NATIONAL OBSTETRIC FISTULA STRATEGY

(2011/2012 – 2015/2016)

MINISTRY OF HEALTH

Table of Contents

abbreviations 2
1 Introduction 5
1.1 Background 5
1.2 Situation Analysis 5
1.3 Development Context 7
1.4 Rationale 8
1.5 The Strategic Plan 9
1.5.1 Vision 9
1.5.2 Goal 9
1.5.3 Objectives 9
1.5.4 Guiding Principles 9
2 Priority Areas and Strategies 10
2.1 Priority area 1: Prevention 10
Objective: To reduce the incidence of obstetric fistula 10
2.1.1 Prevention Strategy I: Improve access and utilization of quality Sexual & Reproductive Health and Family Planning services to prevent Obstetric Fistula 10
Key Activities 10
2.1.2 Prevention Strategy II: Strengthen Intersectoral Collaboration in obstetric fistula prevention 11
2.2 Priority area 2: Treatment 12
Objective: To Reduce Prevalence of Obstetric Fistula 12
2.2.1 Treatment Strategy I: Strengthen health system capacity to provide accessible high quality obstetric fistula treatment 12
2.2.2 Treatment Strategy II: Strengthen community capacity to support women living with fistula to access treatment 14
2.2.3 Treatment Strategy III: Establish a sustainable national fistula treatment support system .. 14
2.2.4 Reintegration Strategy I Provide rehabilitation and support services to all women presenting with fistula 15
Priority area 4: Advocacy and Behaviour Change Communication 16
2.2.5 Strategy 4.1 Develop and implement a communication Plan 16
3 MONITORING AND EVALUATION 18
4 IMPLEMENTATION ARRANGEMENTS 20
5 Roles and responsibilities 22
6 Logframe 24
7 Targets 31

ABBREVIATIONS

VVF	Vesico-Vaginal Fistula
RVF	Recto-Vaginal Fistula
UDHS	Uganda Demographic Health Survey
EmOC	Emergency Obstetric Care
VHT	Village Health Team
HSD	Health Sub-District
CBO	Community Based Organisation
SHG	Self Help Group
IEC	Information Education and Communication
BCC	Behaviour Change Communication
TWG	Technical Working Group
MOH	Ministry of Health
DHT	District Health Team
SRHR	Sexual and Reproductive health and Rights
FBO	Faith Based Organisation
MNH	Maternal and Newborn Health
YFHS	Youth Friendly Health Services
PNFP	Private Not For Profit

Preface

The government has instituted measures to accelerate the reduction of maternal morbidity and mortality including the development of the Roadmap to accelerate reduction of maternal and neonatal morbidity and mortality, increasing funding for reproductive health commodities, increasing the number of regional referral hospitals and improving the capacity of existing regional referral hospitals, and earmarking funds for reproductive health. As we endevour to deliver on the outputs of the Roadmap, we still have women succumbing to complications of pregnancy and in particular obstetric fistula.

Obstetric fistula is the single most important complication of pregnancy. A typical victim of this glaring condition is a young girl that is poor, illiterate and from a rural area. In 2006, 2.63% of women of reproductive age reported to have experienced symptoms of obstetric fistula immediately after birth.

By developing a National Obstetric Fistula Strategy, the government and Ministry of Health is reiterating its commitment towards eliminating this condition. The NOFS is a framework intended to guide the implementation of prevention, treatment and re-integration activities for obstetric fistula. The framework puts forth the key priorities, which should guide both government and non-government support including resource mobilization for the fistula programme. Given the multi-sectoral nature of the causes of obstetric fistula, the strategy stipulates the roles of other sectors if Uganda is to reduce significantly the current fistula burden.
I therefore, call upon all stakeholders from Government, Civil Society, Private sector and Development Partners to utilize this strategy in guiding planning, programmes and activities geared towards eradicating obstetric fistula in Uganda.

Dr Jane Aceng
Director General of Health Services
Ministry of Health

Acknowledgement

The development of this strategy was led by the Clinical Department of the Ministry of Health in collaboration with other departments and divisions at the Ministry of Health. Our appreciation goes to UNFPA for financial and technical assistance rendered to the development of this strategy.

