessment conducted in 2007 as part of the evaluation of the fistula pilot project in two LGAs in Kano and Katsina State, funded by Virgin Unite and implemented by UNFPA, concluded the following:

‘Rehabilitation appears from all indications to be the weakest link in the entire fistula management process. Rehabilitation centres are limited in number and are largely restricted in the range of support services they provide. There is an absence of a uniform structured approach to the rehabilitation of fistula clients while economic empowerment skills provided at the centres are not answering the preferences and

45 Over 80% of the women who received rehabilitation support in Kankara LGA had multiplied the input received after 12 months. (source: Nigeria UNFPA Fistula Campaign Annual Reports 2008; V. Lessons Learned).
socio-economic realities of the women. Most of the social workers in the programme are poorly trained.  

4.3 Nigeria’s indicator framework

Obtaining data to fill out the Nigeria’s Indicator Framework for Fistula Evaluation proved to be a difficult task due to the weaknesses of the data recording and reporting systems discussed previously in section 4.25. As a result of the wide scope of issues covered by the indicator framework a number of sources need to be consulted, and sometimes it is not easy to find out where to look for information. For a number of indicators no routine data collection exists (or it is not pertinent) and information on them is presently available only as a result of specific studies or publications made (not always easy to find). Some of the key lessons derived from this exercise are:

- The NDHS provides information on key indicators regarding the overall context, particularly those related to unmet family planning needs, contraceptive prevalence rate, skilled attendance at birth, female literacy and median age at first birth.

- For indicators of more qualitative nature (i.e. integration of fistula interventions into ongoing safe motherhood and reproductive health policies) the main sources of information are interviews with people working on these areas and consultation of the specific documents.

- It seems that specific data on obstructed labour (management, protocols, referrals, existence of EmOC services) is very scarce. The data found in this area was mostly from “The National Study on EOC facilities in Nigeria”, carried out in 2003.

- Information on treatment services is available at each facility, but not consolidated nationally; it is therefore difficult to assess national indicators. Information on training was basically related to the training carried out within the framework of the National Fistula Project. It was not possible to obtain a clear picture of the overall human resources situation for fistula.

- For reintegration/rehabilitation services it was only possible to collect data on UNFPA supported sites.

- There is an urgent need to streamline the key information required to monitor fistula progress and to establish the necessary mechanisms for this to operate effectively.

Annex 6 presents the Nigeria Indicator framework for evaluation of fistula progress to date.

4.4 Does a National Fistula Programme exist in Nigeria?

Two Ministries are involved in Fistula programming in Nigeria, both at Federal and State levels: the MoH, responsible for the areas of prevention and fistula treatment, and the Ministry of Women Affairs and Social Development (MoWASD), responsible for the

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47 UNFPA Campaign to End Fistula; Report of the Six Month Pilot of the Prevention, Treatment and Rehabilitation of Obstetric Fistula in Northern Nigeria, Supported by Virgin Unite, Submitted by UNFPA.
48 Fatusi, Adesegum O.; Ijadumola, Kayode, National Study on Essential Obstetric Care Facilities in Nigeria, FMoH, UNFPA, May 2003
Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula

Country Assessment Nigeria

rehabilitation and reintegration areas\(^{49}\). Recently, the Office of the First Lady set maternal health as a priority and within this framework UNFPA has been instrumental in organising awareness raising activities for the Wives of State Governors. They are more involved than ever before in maternal health and some even became the key promoters of fistula repair activities, as it is prominently shown in Ebonyi State\(^{50}\).

**FMoH fistula programme/activities**

Initially fistula programming activities at the FMoH were under two areas of the FMoH, the curative services and promotion/advocacy. A fistula office was established at the FMoH in 2003 to take care of all aspects of fistula programming as well as its integration with RH activities. Presently there is a National Fistula Coordinator who is at the same time the head of the RH Division, under the Family Health Department\(^{51}\).

The Fistula Coordinator Office has three technical staff and its main activity last year was to carry out an impact assessment of fistula activities in 3 states (the data collection has been done, but the its analysis and report are not yet available). Presently there are no mechanisms in place for proper data collection, reporting, monitoring and follow up of fistula activities in the country. Management procedures (planning, identification and definition of priorities and strategies, monitoring and evaluation) are lacking or very weak. The main contribution of the Fistula Campaign to strengthening of fistula programming has been the support provided to the FMoH in 2004 for the elaboration of a draft National Strategic Framework and Plan for the eradication of obstetric fistula in Nigeria 2005-2010. This draft is still pending the approval from the relevant authorities. As this draft has become out-dated, the proposal is to revise it and extend it up to 2012. High turnover of government officials at administrative as well as decision-making levels as well as lack of a specific budget to operate makes programme management difficult.

The role of the FMoH in fistula management should be the development of policies, guidelines and standards and the coordination of fistula activities in the country. However at present not much seems to happen at the FMoH concerning these tasks. There is a need for strengthening and building this capacity.

**FMoWASD fistula programme/activities**

The FMoWASD is not directly involved in fistula activities. The Fistula Campaign has not worked directly with the FMoWASD, though this Ministry is an important UNFPA implementing partner on issues related to the gender component and youth targeted

\(^{49}\) Though in Sokoto the MoWASD runs the fistula treatment centre.

\(^{50}\) Mother and ChildCare Initiative (MCCI) of Her Excellency Mrs. Josephine N. Elechi, November 2007.

\(^{51}\) Which has 5 divisions with its main activities in the areas of child health and RH.
activities of the UNFPA CP, some of which are relevant to fistula (i.e. promotion of Child Rights Act, see section 4.2.1).

SMoH and SMoWASD fistula programme/activities

Fistula management and care varies from state to state. In some states OF is not even recognized as a problem yet\(^{52}\). As a result, in some states Fistula is not on the health policy agenda or on the agenda of the SMoWASD. However, there are states where fistula management is integrated in the state health policy or in the policies and activities of the SMoWASD. For example, in those states where the State MoH owns the fistula treatment centres, fistula surgery is provided for free to patients (see annex 5). Kano state is the only state that has a state fistula coordinator. Kano state is also one of the states in Nigeria providing free maternal care which improved the accessibility to EmOC, being favourable for the prevention of fistula.

The SMoWASD are mostly involved in the provision of rehabilitation and reintegration services, either by running specific centres dedicated to receiving fistula patients in their post-operative period (such as the ones described in section 4.2.6) or through facilitating the linkages with their “skill acquisition centres” located at the state capital or in LGA. The Fistula Campaign direct work and support to SMoWASD has been very limited and ad-hoc (i.e. provision of a mini-bus to one centre) or consisted of coordinating activities with these centres during the Fistula Fortnight and for the pilot community based project. The MoWASD runs one treatment centre in Sokoto State and discussions are presently taking place regarding the establishment and running of an additional VVF treatment centre in Kano State.

At state level there are no established coordination mechanisms to ensure fistula stakeholders coordination and collaboration. Though, while in Ebonyi State, the evaluation team was able to see the initial development of a strategy that integrates maternal health and fistula activities, under the leadership of the Office of the Wife of the Ebonyi State Governor.

National Fistula Task Force

A National Fistula Task Force was established in 1990. The National Council of Women’s Societies (NCWS) was a key actor in the establishment and operation of this Task Force. The Task Force was very active in assessing the scope of VVF services offered in the

\(^{52}\) Particularly in some of the southern states, as reported to the team by people of the First Lady of Ebonyi State.
country (particularly in the north) as well as in the adoption of a strategy for training of Nigerian staff (doctors, nurses and other officials) in skills for VVF repair, post-operative management and rehabilitation. This Task Force was dissolved in 1997 and replaced by the National Foundation on VVF. The Foundation is at present not functional. However, last year the FMoH, with support from UNFPA and EngenderHealth, initiated efforts to activate a meeting of fistula stakeholders with the purpose to improve coordination of Fistula activities in the country. Two meetings have been held, but there is no continuity and no tangible results have been achieved yet. According to the federal fistula coordinator, lack of funding and leadership (since 2 years no minister of health has been appointed at the federal level, currently there is an acting minister of health) is the reason for the inactivity of this group. The draft National Strategic Framework for VVF eradication proposes the establishment of an inter-agency/multisectoral coordinating committee(s) VVF at Federal, State and LGA with participation of Government, Private sector, Civil Society Organisations and development partners.

At present a national coordination mechanism to ensure fistula stakeholders’ participation and coordination does not exist.

### 4.5 Management

The UNFPA CO in Nigeria is the only country that has a person contracted exclusively for the coordination of Fistula Campaign activities. The National Programme Officer (Obstetric Fistula) is responsible for the planning and follow-up of the Campaign activities in the country.

UNFPA usually works with implementing partners who are responsible for the implementation of activities. Due to the nature of the Fistula Campaign activities in Nigeria, it can be said that up to now the FMoH has been the only implementing partner in the “formal sense”. Discussions are held annually with the FMoH for the planning of activities to be implemented by them. In spite of this, those interviewed at the FMoH informed us that they do not receive information from UNFPA on the final approval of this plan and the resource envelope allocated for the implementation of these activities.

Up to now, Fistula Campaign activities have not been fully integrated into the overall CP activities. For example, the Campaign has supported activities in states not supported by the UNFPA-Nigeria 5th CP (see table 3) while in those states supported by the UNFPA - Nigeria 5th CP, these activities have not been integrated into the work plans of the respective implementing partners (in part due to the initiation of Campaign activities during mid-execution of the 5th CP as well as to the “project” nature of the Fistula Campaign activities). As mentioned before, a good number of Campaign activities have been ad-hoc responses to specific requests for equipment and consumables, support to treatment campaigns or support for advocacy and awareness raising activities. In all these cases, contacts are established on ad-hoc basis between the requesting organisation (i.e. SMoH) and the UNFPA Fistula Coordinator. The implementation of the pilot project in Kankara and Nasawawa LGAs included local coordination with the LGAs and contracting of services of an official of local NGO for training of community health workers).

Monitoring and follow-up of Fistula Campaign activities is done by the National Programme Officer (Obstetric Fistula), and not part of the regular monitoring and follow-up system of the CO. The Fistula Campaign has its own reporting system (i.e., own reporting format for annual reports) to keep track of the implementation of activities. Fistula indicators were not included as part of the indicators for tracking progress in the implementation of the 5th CP.

In the other countries this function is carried out, in most cases, by the RH officer.
The introduction of Fistula indicators for tracking progress in the implementation of the 6th CP is under consideration.

The supply of equipment and consumables procured by the Fistula Campaign follows the CO procedures for this purpose. The team was informed that equipment is not always of good quality or appropriate for its intended purpose (i.e. supply of 3 cm long needles for spinal anaesthesia).

Within UNFPA, the Fistula Campaign activities could benefit from a more effective integration with the overall CP activities and more specifically with the RH activities.

4.6 Financial aspects

The main sources of funding for the Campaign activities in the country have been UNFPA core resources, Virgin United, The Japanese Human Security Fund, Swedish Fund and Finland Fund. The resource envelope for the period 2005-2008 was USD 2,048,611 (45% allocated for the construction of a national VVF centre in Abuja). Expenditures for this period amount to a total of USD 766,401 for a financial execution rate of 70% without including the construction of the Abuja centre (37% with the construction included). Annex 7 presents a summary table with allocations and expenditures by year and source of funding.

The slow progress in the construction of the Abuja Treatment Centre is a concern. UNFPA usually does not support or engage in construction activities. The implementation of this activity is the responsibility of the FMoH. In addition to the problems faced when legalising the site for the construction, there have also been delays in the tender process for the construction. Additionally, no provisions have been made yet for other issues such as equipment, staffing and operation of the centre.

It was not possible for the team to get information on financial allocations and expenditures by type of activity (prevention, treatment, rehab/reintegration, awareness raising) or by type of expenditures (i.e. equipment and supplies, training, technical assistance, travel, publications).

4.7 Role / assistance from UNFPA’s regional and HQ levels

There is no clear definition of communication lines between the CO and RO and HQ and not enough understanding from the CO on what kind of assistance can be provided by the RO. Up to now there has been no request for technical assistance (TA) from the Nigeria CO to UNFPA’s RO or HQ. The interaction of the CO with the RO has been limited to issues related to budget and financial allocations.

The former set-up with two fistula regional focal points (one for technical issues and the other one for programmatic issues) may have hindered the possibilities of the RO to provide assistance (none of them have the overall picture of what was taking place in the countries). On the other hand, the fact that the UNFPA National Programme Officer (Obstetric Fistula) has a lot of experience in Fistula programming might have reduced the need for TA. The implications of the UNFPA regionalisation process for the support to be provided to CO from the regional level, needs to be communicated to the CO together with the potential for support.

The possibilities for RO to provide assistance to the CO are limited by the amount of staff and financial resources available at this level.
A better communication between all levels has been suggested, with the purpose to avoid overlapping of activities (i.e. the Nigeria National Programme Officer (Obstetric Fistula) has not been able to participate in Regional activities due to overlapping of activities).

Direct interaction of the CO National Programme Officer (Obstetric Fistula) with HQ has taken place for the elaboration of the project proposals to be submitted to Virgin Unite.

The CO suggested that important roles for the RO include the facilitation of south-south collaboration as well as the identification of key cost-effective fistula interventions to be advocated for and supported in the countries.

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

The interviewed stakeholders indicated that in the last few years UNFPA has played an important role in bringing the issue of fistula to the attention of both policy makers and general public. It was also mentioned that due to its relationship and collaboration with national authorities, UNFPA has a comparative advantage to advocate with policy makers. UNFPA has used and should continue using this “privileged position” to approach and advocate for fistula with decision makers as well as religious and traditional leaders. Others referred to UNFPA as being an important “pillar” for OF in the country as well as being an important player with whom to collaborate and coordinate.

All interviewed stakeholders agreed on the need for better coordination, planning, collaboration and exchange of experiences and information between those working on fistula activities in the country. They also recognised that these coordination efforts should be led by the national authorities, particularly the FMoH and that fistula stakeholders should collaborate with the FMoH in order to strengthen its leadership capacities in fistula programming. The need for establishment of coordination mechanisms at state level was also suggested.

### 5. Conclusions

#### 5.1 Relevance

UNFPA involvement in Fistula in Nigeria is very relevant. Not only because OF is an important problem in the country - as indicated by its prevalence and incidence - but also because the presence of OF is linked to issues related to RH (i.e. family planning and EmOC) as well as gender, which are important components of UNFPA’s mandate. In spite of being an important problem in the country, OF is not yet a national priority, as indicated by OF not being integrated or even mentioned in key policy documents related to maternal health such as the Integrated Maternal Newborn and Child Health Strategy (2007), or by the fact that in some states OF is not yet recognised as a problem or by the lack of specific budget allocations to fistula activities at Federal or state levels. This makes the advocacy and awareness raising activities supported by the Fistula Campaign very relevant, particularly those directed to policy makers, traditional and religious leaders. For example, the presentation of information on fistula and the participation of Fistula Advocates in the discussion regarding the challenges of maternal morbidity and mortality during meetings of the First Lady with the wives of the State Governors as well as national meetings of traditional and religious leaders.
5.2 Effectiveness

The CO made explicit that the Fistula Campaign funds were not going to be used to support activities related to direct prevention of fistula (i.e. EmOC) as these activities are part and parcel of UNFPA’s mandate and the country receives support for its implementation under the RH component of the UNFPA/Nigeria CP. This is a reasonable choice. In fact, the present situation in the country indicates that a lot of work still needs to be done in order to effectively prevent OF, as shown by key indicators (among others: access and availability of EmOC, CPR, use of partograph, timely referral of obstructed labour). As mentioned before, the strategies and supported interventions have not yet reached the required coverage for the desired impact. Therefore the need for UNFPA continued support exists in this area.

The support for treatment of OF provided by the Fistula Campaign in Nigeria contributed to scaling-up treatment services (though modest number of fistula repairs made) as well as to improving conditions for service provision and to training human resources for the provision of these services. The overall effectiveness of this support is reduced by its ad-hoc nature, its limited coverage and lack of integration in an overall well structured national programme. Support to ad-hoc activities contributes to solving acute needs or problems but does not facilitate the strengthening or addressing of structural and systemic problems required for the establishment of sustained quality service provision.

The support provided for rehabilitation services through the CBR pilot project in Kankara and Nasarawa LGA had good results and those were highly appreciated by the fistula clients. However, only 35 women received CBR through this UNFPA initiated pilot project; a largely inadequate number to have any impact on the rehabilitation component of the fistula programme in Nigeria. The project tested a different modality for the provision of rehabilitation (social support) services where the participation of local government authorities, local primary health care network, local skills development centres, fistula clients, male members of the community, local leaders and community based activities is a key element. How this modality compares to other existing modalities for provision of rehabilitation services in the country needs further exploration in order to facilitate informed discussions on this issue and recommendations for decision making.

5.3 Efficiency

The most important measure taken by the Fistula Campaign to secure efficiency in the use of resources has been to work with existing facilities providing fistula treatment or rehabilitation services as well as coordinating with LGA to secure commitment and continuity of activities after the Campaign support stops.

The CO has received no guidance from RO or HQ on most cost-effective interventions that could be supported. There are no defined criteria for allocation of resources to activities, to guide decisions on what to support or where. Possible activities are for example: to invest in the construction of a new treatment centre in Abuja, to pay for fistula treatment, advocacy and awareness raising activities or training of staff.

National experts were consulted to advice on the type of equipment and consumables to be provided by the Campaign.

54 Over 80% of the women who received rehabilitation support in Kankara LGA had multiplied the input received after 12 months. (source: Nigeria UNFPA Fistula Campaign Annual Reports 2008; V. Lessons Learned)

55 For example, the facility based modality promoted by the MoWASD or linking the fistula repaired women directly to NGOs providing support to women empowerment.
5.4 Impact

The advocacy and awareness raising activities supported by the Campaign brought renewed interest on fistula in the country as well as it brought fistula to the attention of high level officials in the country. For example, government authorities at federal and state level were involved and provided support to the organisation of the Fistula Fortnight (i.e. support was provided for rehabilitation or improvement of the treatment facilities by participating state governments). Similarly, as a result of advocacy and sensitisation activities directed to policy makers, religious leaders, health workers and various community groups, Ebonyi State developed a two-year state action plan on Obstetric Fistula Programming within the overall framework of maternal mortality reduction /safe motherhood.

Considerable investment is required in order to reduce the incidence and prevalence and eventually eliminate OF in the country. Therefore there is a need to continue advocating for adoption of specific policies and implementation of strategies and interventions to address fistula as an important component of reproductive health /maternal health policies and interventions.

The Fistula Campaign also facilitated awareness raising and interest on Fistula within UNFPA CO. For the 6th CP, fistula activities are being integrated in the RH component of the action plans of those states (five out of twelve) that have included fistula activities in their respective plans. Fistula competes for resources with other priorities within RH; the challenge ahead is to make sure that an adequate response is provided in those states that have included fistula as a priority.

5.5 Sustainability

Regained self-esteem, improved quality of life, reinsertion to the community and in some cases economic empowerment are among the long-lasting benefits for those women whose fistulas have been repaired.