Special tribute goes to the members of the Fistula Technical Working Group that were tirelessly involved in the development of this document: Dr Amone Jackson, Dr Opar Bernard.T ,Dr Okui Albert Peter, Mr. Eric Kakole, Dr Kadowa Isaac, Dr Tusingwire Collins, Dr Anthony Sikyatta , Dr Ssentumbwe Olive , Ms. Mukisa Edith, Dr Mukasa Peter, Ms. Joslyn Meier, Dr Mukisa Rose, Dr Ismail Ndifuna, Dr Wilfred Ochan, Dr Maura Lynch, Dr Barageine Justus, Dr Alia Godfrey, Dr Frank Asiimwe, Dr Ahimbisibwe Assa, Dr Odong Emintone, Dr Agel Yuventine, Dr Susan Wandera, Dr Waswa Ssalongo, Dr Kayondo Musa, Dr Mihayo Placid, Dr Busingye Pricilla, Dr Otim Tom, Dr Osinde Michael, Dr Banya Francis, Dr Kimera Charles, Dr Andrew Balyeku, Dr Kirya Fred, Dr Mwanje Haruna, Dr Byamugisha Josaphat, Dr Bawakanya Mayanja Stephene, Dr Adupa Drake, Joan Kabayambi, Dr Peter Waiswa, Dr Obore Susan, Dr Engenye Charles, Maikut Irene, Dr Olupot Robert.

It is hoped that this strategy will be used to guide all stakeholders in implementing fistula related activities.

Dr Amandua Jacinto
Commissioner Clinical Services
Ministry of Health

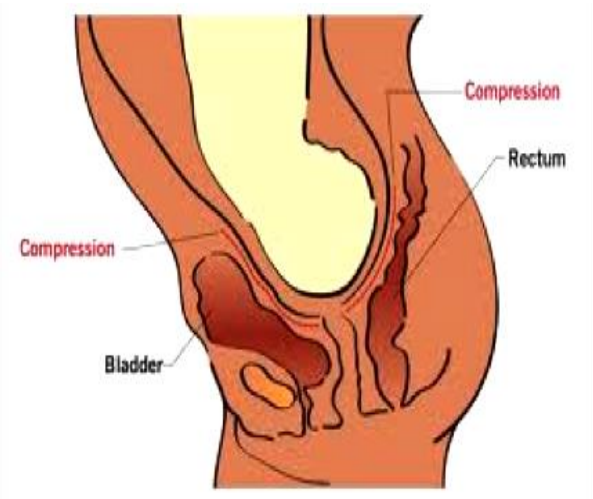
1 INTRODUCTION

1.1 BACKGROUND

This Obstetric Fistula Strategy 2010/2011 –2014/2015 of the Ministry of Health is premised on the need to accelerate access and quality of obstetric fistula prevention, treatment and rehabilitation services as the overarching themes of the global, regional and national campaign to eliminate obstetric fistula.

An obstetric fistula is an abnormal opening between the vagina and the bladder/ureter or rectum of a woman that results in constant leakage of urine and/or faeces through the vagina. According to World Health Organisation, obstetric fistula is the single most devastating consequence of obstructed/difficult labour to a mother in Sub-Saharan Africa. During obstructed labour, the bladder, vagina and rectum are compressed between the baby's head and the pelvis (see Figure 1). Prolonged pressure cuts off blood supply to the compressed tissue causing tissue death, sloughing and eventual "hole" between the bladder and vagina (Vesico-vaginal Fistula or VVF) or vagina and rectum (RVF) or both.

Figure 1: Pressure Points in Obstructed Labour



Other less common causes of fistula are from accidental surgical injuries especially Caesarean section/hysterectomy, Gynaecological cancers especially cancer of the cervix and its radiotherapy, sexual abuse and rape, complications of unsafe abortions.