The sustainability of Fistula Campaign efforts has to be seen in the light of the overall sustainability of the Fistula efforts in the country. The Fistula Campaign has brought renewed interest in fistula and has contributed to the performance of a relatively small number of additional fistula surgeries in the country (in places where these services where already provided and will continue to be provided). It has also brought attention to issues related to the rehabilitation /reintegration services (which the National Programme Officer prefers to call social support services). A number of factors are presently a threat to sustainable Fistula efforts in the country. The present financial support (federal or state) for fistula activities does not secure the continuous operation of the existing treatment facilities, newly built or planned new ones. Important barriers for access and utilisation of services are payment for treatment, transport or other costs. Therefore there is a need to secure policies and actions to effectively remove these barriers.

Securing the availability of human resources in quantity and skills to provide care (prevention, treatment and social support) is also a challenge. Of great importance is to make sure that those members of staff that have been trained (surgeons, nurses) are engaged in provision of services. Equally important is to secure that in-country training can continue to be performed in the country, most likely with the formation of a Master training. The strengthening of institutional capacities at federal and state level for planning of fistula care as well as monitoring and follow-up of the progress made with the implementation of strategies and interventions, is also critical to sustainability.
The existence of OF is strongly related to the prevention of obstructed labour and access and utilisation of EmOC. Fistula efforts cannot be seen isolated from the efforts to improve RH and maternal health and to reduce maternal morbidity and mortality. There is therefore a need to fully integrate Fistula programming into the overall policies, strategies and interventions related to RH and particularly maternal health.

6. Lessons learnt

According to those interviewed the Fistula Fortnight in four states was an event that contributed to increase interest and to raise awareness among the general public, as well as to scale-up treatment services. Carrying out this event simultaneously in four states is an undertaking that requires considerable organisation, coordination and management, which is not always possible to gather. An effort of this nature was crucial to renew the attention on fistula in the country. Future efforts of this nature which might better be called Fistula Workshops or Fistula Treatment Campaigns - might be aimed at supporting one treatment centre at the time to a) take care of their backlog of cases, b) use this event for supervised training and for improvement of the skills of the existing staff in the participating facility and c) to increase awareness of fistula in the geographic area where the centre is located. This is in fact already taken place.

In a country like Nigeria, networking and establishing linkages with religious, traditional and political leaders with the purpose of raising awareness on maternal mortality and morbidity as well as on OF, has proven to be an important tool for breaking out the stigma attached to fistula, for recognising that the problem exists, for involving these leaders in carrying out health education messages and in some cases generating actions and decisions to implement strategies and interventions.

From the observations made by the evaluation team during the field visit, the evaluation team concludes that for rehabilitation services there is a need to differentiate between rehabilitation services needed during the post-operative period (two to eight weeks after surgery) and social support/reintegration services. In the post-operative period there is a need to provide nursing care, health education and psychological support. In the case of the social support/reintegration services (that can start as soon as possible after surgery), the service needs for patients are related to supporting their reintegration into the family and community as well as their economic empowerment.

Nigeria has a number of trained fistula surgeons who could potentially become Master trainers thus constituting a generation of local trainers who would continue building the national capacities and skills required for fistula treatment. Nigeria could also continue to contribute to the training of staff from other countries. This potential should not be allowed to get lost.

The implementation of the CBR project showed that strengthening the capacity of health systems to deliver quality maternal health services alone is not sufficient to achieve the intended results with respect to utilisation of services and maternal outcomes. There is a need to facilitate linkages with community level activities (in this case through the community educators). The community level interventions facilitated access to key gatekeepers, groups, families and individuals. It also allowed local community members to address culturally sensitive issues related to OF and maternal health. This experience also
7. Recommendations

The evaluation team recommends:

7.1 Opportunities for strengthening UNFPA engagement on Fistula in Nigeria

1. Move from ad-hoc support to more systemic and programmatic approach. It is due time for the Fistula Campaign in Nigeria to move from ad-hoc support towards a more systematic and programmatic approach. Important issues to address as part of this approach include the review and approval of the draft National Strategic Framework and Plan for VVF eradication in Nigeria and its corresponding dissemination and implementation plan. Ideally all activities supported by UNFPA should be in line with and complementary to the implementation of the National Strategic Framework.

2. Balance efforts in OF prevention, treatment and rehabilitation. The activities in Nigeria confirmed that fistula programming has to include prevention, treatment and rehabilitation/reintegration interventions. The proper balance between these interventions should be found. For example in Nigeria where incidence and prevalence are high, scaling-up efforts for prevention and treatment services are a must.

3. Support for strengthening the national capacities for fistula programming at both federal and state level. The evaluation revealed some of the weaknesses of the existing fistula programming capacities both at federal and state level. Key areas in need of strengthening are planning, availability of evidence to decide on priorities, interventions and strategies to implement, advocate for allocation of resources, monitoring and evaluation of fistula activities, budgeting and costing of fistula interventions, and integration of fistula issues into major RH and maternal health policies and strategies.

4. Address issues that need attention in the short-term. The evaluation team identified three issues that need attention in the short term, where the technical support from UNFPA can be valuable: a) definition of a human resources development strategy, b) setting in place of information systems and c) support the national authorities in defining the service level provision for OF. All these issues have immediate implications for ongoing and future investments.

5. Support the Federal Government in advocating for integration of fistula policies, strategies and interventions into major RH and maternal health policy documents as well as in its effort for mobilising financial resources for fistula. Fistula interventions compete for resources with a number of RH and maternal health interventions. There are a number of possible venues in the country where additional national resources for fistula could be found if it is advocated and if it is part of the maternal health package of interventions, for example the debt relief funds or as part of strengthening the provision of secondary level services.
6. **Support and document the experience of Ebonyi State.** Ebonyi State has been included in the 6th CP as one of the 12 UNFPA programme states. The evaluation team was informed that Ebonyi state included fistula as an area of work with UNFPA. As mentioned in section 4.4, a number of conditions are currently present in this State to facilitate the implementation of an integrated approach to fistula care. Potential areas of support identified by the evaluation team include: support to secure that adequate coverage with interventions is reached, strengthening of the information system, assist the State in formulating a plan to secure the continued operation of the newly built Regional South East Treatment Centre as well as its possible operation as a training centre and research centre. Systematising and documenting this experience is another potential area of work.

7.2 **General recommendations to UNFPA**

1. **Monitor the integration of Fistula activities in the existing RH component of the UNFPA / Nigeria CP.** For the implementation of the 6th CP, the UNFPA CO intends to put into practice a more integrated approach for the implementation of the RH component. Fistula activities are included as part of this component. As this is a new approach, it is advisable to monitor closely how this integration evolves and to secure that fistula activities are given adequate consideration as well as resources. It is also advisable that fistula activities utilise as much as possible the programme management mechanisms of other components (i.e. planning and reporting).

2. **Improve coordination between the CO - RO and plan for technical assistance from RO.** Up to now the CO has made no use of the potential for technical assistance to be provided by the RO. The CO needs to be informed on how they can best make use of the RO to support the national efforts. The CO should also be informed on how the UNFPA regionalisation process will affect the provision of assistance from the RO to the CO. Equally important is that a regular flow of information from the CO to the RO is secured, to be able to identify potential areas of support. It is advisable that the required assistance from the RO gets included in the annuals plans.

The assessment of the Fistula Campaign activities in Nigeria revealed important areas where technical support and guidance from RO and HQ might be necessary. These are related to the establishment of M&E mechanisms for fistula activities as well as the establishment of quality control mechanisms for treatment services at country level.
ANNEXES

Annex 1. Terms of Reference

Thematic Evaluation of
National Programmes and UNFPA experience in
The Campaign to End Fistula

A. ABOUT UNFPA

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 organizations 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 (STIs) - 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 recognized as a human right, part of the right to health.

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

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

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

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

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. 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. The World Health Organization estimates an annual incidence of approximately 73,000 new cases. 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.

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 industrialized world by 2015, in line with ICPD and MDG targets. The Campaign is a component of UNFPA’s overall strategy to improve maternal health.

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Beginning with just 12 countries in 2003, the Campaign is now active in more than 40 countries in sub-Saharan Africa, Asia and the Arab region. At the national level, each country undergoes three programmatic phases: 1) rapid needs assessment, 2) collaborative planning of a national fistula elimination strategy and 3) implementation of the national strategy. The Campaign's three strategic intervention points – prevention, treatment and reintegration – are flexible to allow for country context and designed to situate fistula within national maternal health strategies and UNFPA country programmes. The strategy and phases were developed through consensus with national and global partners. Throughout, the Campaign emphasizes political advocacy and capacity development to ensure that fistula elimination is sustainable.

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 utilization of quality basic and emergency obstetric care services
- Increased access to and utilization 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 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 Mobilization; 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 organizations 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

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64 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 Mobilization Division and Technical Support Division. Other Divisions participate as needed.
was very little documentation or evaluation of fistula-related interventions, both clinical and programmatic, when the Campaign began.\textsuperscript{65} For example, in the area of treatment, no aspect, from diagnosis to treatment techniques to assessing outcomes, is standardized or supported by an adequate evidence base.\textsuperscript{66} 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 organizations, health professional associations and academic institutions. At the same time an internal coordination 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\textsuperscript{67} 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, utilizing 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;\textsuperscript{68} 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.

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 learned 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 learned 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 organizations 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 utilized 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 Mobilization; 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 utilized?

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 Mobilization:
What has been the role of the Campaign in raising awareness of obstetric fistula among policy makers, international organizations, 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 learned 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 learned.

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 organized 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 utilizing 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 organizations 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**

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

69 Schedule adapted as per contract of 25 March 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
## Annex 2. List of people met

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
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<tr>
<td>22 May 2009</td>
<td>Abuja</td>
<td>Iyeme Efem</td>
<td>USAID ACQUIRE-Fistula Care Project (EngenderHealth)</td>
<td>Country Director/Project Manager</td>
<td>+234 9 874 8320/21 <a href="mailto:iefem@engenderhealth.org">iefem@engenderhealth.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 May 2009</td>
<td>Abuja</td>
<td>Magali Rommedamme</td>
<td>UNFPA ARO</td>
<td>Regional Fistula Focal Point</td>
<td><a href="mailto:romedenne@unfpa.org">romedenne@unfpa.org</a></td>
</tr>
<tr>
<td>25 May 2009</td>
<td>Abuja</td>
<td>Christian Ibeh</td>
<td>UNFPA Nigeria</td>
<td>RH Advisor CIDA Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Hanatu Yaro</td>
<td>UNFPA Nigeria</td>
<td>National Project Analyst - Gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Ademola Olajide</td>
<td>UNFPA Nigeria</td>
<td>National Programme Officer (Obstetric Fistula)</td>
<td>+234 9 461 6100 <a href="mailto:olajide@unfpa.org">olajide@unfpa.org</a></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Bannet Ndyanabangi</td>
<td>UNFPA Nigeria</td>
<td>Deputy Representative</td>
<td>+234 9 461 6574 <a href="mailto:ndyanabangi@unfpa.org">ndyanabangi@unfpa.org</a></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Dr. Wapada I. Balami</td>
<td>FMOH, Department of Family Health</td>
<td>Head RH Division/National fistula coordinator</td>
<td>080 236 671 83 <a href="mailto:wapadabalami@yahoo.com">wapadabalami@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Oluyomi E.O.</td>
<td>FMOH, Department of Family Health</td>
<td>Deputy RH Division/ fistula</td>
<td>070 309 800 95</td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Okara Dogary</td>
<td>FMOH, Department of Family Health</td>
<td>Deputy RH Division</td>
<td>080 345 048 69</td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Oyinbo O. Manuel</td>
<td>FMOH, Department of Family Health</td>
<td>Deputy RH Division</td>
<td>080 527 444 15</td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Dr. Aganaba</td>
<td>Federal Capital Territory Office</td>
<td>Focal person for UNFPA RH project/Deputy Director</td>
<td></td>
</tr>
<tr>
<td>26 May 2009</td>
<td>Kano</td>
<td>Dr. Kees Waaldijk</td>
<td>FMOH and Babar Ruga Hospital (SMOH Specialist Hospital), visiting surgeon/trainer in several SMOH hospitals in Northern Nigeria</td>
<td>Fistula surgeon/trainer based in Katsina Babar Ruga Hospital (SMOH Specialist Hospital)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Katsina State, Kankara LGA</td>
<td>Kabir Abubakar</td>
<td>Kankara LGA</td>
<td>LGA Director Primary Health Care</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Place</td>
<td>Name</td>
<td>Organisation</td>
<td>Position</td>
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<td>Katsina State, Kankara LGA</td>
<td>Amina Mussa</td>
<td>Kankara LGA</td>
<td>RH Coordinator</td>
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</tr>
<tr>
<td></td>
<td>Katsina State, Kankara LGA</td>
<td>Female and Male Fistula Community Educators</td>
<td>Kankara LGA</td>
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<tr>
<td></td>
<td>Katsina State, Kankara LGA</td>
<td>Ex-fistula patients who received economic empowerment</td>
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<tr>
<td></td>
<td>Katsina</td>
<td>Alhaji Abdullahi Haruna</td>
<td>VVF Fistula Centre Babbar Ruga General Hospital</td>
<td>Chief Nursing Office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Katsina</td>
<td>Hajiy Nafisat Ade Ajagu</td>
<td>VVF Fistula Centre Babbar Ruga General Hospital</td>
<td>i/C Pre-post-operative wards, Chief Nursing Officer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Katsina</td>
<td>Zubaidah Aliyu</td>
<td>Dr. Kees Waaldijk VVF Rehabilitation Centre</td>
<td>Principal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Katsina</td>
<td>Binta Ayi Ibrahim</td>
<td>Ministry of Women Affairs and Social Development, Katsina State</td>
<td>Permanent Secretary</td>
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<tr>
<td></td>
<td>Katsina</td>
<td>Zulai Sule Ingawy</td>
<td>Ministry of Women Affairs and Social Development, Katsina State</td>
<td>Director Women Affairs</td>
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</tr>
<tr>
<td></td>
<td>Katsina</td>
<td>Idriss A. Halliru</td>
<td>Katsina State Ministry of Health</td>
<td>Director of Public Health</td>
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<tr>
<td></td>
<td>Katsina</td>
<td>Mustapha Mohamed Kufi</td>
<td>Nigeria Red Cross, Katsina Branch</td>
<td>State Secretary</td>
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<tr>
<td></td>
<td>Katsina</td>
<td>Ibrahim Alimu Gafai</td>
<td>Nigeria Red Cross, Katsina Branch</td>
<td>School Unit Coordinator</td>
<td></td>
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<tr>
<td>27 May 2009</td>
<td>Kano</td>
<td>Dr. Bello Dikko</td>
<td>Murtala Mohammed Specialist Hospital, Kano</td>
<td>Acting Chair of Anti-natal Services/Consultant Gynaecology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kano</td>
<td>Hauwa Isa Borodo</td>
<td>Murtala Mohammed Specialist Hospital, Kano</td>
<td>Chief Matron</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kano</td>
<td>Dr. Amir Imam</td>
<td>Kano SMOH</td>
<td>State Fistula Coordinator (since 4 years)/Fistula Surgeon (since 13 years)</td>
<td></td>
</tr>
<tr>
<td>Date</td>
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<td>Name</td>
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<tr>
<td>28 May 2009</td>
<td>Abuja</td>
<td>Ismailia Sulaiman</td>
<td>UNFPA, Nigeria</td>
<td>Assistant Representative/Population and Development Strategies</td>
<td>+234 (0)9 461 6591 <a href="mailto:sulaiman@unfpa.org">sulaiman@unfpa.org</a></td>
</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Salamatu H. Suleiman</td>
<td>Federal Ministry of Women Affairs and Social Development (FMOWASD)</td>
<td>Honourable Minister</td>
<td>+234 (0)9 290 2382 <a href="mailto:shsuleiman@fmwa.gov.ng">shsuleiman@fmwa.gov.ng</a></td>
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<tr>
<td>29 May 2009</td>
<td>Abuja</td>
<td>Emmanuel Gemade</td>
<td>UNICEF</td>
<td>Health Specialist &amp; Team Leader MNU5MR Project</td>
<td>+234 9 4616415 <a href="mailto:egemade@unicef.org">egemade@unicef.org</a></td>
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<tr>
<td></td>
<td>Abuja</td>
<td>Naawa S.</td>
<td>UNICEF</td>
<td>Health &amp; Nutrition</td>
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<td>Abuja</td>
<td>Bannet Ndyanabangi</td>
<td>UNFPA Nigeria</td>
<td>Deputy Representative</td>
<td>+234 9 461 6574 <a href="mailto:ndyanabangi@unfpa.org">ndyanabangi@unfpa.org</a></td>
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<tr>
<td></td>
<td>Abuja</td>
<td>Ademola Olajide</td>
<td>UNFPA Nigeria</td>
<td>National Programme Officer</td>
<td>+234 9 461 6100 <a href="mailto:olajide@unfpa.org">olajide@unfpa.org</a></td>
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<tr>
<td>30 May 2009</td>
<td>Abuja</td>
<td>Okonokhua Ozy</td>
<td>Federal Capital Territory</td>
<td>Desk Officer Free Antenatal Care</td>
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<td>Abuja</td>
<td>Agnes E. Olra</td>
<td>Federal Capital Territory</td>
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<td></td>
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<td>Rakiye Musa</td>
<td>Asokoro General Hospital, Federal Capital Territory</td>
<td>RMN, Principal Nursing Officer</td>
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<td></td>
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<td>Three staff</td>
<td>Jikwoyi Primary Health Care Clinic</td>
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<tr>
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<td>Name</td>
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<tr>
<td>1 June 2009</td>
<td>Abakaliki, Ebonyi State</td>
<td>Steve O. Orugwu</td>
<td>Ministry of Health Abakaliki, Ebonyi State Government of Nigeria</td>
<td>Permanent Secretary</td>
<td>08035852955 <a href="mailto:steveorogwu@yahoo.com">steveorogwu@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Abakaliki, Ebonyi State</td>
<td>Sunday Nwangele</td>
<td>State Ministry of Health, Ebonyi State Government of Nigeria</td>
<td>Hon. Commissioner for Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abakaliki, Ebonyi State</td>
<td>Her Excellency, Ms. Josephine N. Elechi</td>
<td>Office of the Wife of the Governor of Ebonyi State</td>
<td>Ebony State Governor's Wife</td>
<td>+234 043 220027 <a href="mailto:motherandchildcareinitiative@yahoo.com">motherandchildcareinitiative@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Abakaliki, Ebonyi State</td>
<td>Sunday Adeoye</td>
<td>Office of the Wife of the Governor of Ebonyi State</td>
<td>Coordinator of the Mother and Child Care Initiative, Director South East Regional Fistula Centre</td>
<td><a href="mailto:juladeoye@yahoo.co.uk">juladeoye@yahoo.co.uk</a></td>
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<td>UNFPA Nigeria</td>
<td>National Programme Officer</td>
<td>+234 9 461 6100 <a href="mailto:olajide@unfpa.org">olajide@unfpa.org</a></td>
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<tr>
<td>2 June 2009</td>
<td>Abakaliki</td>
<td>Aliyo Yakubu</td>
<td>UNFPA Nigeria, Abakaliki</td>
<td>Zonal Head, Abia Zonal Office, former UNFPA Programme Adviser for Sokoto</td>
<td>+234 9 461 6100 <a href="mailto:olajide@unfpa.org">olajide@unfpa.org</a></td>
</tr>
<tr>
<td></td>
<td>Abakaliki</td>
<td>Ademola Olajide</td>
<td>UNFPA Nigeria</td>
<td>National Programme Officer</td>
<td>+234 9 461 6100 <a href="mailto:olajide@unfpa.org">olajide@unfpa.org</a></td>
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<tr>
<td></td>
<td>Abakaliki</td>
<td>Cecilia Akano</td>
<td>Ebony State Government of Nigeria</td>
<td>Special Advisor to the Governor on Women Mobilisation</td>
<td></td>
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<tr>
<td>3 June 2009</td>
<td>Abuja</td>
<td>Gabriel Bako</td>
<td>UNFPA Nigeria</td>
<td>Operations Manager</td>
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<tr>
<td></td>
<td>Abuja</td>
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<td>NPO – Health Economics</td>
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</tr>
<tr>
<td>4 June 2009</td>
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<tr>
<td></td>
<td>Abuja</td>
<td>Godwin Asuguo</td>
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<td>Head Reproductive Health</td>
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</tr>
<tr>
<td></td>
<td>Abuja</td>
<td>Hauwa Yaro</td>
<td>UNFPA Nigeria</td>
<td>NPA - Gender</td>
<td><a href="mailto:yaro@unfpa.org">yaro@unfpa.org</a></td>
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</table>
## Date, Place, Name, Organisation, Position, Tel/e-mail