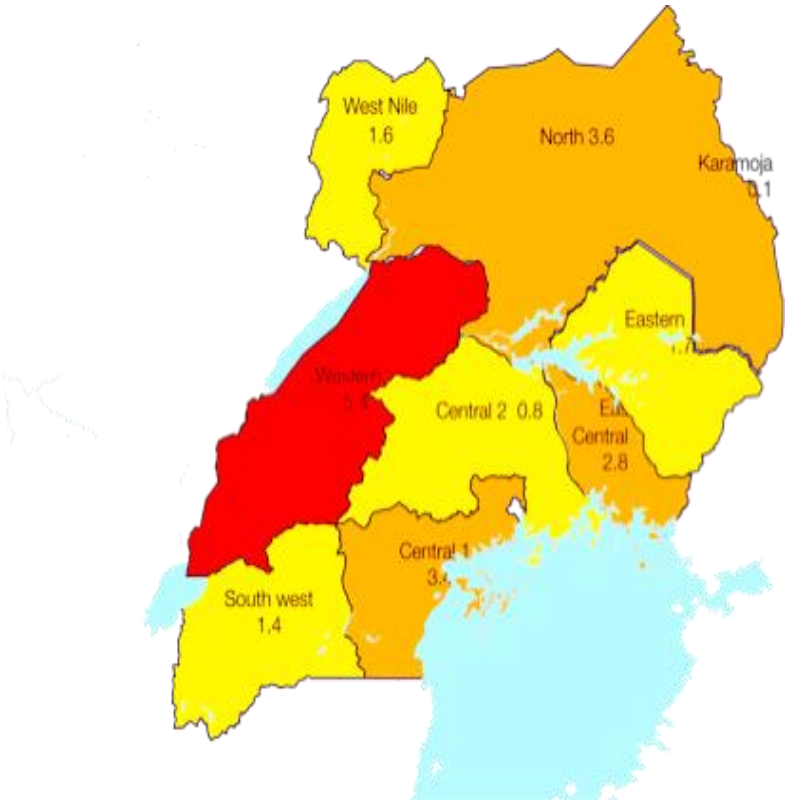
Women and girls with obstetric fistula are constantly soiled and wet, and they smell. This is further complicated by recurring infections, infertility, damage to their vaginal tissue that makes sexual activity difficult, and paralysis of the muscles in their lower legs. Many are often abandoned by their husbands, families and communities and end up living in abject poverty. Affected young girls or women tend to live with their fear and stigmatization in silence and isolation, unknown to the health-care system.

1.2 SITUATION ANALYSIS

Worldwide over two million women live with untreated obstetric fistula mainly in sub-Saharan Africa and Asia with an estimated 50,000 and 100,000 new cases annually. The number of women suffering from obstetric fistula in Uganda is estimated at 200,000 and about 1,900 new cases per year.

The most vulnerable group are the young, poor, illiterate and rural women who are economically disadvantaged. In Uganda, obstetric fistula symptoms are more prevalent among the western and central regions as shown in Figure 2.

Figure 1: Distribution of Fistula Symptoms In Uganda (UDHS 2006)



Young women under the age of 19 are at a higher risk of suffering pregnancy related disability such as obstetric fistula. Uganda has one of the highest teenage pregnancy rates in the world with one out of every four pregnancies in Uganda occurring among women less than 19 years of age. Illiteracy and early marriage make women more vulnerable to teenage pregnancy. Around 56% of all teenagers are already married and 80% of pregnant teenagers have had no education at all. Contraceptive prevalence among adolescents is only 9%.

Obstructed labour, globally estimated at 5% of live births, is the commonest immediate cause of obstetric fistula. Obstructed labour, like other pregnancy complications, usually presents unexpectedly and requires emergency obstetric care especially Caesarean Section. However, capacity of the health system to recognise and relieve obstructed labour in time is limited. Although over 90% of pregnant women attend ANC at least once, only 42% deliver in health facilities, worsened by the low use of a Partograph in monitoring labour. The national met need for EmOC is low at 40% and the Caesarean Section rate at 2.7% below the recommended minimum of 5%.

Obstetric fistula requires surgical repair. However many affected women often do not even know that a treatment exists for fistula and are often too poor to transport and support themselves in Hospitals. Out of the estimated 200,000 women with fistula, less than 3% have sought care.