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<tr>
<th>Date</th>
<th>Place</th>
<th>Name</th>
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<th>Position</th>
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<tr>
<td>Abuja</td>
<td>Kori a. Habib</td>
<td>UNFPA Nigeria</td>
<td>Media Associate</td>
<td><a href="mailto:habib@unfpa.org">habib@unfpa.org</a></td>
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### Annex 3. Programme of the mission

#### Work Programme, Field Visit to Nigeria

**Evaluation of the End Fistula Campaign, 21 May – June 4th, 2009**

<table>
<thead>
<tr>
<th>Date / Place</th>
<th>Activity</th>
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<tbody>
<tr>
<td>21/05/09 Abuja</td>
<td>Arrival of team – (Marta Medina and Magali Rommedamme)</td>
</tr>
</tbody>
</table>
| 22/05/09 Abuja | - 04:30 Arrival of team: Els Duysburg  
- 10:00 Meeting with UNFPA National Programme Officer (Obstetric Fistula)  
- 13:30 Meeting with Coordinator Engender Health |
| 23/05/09 Abuja | 10:00 Meeting with UNFPA Regional Focal point for Fistula  
18:45 Arrival of team: Marcel Reyners |
| 24/05/09 Abuja | Team work |
| 25/05/09 Abuja | - 09:00 Introductory meeting with UNFPA CO staff  
- 11:00 Meeting with National Fistula Coordinator, Federal Ministry of Health  
- 15:00 Meeting with Acting Director Medical Services, Federal Capital Territory  
18:00 Air travel to Kano |
| 26/05/09 Katsina State | - 08:00 Meeting with Dr. Kees Waaldijk  
- 09:30 Group A, travel to Katsina  
  o Babbar Ruga General Hospital:  
    - Visit to Hajia Fatima VVF/RVF Theatre  
    - Visit to VVF Fistula Centre  
    - Interview Fistula Clients  
  o Visit to Dr. Kees Waaldijk VVF Rehabilitation Centre  
  o Meeting with Permanent Secretary, Ministry of Women Affairs and Social Development, Katsina State  
  o Meeting with Director of Public Health  
  o Meeting with State Secretary Red Cross  
  o Meeting with MState Fistula Coordinator  
- 09:30 Group B, travel to Kankara:  
  o Meeting with LGA Primary Health Care Coordinator and RH Coordinator  
  o Meeting with female and male Fistula Community Educators  
  o Meeting with ex-fistula patients  
15:30 Travel back to Kano |
| Kankara LGA, Katsina State |  
| 27/05/09 Kano State | - 08:00 Mutamar Mohammed Specialist Hospital, Kano  
  o Visit to VVF Centre  
  o Meeting with Head of Dept. Obstetrics & Gynaecology  
  o Visit to Obstetric Ward  
- 12:00 Meeting with Kano State Fistula Coordinator |
<table>
<thead>
<tr>
<th>Date / Place</th>
<th>Activity</th>
</tr>
</thead>
</table>
|             | - 13:00 Visit to Kwali Rehabilitation Centre  
|             | - 14:00 Meeting with Commissioner of Ministry of Women Affairs and Social Development, Kano State  
|             | - 15:00 Meeting with Assistant Commissioner for Health Promotion and Primary Health Care, Kano State Ministry of Health  
|             | - 16:00 Meeting with Fistula Project, Rotary International Night in Kano |
| 28/05/09 Abuja | - 08:00 Air travel Kano to Abuja  
|             | - 11:00 Meeting with UNFPA Assistant Representative  
|             | - 15:00 Meeting with Minister, Federal Ministry of Women Affairs and Social Development  
|             | - 16:00 Meeting with Rotary International |
| 29/05/09 Abuja | - 06:15 Departure Els Duysburg  
|             | - 08:00 Meeting with UNICEF  
|             | - 08:45 Meeting with UNFPA Deputy Representative  
|             | - 10:30 Meeting with UNFPA National Programme Officer (Obstetric Fistula)  
|             | - Afternoon: Individual work for team members  
|             | - 16:00 Departure Magali Rommedane |
| 30/05/09 Abuja | - 10:30 Visit to Asokoro General hospital, Federal Capital Territory  
|             | - 11:30 Visit to Jikwoyi Primary Health Care Clinic, Federal Capital Territory  
|             | - Afternoon: Individual work for team members |
| 31/05/09 Travel to Ebonyi State | - Morning: Team work  
|             | - 17:00 Air travel from Abuja – Enugu  
|             | - 18:30 Travel from Enugu – Abakaliki |
| 1/06/09 Abakaliki, Ebonyi State | Morning:  
|             | - Meeting with Permanent Secretary, Ministry of Health, Ebonyi State  
|             | - Meeting with Hon. Commissioner for Health, Ebonyi State  
|             | - Meeting with UNFPA National Programme Officer (Obstetric Fistula)  
|             | - Meeting with Her Excellency Wife of the Ebonyi State Governor  
|             | Afternoon  
|             | - Meeting with Director of Mother and Child Care Initiative and Director of South East Regional Fistula Centre  
|             | - Interview with fistula clients  
|             | - Visit to South East Regional Fistula Centre |
| 2/06/09 Abakaliki, Ebonyi State | Morning:  
|             | - Meeting with UNFPA National Programme Officer (Obstetric Fistula)  
|             | - Meeting with Special Advisor to the Governor on Women Mobilisation  
|             | - Meeting with UNFPA Zonal Coordinator South (cont)  
|             | Afternoon:  
|             | - 13:00 Travel to Enugu  
|             | - 15:25 Air travel Enugu – Abuja |
| 3/06/09 | - 09:30 Meeting with UNFPA Operations Manager  
<p>|             | - 10:30 Meeting with UNFPA NPO – Health Economics |</p>
<table>
<thead>
<tr>
<th>Date / Place</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuja</td>
<td>Afternoon</td>
</tr>
<tr>
<td></td>
<td>- Team work, prepare debriefing</td>
</tr>
<tr>
<td>4/06/09</td>
<td>10:30 Debriefing with UNFPA</td>
</tr>
<tr>
<td>Abuja</td>
<td>Team Departs</td>
</tr>
</tbody>
</table>
Annex 4. List of documents available to the team

Reports, work documents, frameworks

24. Report of the six Months Pilot of the Prevention, Treatment and Rehabilitation of Obstetric Fistula in Northern Nigeria. Supported by Virgin Unite, submitted by UNFPA.
37. Tsui S, Williamson NE. Child spacing and family planning attitudes of young married men and women in selected areas of North West Nigeria. In: Child Spacing Attitudes in Northern Nigeria. USAID and FHI.
42. Wolf M, Abubakar A. Islam and Family Planning with special emphasis on Northern Nigeria. Literature review. In: Child Spacing Attitudes in Northern Nigeria. USAID and FHI.
43. Fatusi, Adesegum O.; Ijadumola, Kayode, National Study on Essential Obstetric Care Facilities in Nigeria, FMoH, UNFPA, May 2003

UNFPA Campaign to end fistula

4. Campaign to End Fistula, Nigeria. Phase III, Country Situation at Baseline, September, 2004
10. The Fistula Fortnight. Healing Wounds, Renewing Hope. 21 February – 6 March 2005; Kano, Katsina, Kebbi and Sokoto states, Nigeria. Campaign to end fistula, UNFPA,
12. UNFPA State Population and development programmes

Selected Medical literature


This recent publication contains all VVF publications of the author.
14. Wall, LL. Dead Mothers and Injured wives: the social context of maternal morbidity and mortality among the Hausa of northern Nigeria.