So far, a number of fistula surgeons have been trained and only 40% of regional referral hospitals are offering routine obstetric treatment services. The majority of patients are treated in obstetric fistula surgical camps by local and visiting fistula surgeons, with success rates of above 80% being reported. Despite these efforts, the capacity to repair and reintegrate obstetric fistula cases in the country remains low with an accumulated 4,300 fistula cases that reported to health facilities still awaiting repair countrywide. Hospitals are generally understaffed, ill-equipped and insufficient in supplies, limiting the annual number of obstetric fistula repairs to below the number of new cases. The cost of one operation

and adjunct care is approximated at USD $ 300, which is prohibitive to wide scale availability and utilisation of treatment services.

Rehabilitation and re-integration services generally lack guidance on standards. Most reintegration services are facility based offering mainly counselling and transport refund to treated patients. Despite the civil society being relevant to community level reintegration, only a few organisations are offering services and at small scale.

Efforts to manage fistula where accelerated by the UNFPA led Campaign to End Fistula that was launched in 2003. Currently, coordination of fistula activities is led by the fistula technical working group in the Ministry of Health which brings together development partners, Academia, Civil society and treatment centres. The major partners include UNFPA, WHO, Engender Health, AMREF. Despite these efforts, there is still disjointed implementation especially in regards to data systems, capacity building, clinical standards and support by partners

1.3 DEVELOPMENT CONTEXT

Currently there is a worldwide effort to reduce maternal mortality by 75% by the year 2015 in line with the Millennium Development Goals (MDGs). Achieving the target of Millennium Development Goal 5, i.e. Universal access to reproductive health services will significantly reduce the burden of obstetric fistula.

The Health Sector Strategic and Investment Plan (2010/11 – 2014/15) contributes to the National Development Plan through its goal of attaining a good standard of health by all the people in Uganda, in order to promote a healthy and productive life. To achieve its goal, the Ministry of Health prioritizes reproductive health services under the second cluster of the National Minimum Heath Care Package and clinical services.

Obstetric fistula is a manifestation of deep socioeconomic inequalities and weak reproductive health services. Reducing new cases of obstetric fistula is therefore an indicator of effectiveness and performance of reproductive health services. In addition, reducing the backlog of obstetric fistula cases is an indicator of performance of hospital surgical services. Re-integration services will reflect performance of referral system and community based structures mainly VHTs.

This strategy is developed in the context of the following guiding documents:

- The National Development Plan (2010/11 – 2014/15)
- The Millennium Development Goals
- The National Health Policy II (2010/11 – 2014/15)
- The Health Sector Strategic and Investment Plan (2010/11 – 2014/15)
- The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2006

- Road map to accelerate the reduction of maternal and neonatal mortality and morbidity (2007-2015)

1.4 RATIONALE

- Despite its reality and debilitation, obstetric fistula has remained a "hidden" condition, mainly because it affects some of the most marginalized members of the population. Therefore, it has limited visibility in decision-making processes at all levels in the health system.
- Obstetric Fistula is an entirely preventable condition and yet the number of cases is still rising in the country
- The large backlog coupled with ever increasing new cases has surpassed the existing capacity to repair the cases.
- There are known simple, effective interventions for prevention of obstetric fistula and surgical repair.
- Stigma, poverty, ostracism and psychosocial effects of obstetric fistula remain unaddressed by the service systems despite being known as key areas to improve care seeking and reintegration.
- While some work on obstetric fistula has gone on, efforts have largely been fragmented leading to sub-optimal service delivery and challenges, duplication of services and inadequate coverage and weak coordination.
- Obstetric fistula is addressed in other Reproductive Health documents, and its prevention is underpinned on the progress made in the national road map to reduce maternal and child mortality. However gaps exist especially in tertiary prevention and treatment

1.5 THE STRATEGIC PLAN

1.5.1 VISION

A Uganda free of Obstetric Fistula

1.5.2 GOAL

To accelerate prevention and management of obstetric fistula in Uganda

1.5.3 OBJECTIVES

Objective 1: To reduce the incidence of obstetric fistula

Objective 2: To reduce the prevalence of obstetric fistula

Objective 3: To reintegrate all women affected by obstetric fistula into social life