15. Wara HL. Strengthening Fistula Services at Kebbi VVF Center: the journey so far. April 2008


Websites:

- Campaign to End Fistula
- The Fistula Care Project
- Fistula Foundation
- Hamlin Fistula Welfare and Research Ltd (The Fistula Trust)
- International Organization For Women and Development, Inc. (IOWD)
- Love Labor Loss: A Film-based Campaign on Obstetric Fistula
- One By One
- SafeHands for Mothers
- Virgin Unite - End Fistula
- The Worldwide Fistula Fund
- “Carry me Home”, documentary about women with VVF in northern Nigeria
- Natalie Imbruglia and the Campaign to End Fistula: Interview in Indian press

Other websites:

- Medical Missionaries of Mary
- UNFPA: [www.unfpa.org](http://www.unfpa.org)
- Hamlin Fistula Relief and Aid Fund: [www.fistulatrust.org](http://www.fistulatrust.org)
- MaterCare International: [www.matercare.org](http://www.matercare.org)
- International Federation of Gynecology and Obstetrics: [www.figo.org](http://www.figo.org)
- World Health Organization: [www.who.int](http://www.who.int)
- EngenderHealth: [www.engenderhealth.com](http://www.engenderhealth.com)
- FIGO endorsed Women’s Health Portal: [www.obgynworld.com](http://www.obgynworld.com)

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Annex 5. Overview of fistula activities in the country, including main providers of fistula services in the country

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>State</th>
<th>Town</th>
<th>VVF repairs done</th>
<th>No. Doctors carrying out VVF repairs 2009</th>
<th>Average Cost per VVF repair</th>
<th>Rehab</th>
<th>Proprietor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North West Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babbar Ruga Fistula Hospital</td>
<td>Katsina</td>
<td>Katsina</td>
<td>560</td>
<td>2</td>
<td>N300</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Murtala Moh’d Specialist Hospital</td>
<td>Kano</td>
<td>Kano</td>
<td>443</td>
<td>3</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Maryam Abacha Women &amp; Children hospital</td>
<td>Sokoto</td>
<td>Sokoto</td>
<td>125</td>
<td>3</td>
<td>N10,000 to N50,000</td>
<td>Free</td>
<td>MoWA</td>
</tr>
<tr>
<td>General Hospital Jahun</td>
<td>Jigawa</td>
<td>Jahun</td>
<td>176</td>
<td>2</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Special fistula center Birni Kebbi</td>
<td>Kebbi</td>
<td>Kebbi</td>
<td>67</td>
<td>2</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Faridat Yakubu VVF hospital</td>
<td>Zamfara</td>
<td>Gusau</td>
<td>22</td>
<td>2</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Aminu Kano Teaching Hospital</td>
<td>Kano</td>
<td>Kano</td>
<td>2</td>
<td>4</td>
<td>N35,000</td>
<td>No</td>
<td>Federal MOH</td>
</tr>
<tr>
<td>Wudil General Hospital</td>
<td>Wudil</td>
<td></td>
<td>42</td>
<td>2</td>
<td>Free (Rotary pays)</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>General Hospital Dambatta</td>
<td>Kano</td>
<td>Dambatta</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Gambo Sawaba General Hospital, Kofan Gayan</td>
<td>Kaduna</td>
<td>Zaria</td>
<td>64</td>
<td>3</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Ahmadu Bello University Teaching Hospital, Zaria</td>
<td>Kaduna</td>
<td>Zaria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>sub-total</strong></td>
<td></td>
<td></td>
<td>1459</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>North East Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist hospital VVF centre</td>
<td>Borno</td>
<td>Maiduguri</td>
<td>13</td>
<td>2</td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
</tbody>
</table>
## Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula
### Country Assessment Nigeria

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>State</th>
<th>Town</th>
<th>VVF repairs done</th>
<th>No. Doctors carrying out VVF repairs 2009</th>
<th>Average Cost per VVF repair</th>
<th>Rehab Programme</th>
<th>Proprietor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2004  2005  2006  2008</td>
<td></td>
<td></td>
<td>Actual Cost</td>
<td>Cost to patient</td>
</tr>
<tr>
<td>Federal Medical centre Nguru</td>
<td>Yobe</td>
<td>Nguru</td>
<td>6    9    14    27    3</td>
<td>N16,000</td>
<td>No</td>
<td>Federal MOH</td>
<td></td>
</tr>
<tr>
<td>University of Maiduguri Teaching</td>
<td>Borno</td>
<td>Maiduguri</td>
<td>15   10   14    9    3</td>
<td>N35,000 to N45,000</td>
<td>No</td>
<td>Federal MOH</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Medical centre Gombe</td>
<td>Gombe</td>
<td>Gombe</td>
<td>18   21   18    21    4</td>
<td>N20,000</td>
<td>No</td>
<td>Federal MOH</td>
<td></td>
</tr>
<tr>
<td><strong>sub-total</strong></td>
<td></td>
<td></td>
<td>52   57   69    91    12</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>North Central Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evangel Hospital</td>
<td>Plateau</td>
<td>Jos</td>
<td></td>
<td></td>
<td>Free</td>
<td>Yes</td>
<td>ECWA Missionary</td>
</tr>
<tr>
<td>Jos University Teaching Hospital</td>
<td>Plateau</td>
<td>Jos</td>
<td>15   18   16    20    3</td>
<td>N16,000</td>
<td>No</td>
<td>Federal MOH</td>
<td></td>
</tr>
<tr>
<td><strong>sub-total</strong></td>
<td></td>
<td></td>
<td>15   18   16    20    3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>South East Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East Zonal VVF centre,</td>
<td>Ebonyi</td>
<td>Abakaliki</td>
<td></td>
<td></td>
<td>Free</td>
<td>Yes</td>
<td>State MOH</td>
</tr>
<tr>
<td>Abakaliki</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Life centre Itam Mbirit</td>
<td>Akwaibom</td>
<td>Itam-Mbirit</td>
<td></td>
<td></td>
<td>Free</td>
<td>Yes</td>
<td>Missionary</td>
</tr>
<tr>
<td><strong>sub-total</strong></td>
<td></td>
<td></td>
<td>238  349  216   220    5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>South West Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University College Hospital</td>
<td>Oyo</td>
<td>Ibadan</td>
<td>36   41   35    39    4</td>
<td>N35,000</td>
<td>Yes</td>
<td>Federal MOH</td>
<td></td>
</tr>
<tr>
<td><strong>sub-total</strong></td>
<td></td>
<td></td>
<td>36   41   35    39    4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>1800  2283 1982  1730    47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Annex 6. Indicator framework for Nigeria

### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td><strong>Result 1: Enhanced political and social environment for the reduction of maternal mortality and morbidity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median age at first childbirth (DHS, use of Services, PS6 Core)</td>
<td>19.3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NDHS  03</td>
<td></td>
</tr>
<tr>
<td>CPR (DHS, Use of services, P.5.1 Core)</td>
<td>8.20%</td>
<td></td>
<td></td>
<td></td>
<td>15%</td>
<td>NDHS  03, NDHS 08</td>
<td></td>
</tr>
<tr>
<td>Unmet need FP (DHS, Access/demand, P.3.1 Additional)</td>
<td>17%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NDHS  03</td>
<td></td>
</tr>
<tr>
<td>Skilled attendance at delivery (use of services, P.5.3) or facility births (P.5.2 Core)</td>
<td>36.3% (2003); 32.6% (2008)</td>
<td></td>
<td></td>
<td>39% (2003); 35% (2008)</td>
<td></td>
<td>NDHS  03, NDHS 08</td>
<td></td>
</tr>
<tr>
<td>RHCS (access/availability, any info on facilities with 3 FP methods, P.4.1 Core) any stock-outs (access/availability, P.4.2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>
### Nigeria Indicator Framework for evaluation of Fistula progress to date

#### Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women, partners who know they need to go to a health facility if no delivery after 12 hours hard labour (DHS[3][4], access / information, P.2.1 Core)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
</tr>
<tr>
<td>Female literacy 15-24 (DHS, PS.5 Core)</td>
<td>15-19 (61.3%); 20-24 (56.4%)</td>
<td></td>
<td></td>
<td>64.50%</td>
<td></td>
<td>NDHS 03 &amp; NDHS 08</td>
<td></td>
</tr>
<tr>
<td>Proportion of national budget allocated to RH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laws which delay the age of marriage after 18 (PS.9 Extended)</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td>FMWA &amp; SD</td>
<td></td>
</tr>
</tbody>
</table>

**Result 2:** Integration of fistula interventions into ongoing safe motherhood and reproductive health policies, services and programmes
### Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula
#### Country Assessment Nigeria

**Nigeria Indicator Framework for evaluation of Fistula progress to date**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric fistula integrated into national reproductive health strategies and plan&lt;sup&gt;5,6&lt;/sup&gt;</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td>OF information reported by the existing HIS database (PS.10 Core)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Of indicators to be included in UNFPA CP M&amp;E from 09</td>
</tr>
<tr>
<td>Proportion of health facilities with surgical capacity recording data on obstetric fistula at facility, regional and national levels (PS.11).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Only sites providing surgical treatment for VVF keep records at facility level</td>
</tr>
</tbody>
</table>

**Result 3**: increased national capacity to reduce maternal mortality and morbidity

| % of labours managed with a partograph and with the adherence to a management protocol (audits, access/quality, | | | | | | | Not available |
### Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.5.6 Extended)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td>Management of obstructed labour by protocol (P.5.5 Extended)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual tertiary institutions have protocol, manuals have also been produced by FMOH with support of partners for PHC and first referral centres</td>
</tr>
<tr>
<td>Obstructed labour case/fatality rate (access/quality)</td>
<td>13.8% for Referral facilities &amp; 4.1% for EOC facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National Study on EOC facilities in Nigeria, 2003</td>
<td>This study was conducted by the FMOH supported by UNFPA</td>
</tr>
</tbody>
</table>
Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula
Country Assessment Nigeria

### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities with functioning quality review/improvement process in the maternity unit (focuses on all levels of prevention, emergency response, and treatment) (Access/quality)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National data, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites</td>
<td>The Teaching hospitals (about 15) &amp; Federal Medical centres (About 18) conduct mortality reviews. This rarely happens at PHC and secondary health facilities</td>
</tr>
<tr>
<td>% of women who survived obstructed labours with or without a Caesarean section and who are appropriately managed according to WHO protocols (facilities audits, Access/quality)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National data, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites, UNFPA supported sites</td>
<td></td>
</tr>
</tbody>
</table>

The Teaching hospitals (about 15) & Federal Medical centres (About 18) conduct mortality reviews. This rarely happens at PHC and secondary health facilities.
### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of EmOC facilities established/strengthened according to the standard guidelines and functioning 24/7 (P.1.3 Additional)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
</tr>
<tr>
<td>50.1% PHC, 90.2% Secondary Health facilities and 100% tertiary Health facilities provide 24 hour obstetric services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Health facilities with basic/essential and with comprehensive care per 500,000 people and geographical | Lagos state had 4 BEOC/50,000 population, Seven other states had 1 CEOC/50,000 | - | - | - | - | National Study on EOC facilities in Nigeria, 2003, Overall 18.5% of facilities met EOC criteria |

| Result 4: Increased access to and utilization of quality basic and emergency obstetric care services | |

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Annexes - Page 30
<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of women with obstetric complications treated in an EmOC facility in identified sites (disaggregate for obstructed labour and uterine rupture). According to The Campaign this has been the most difficult indicator for which to collect data. (access/demand, P.3.2 Additional)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td>C-section rate by income quintile, education of mother (DHS, use of services, P.5.4 Core) If possible, disaggregate by urban/rural</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National Study on EOC facilities in Nigeria, 2003</td>
<td></td>
</tr>
</tbody>
</table>

Result 5: Increased access to and utilization of quality fistula treatment services (Treatment goal)
### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of guidelines and standards on fistula management and training (access/quality, T.2 Core). Status of protocols for diagnosis, treatment, and counselling of women with obstetric fistula</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td>Number of women treated for obstetric fistula per year (disaggregate by simple and complex) (Access/availability, T.3 Core)</td>
<td>1800</td>
<td>2283</td>
<td>1982</td>
<td>1730</td>
<td>see Annex 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>UNFPA supported sites</th>
<th>2005</th>
<th>UNFPA supported sites</th>
<th>2006</th>
<th>UNFPA supported sites</th>
<th>2007</th>
<th>UNFPA supported sites</th>
<th>2008</th>
<th>UNFPA supported sites</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number/percent of repair surgery (outcome, access/quality) (Closed and dry: closed with stress incontinence/improved T.5 Core; closed but still leaking; irreparable; complications; death) (Access/quality). Case fatality rates of OF repair if available (T.7 Core)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National VVF Project Nigeria Evaluation Report XXII 2005</td>
<td>Data available only for centres visited by Dr Kees</td>
</tr>
<tr>
<td>Success rate at VVF closure = 90% per operation; Success rate at RVF repair = 85% per operation; Stress incontinence = 2-3%; Wound infection rate &lt; 0.5%; Post op mortality rate 0.5-1%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OF onset-to-repair interval (&lt; 3 months; 3 months to 1 year, &gt; 1 year) (use of services, T.3.A Core, T.8 additional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
</tr>
</tbody>
</table>
## Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of functioning referral centres for fistula treatment - should be at least one per country (access/availability, T.1 core)</td>
<td>National data</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
</tr>
<tr>
<td>Number of fistula repair trainers in the country; at least two (Training)</td>
<td>Three: Dr. Kees, Prof. Ojengbede and formerly Dr. Ann Ward were considere d trainers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UNFPA Progress report 08</td>
<td>Potentially the following can be trainers: Drs Amir Yola, Idris halliru, Z. Iliyasu, J. Karshima, S. lengman, Idris Abubakar, Mairiga, Sunday Adeoye.</td>
</tr>
<tr>
<td>Indicators</td>
<td>2004</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>Sources</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>---------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of medical schools with standard simple fistula repair programme for doctors and surgeons (Training)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>Currently none. Potentially, Aminu Kano Teaching Hospital, Ahmadu Bello University Teaching Hospital, UDUTH Sokoto &amp; Ebonyi State Univ. Abakaliki.</td>
</tr>
<tr>
<td>Indicators</td>
<td>2004</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>Sources</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Proportion of professionals trained practicing fistula treatment and care (disagggregated by cadre – e.g. doctors, nurses, other paramedical staff, social workers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National data</td>
<td>From 1989-2008, Dr. Waaldijk from the National Fistula Project reports training 707 people from various disciplines (350 doctors, 322 nurses and 70 others)</td>
</tr>
<tr>
<td>(Training)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UNFPA supported sites</td>
<td>7 out of 12 surgeons trained during the fortnight are practicing in 2009</td>
</tr>
<tr>
<td>Surgical competency upon completing the entire training program for fistula repair (T.9 Core)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National data</td>
<td>It is reported that these data are not very available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UNFPA supported sites</td>
<td>Basic competency to handle simple fistulas</td>
</tr>
</tbody>
</table>
### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance and improvement of skills among surgeons with OF repair training (T.10 Additional)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advanced &amp; refresher training provided</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Result 6: increased availability of services to assist women with repaired fistula to reintegrate into their community (Reintegration Goal)**

<table>
<thead>
<tr>
<th>Proportion of treatment facilities which offer social reintegration services (including direct offer, referral, etc.) (SR1, Core)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>UNFPA Progress report 08</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pilot sites in Nassarwa LG, Kano, Kankara LGA Katsina &amp; Abakaliki, Ebonyi state</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number and distribution of community-based reintegration services</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data not available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proportion of former fistula clients who came back with recurrent obstetric</th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>Indicators</td>
<td>2004</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>Sources</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------</td>
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<td>------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>fistula</strong></td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td>Number of former fistula clients who serve as peer educators or advocates in their communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of treatment facilities with skilled staff for psychological/social support and follow up. (SR. 3 Additional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of women with OF repair who (1) a received reintegration services (SR.2); (2) actually started small businesses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Global/regional level</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Result 7 : increased national capacity for obstetric fistula elimination and improvement of maternal health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nigeria Indicator Framework for evaluation of Fistula progress to date

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of health budget for RH/maternal health including OF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
</tr>
<tr>
<td>National plan/strategy for OF elimination available, costed and funded</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Draft strategy available and costed</td>
</tr>
<tr>
<td>See also indicators above related to training and number of functioning facilities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Result 8: Enhanced decision-making through global monitoring and evaluation of progress in fistula elimination**

| Degree of analysis and use of data for national plan evaluation (at the facility and national level), *(qualitative assessment)* |         |         |         |         |         |         | Poor to none |

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**Annexes - Page |39**
<table>
<thead>
<tr>
<th>Nigeria Indicator Framework for evaluation of Fistula progress to date</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional recording and reporting system in countries in place, (qualitative assessment)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>Non-existing</td>
</tr>
<tr>
<td>Monitoring mechanisms established and operational in countries, (qualitative assessment)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>Non-existing</td>
</tr>
</tbody>
</table>

**Result 9: Increased visibility and support for obstetric fistula elimination from policy makers, international organisations and donors**

<p>| Amount of financial resources available for fistula programming by country, by year and source of funding. |  |  |  |  |  | No specific government budget line for OF |
| Specific actions derived from any special public declaration /commitment from policy makers, international organizations and donors for fistula elimination. |  |  |  |  |  | Ebonyi state issued the law for monitoring maternal mortality |</p>
<table>
<thead>
<tr>
<th>Nigeria Indicator Framework for evaluation of Fistula progress to date</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Sources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(qualitative assessment)</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
<td>UNFPA supported sites</td>
<td>National data</td>
</tr>
<tr>
<td><strong>Result 10</strong>: Enhanced collaboration and coordination of global and regional efforts in the elimination of obstetric fistula</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main achievements derived from the operation and functioning of the national fistula working group, <em>(qualitative assessment)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Fistula Working Group not functioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main achievements derived from National and/or regional conferences/fora or exchange of experiences <em>(technical, programmatic)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators</td>
<td>2004</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>Sources</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Main achievements derived from the operation and functioning of the</td>
<td>National</td>
<td>National</td>
<td>National</td>
<td>National</td>
<td>National</td>
<td>UNFPA supported sites</td>
<td></td>
</tr>
<tr>
<td>international fistula working group and each of its respective</td>
<td>data</td>
<td>data</td>
<td>data</td>
<td>data</td>
<td>data</td>
<td>sites</td>
<td>Not</td>
</tr>
<tr>
<td>committees, (qualitative assessment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>sources</td>
<td>applicable</td>
</tr>
</tbody>
</table>
### Annex 7. Financial tables

**Nigeria Fistula Campaign 2005-2008; Funds allocations and expenditures**

By year and source of funding in USD

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Allocations</th>
<th>Expenditures</th>
<th>Balance</th>
<th>Financial Exec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2005</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA CO Core Resources</td>
<td>176,000.00</td>
<td>167,592.97</td>
<td>8,407.03</td>
<td>95%</td>
</tr>
<tr>
<td>Virgin Unite (VF101)</td>
<td>32,942.53</td>
<td>27,365.67</td>
<td>5,576.86</td>
<td>83%</td>
</tr>
<tr>
<td>Swedish Fund (SEA27)</td>
<td>350,000.00</td>
<td>144,769.43</td>
<td>205,230.57</td>
<td>41%</td>
</tr>
<tr>
<td>Finland Fund (FIA03)</td>
<td>36,716.00</td>
<td>34,154.49</td>
<td>2,561.51</td>
<td>93%</td>
</tr>
<tr>
<td><strong>subtotal 2005</strong></td>
<td>595,658.53</td>
<td>373,882.56</td>
<td>221,775.97</td>
<td>63%</td>
</tr>
<tr>
<td><strong>2006</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSF (Japan)</td>
<td></td>
<td>26,524.53</td>
<td>(26,524.53)</td>
<td></td>
</tr>
<tr>
<td><strong>subtotal 2006</strong></td>
<td></td>
<td>26,524.53</td>
<td>(26,524.53)</td>
<td></td>
</tr>
<tr>
<td><strong>2007</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA (ZZT03)</td>
<td>178,695.00</td>
<td>140,444.00</td>
<td>38,251.00</td>
<td>79%</td>
</tr>
<tr>
<td>Virgin Unite (VF101)</td>
<td>206,079.00</td>
<td>76,328.00</td>
<td>129,751.00</td>
<td>37%</td>
</tr>
<tr>
<td>HSF (Japan) *</td>
<td>939,975.00</td>
<td>19,683.00</td>
<td>920,292.00</td>
<td>2%</td>
</tr>
<tr>
<td><strong>subtotal 2007</strong></td>
<td>1,324,749.00</td>
<td>236,455.00</td>
<td>1,088,294.00</td>
<td>18%</td>
</tr>
<tr>
<td><strong>2008</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA UU201</td>
<td>46,204.35</td>
<td>44,558.35</td>
<td>1,646.00</td>
<td>96%</td>
</tr>
<tr>
<td>Virgin Unite (VF101)</td>
<td>129,751.00</td>
<td>-</td>
<td>129,751.00</td>
<td>0%</td>
</tr>
<tr>
<td>HSF Japan*UHA 10</td>
<td>920,292.00</td>
<td>4,018.00</td>
<td>916,274.00</td>
<td>0.44%</td>
</tr>
<tr>
<td>UNFPA (FPA90)</td>
<td>82,000.00</td>
<td>80,963.10</td>
<td>1,036.90</td>
<td>99%</td>
</tr>
<tr>
<td><strong>subtotal 2008</strong></td>
<td>1,178,247.35</td>
<td>129,539.45</td>
<td>1,048,707.90</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Gran Total</strong></td>
<td></td>
<td></td>
<td></td>
<td>766,401.54</td>
</tr>
</tbody>
</table>

Source: team elaboration from Annual Country reports 2005-2008

*HSF Japan: low implementation rate due to delays in construction of the Abuja Treatment Centre.
### Nigeria Fistula Campaign 2005-2008; Funds allocations and expenditures

By source of funding in USD

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Allocations</th>
<th>Expenditures</th>
<th>Balance</th>
<th>Financial Exec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Virgin Unite</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virgin Unite (VF101)</td>
<td>32,942.53</td>
<td>27,365.67</td>
<td>5,576.86</td>
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<td>37%</td>
</tr>
<tr>
<td>Virgin Unite (VF101)</td>
<td></td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total Virgin Unite</strong></td>
<td>239,021.53</td>
<td>103,693.67</td>
<td>135,327.86</td>
<td>43%</td>
</tr>
<tr>
<td><strong>Total UNFPA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNFPA CO Core Resources</td>
<td>176,000.00</td>
<td>167,592.97</td>
<td>8,407.03</td>
<td>95%</td>
</tr>
<tr>
<td>UNFPA (ZZT03)</td>
<td>178,695.00</td>
<td>140,444.00</td>
<td>38,251.00</td>
<td>79%</td>
</tr>
<tr>
<td>UNFPA (UU201)</td>
<td>46,204.35</td>
<td>44,558.35</td>
<td>1,646.00</td>
<td>96%</td>
</tr>
<tr>
<td>UNFPA (FPA90)</td>
<td>82,000.00</td>
<td>80,963.10</td>
<td>1,036.90</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Total UNFPA</strong></td>
<td>482,899.35</td>
<td>433,558.42</td>
<td>49,340.93</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Total HSF (Japan)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSF (Japan)</td>
<td></td>
<td>26,524.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSF (Japan) (to revise with Ademola)</td>
<td>939,975.00</td>
<td>19,683.00</td>
<td>920,292.00</td>
<td>2%</td>
</tr>
<tr>
<td>HSF (Japan)UHA 10</td>
<td></td>
<td>4,018.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total HSF (Japan)</strong></td>
<td>939,975.00</td>
<td>50,225.53</td>
<td>889,749.47</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Swedish Fund (SEA27)</strong></td>
<td>350,000.00</td>
<td>144,769.43</td>
<td>205,230.57</td>
<td>41%</td>
</tr>
<tr>
<td><strong>Finland Fund (FIA03)</strong></td>
<td>36,716.00</td>
<td>34,154.49</td>
<td>2,561.51</td>
<td>93%</td>
</tr>
<tr>
<td><strong>GRAN TOTAL</strong></td>
<td>2,048,611.88</td>
<td>766,401.54</td>
<td>1,282,210.34</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: team elaboration from Annual Country reports 2005-2008; * HSF Japan: low implementation rate due to delays in construction of the Abuja Treatment Centre
Annex 8. Modelling of the fistula dynamics in Nigeria

This modelling is based on following estimations:
- Prevalence (backlog) of fistula patients varies between 200,000 and 800,000
- Natural mortality among these patients (between 15 and 65 years) is ±20‰
- Incidence rate (new cases) is 20,000/year
- Number of current repairs: 4,000/year

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Repairs</th>
<th>Deaths</th>
<th>New cases: incidence</th>
<th>Comments: yearly changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number: prevalence</td>
<td>Type scenario</td>
<td>Backlog</td>
<td>New</td>
<td>(±20‰)</td>
</tr>
<tr>
<td>800,000</td>
<td>Worst</td>
<td>4,000</td>
<td>16,000</td>
<td>20,000</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>5,000</td>
<td>7,500</td>
<td>16,000</td>
</tr>
<tr>
<td></td>
<td>Best</td>
<td>10,000</td>
<td>10,000</td>
<td>16,000</td>
</tr>
<tr>
<td>500,000</td>
<td>Worst</td>
<td>4000</td>
<td>10,000</td>
<td>20,000</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>5,000</td>
<td>7,500</td>
<td>10,000</td>
</tr>
<tr>
<td></td>
<td>Best</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>200,000</td>
<td>Worst</td>
<td>4,000</td>
<td>4,000</td>
<td>20,000</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>5,000</td>
<td>7,500</td>
<td>4,000</td>
</tr>
<tr>
<td></td>
<td>Best</td>
<td>5,000</td>
<td>15,000</td>
<td>4,000</td>
</tr>
</tbody>
</table>

- **Worst scenario**: current situation, repair 4,000 cases annually, mortality 20/1000
- **Moderate scenario**: decrease in incidence by better emergency obstetric care and more treatments, repair half of all new cases and 5,000 “old” ones, incidence rate reduced by 25%, mortality: 20/1000
- **Best scenario**: all new cases treated plus backlog and optimal EmOC, incidence rate reduced by 50%, mortality: 20/1000

Formula’s used:

\[ I(t) = \text{Number of Persons with fistula at time } t \]
\[ T(t) = \text{Number of Corrections made at time } t \]
\[ K = \text{Backlog at time } t \]
\[ N = \text{Total number having Fistula at time } t \]

Assuming this number is constant over time then:

\[ N = K + I \left( \text{Backlog+New Infections} \right) \]

The equation of the model would therefore take the form
\[ \frac{dl}{dt} = \text{incidence rate} - \text{rate of removal} \]

Removal includes the treated and the dead
Thus the general equation of the model would be:
\[ \frac{dl}{dt} = \text{Backlog+New Infection- Repairs-Deaths} \]
This general equation applies the Euler’s method to arrive at the model.
Conclusion:

If we look at the scenarios with a backlog of 200,000 cases in 2009 and considering that it is estimated that presently only 4000 repairs are taken place every year. Tripling the number of repairs (12,500 per year) will not make a big difference in the number of backlog cases in year 2030. The country needs a big effort in scaling up the number of repairs (increase the number of yearly repairs five times the present number= 20,000 ) in order to reach in 14 years (2023) to a situation in which there will be no backlogs and all new cases will be repaired.

In the case of 500,000 backlog cases in 2009, a five times increase in number of repairs will not bring the country to the 0 point situation in the next 20 years (2030) where there will be still a backlog of 80,000.

In the case of 500,000 backlog cases in 2009, a five times increase in number of repairs will not bring the country to the 0 point situation in the next 20 years (2030) where there will be still a backlog of 254,000 cases.

The key message is that in order to eradicate fistula the country needs to make a substantial effort in increasing the number of repairs done every year and secure that this effort is sustained through the years to come.


FITSARI ‘DAN DUNIYA (URINE, THE OPPRESSOR OF THE WORLD)

Fitsari ’dan duniya fitsari ’dan Dandi.
Urine, the Oppressor of the world. Urine, who has forced me from my home.

Muna neman lafiya; sun ce mu tafi Dandi.
We went out looking to be healed, but they said we were all whores.

Ciwo ya same ni tun ina yarinya ta.
This sickness "caught me", when I was only a young girl.

Ina zauna a gida na ji labari mai kyau.
I sat confined at home until I heard the good news.

Nace:Wayyo, iya! Sai kiba ni ku’di .
I said, 'My word, mother! Give me the money’

Zan je Jos Jankwano zan sauka zan ga sabbin Turawa.
I will go to Jankwano in Jos! I will go down there and see the new Europeans!

Kamman gobe haka tiata zan sauka.
By this time tomorrow I will have arrived in the [operating] theatre.

Can wurin Karshima zaune.
I will remain there at Dr. Karshima’s place.

Dakta Karshima sai godiya muke Allah saka mar.
Doctor Karshima I thank you! May God bless you!

Ya dinken mata masu ciwin gana yoyo.
You have sewn up the leaking women.

Maigida ya yarda ni domin ina ciwon yoyo.
My husband threw me out because I was leaking.

Ciwo ya same ka sai su kai ka su yarda kai.
If this sickness "catches you" they’ll carry’ you out and throw you away too.