1.5.4 GUIDING PRINCIPLES

The guiding principles driving the conceptualisation and implementation of the National obstetric fistula strategy are:

1. Stewardship by the Ministry of Health
2. Civic leadership
3. Partnership and inter-sectoral collaboration
4. Community participation
5. Integration into Sexual and Reproductive Health and Rights and other essential health care package
6. Accountability
7. Quality Assurance

2 PRIORITY AREAS AND STRATEGIES

This strategy emphasizes fourpriority areas namely:

a) Prevention
b) Treatment
c) Reintegration
d) Advocacy and Behavioural Change Communication

2.1 PRIORITY AREA 1: PREVENTION

OBJECTIVE: TO REDUCE THE INCIDENCE OF OBSTETRIC FISTULA

While fistula surgery will reduce the number of existing cases, it is necessary to concurrently accelerate preventive measures to reduce the incidence of obstetric fistula. Primary prevention therefore emphasises access to quality maternal health care services, including family planning, skilled birth attendance, and emergency obstetric care. Improvements in access to family planning, maternal and adolescent health services would reduce the incidence of unintended pregnancies and obstetric fistula especially among the youth.In the wider context, preventionrequires tackling underlying social and economic inequities by empowering women and girls, enhancing their life opportunities and delaying marriage and childbirth. When women undergo difficult labour, there is need to prevent the development of fistula in labour or in recently delivered women who are at risk through catheterisation or early referral if services are not available on site. This effort could prevent an estimated 10% to 20%[1] fistula cases from occurring.

2.1.1 PREVENTION STRATEGY I: IMPROVE ACCESS AND UTILIZATION OF QUALITY SEXUAL &REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES TO PREVENT OBSTETRIC FISTULA

KEY ACTIVITIES

2.1.1.1 Provide skilled attendance at births

- Recruit, train and deploy skilled staff especially midwives in Health Centre II and III
- Train, facilitate and supervise the use of partograph in labour at all facilities
- Village Health Teams to create awareness on skilled attendance and encourage referral.

2.1.1.2 Scale up goal oriented antenatal care and emergency obstetric care at sub-county level

- Facilitate Regional Referral Hospitals to offer hands on EmOC training and support supervision in lower health facilities in particular General Hospitals and Health Centre IVs
- Procure EmOC equipment, medicines and supplies
- Train, facilitate and supervise the use of catheterisation or early referral in all cases of obstructed labour.

[1] *Waaldijk K. The immediate management of fresh obstetric fistula. American Journal of Obstetrics and Gynecology, 2004, 191: 795-799.*

2.1.1.3 Increase access to accurate and quality family planning information and services especially for adolescents

- Provision of contraceptive services at Youth Friendly Service Centres
- Procuring family planning commodities and supplies
- Training health workers, providers at youth friendly sites and private health facilities in family planning
- Partnership with Non government actors in the provision of family planning services especially to hard to reach areas
- Provision of family planning services to fistula survivors

2.1.1.4 Establish appropriate and effective referral system

- Facilitate VHTs, Health Centre IIs and Health Centre IIIs with appropriate communication and transport tools for emergency referral of pregnant women

2.1.1.5 Promote adolescent sexual and reproductive health services

- Integrating adolescent health services in health and other social welfare facilities especially HCIIIs, HCIIs and community centres
- Integrate obstetric fistula awareness in school health programmes
- Facilitate out of school peer educators to create awareness on prevention of obstetric fistula and other complications of teenage pregnancy

2.1.2 Prevention Strategy II: Strengthen Intersectoral Collaboration in obstetric fistula prevention

Key activities

2.1.2.1 Collaborate with Ministry of Gender Labour and Social Development to integrate obstetric fistula prevention and reintegration especially in programs for out of school adolescents, orphans and vulnerable children, sexual and gender based violence

2.1.2.2 Collaborate with Ministry of Education and Sports to sensitize in-school adolescents on complications of teenage pregnancy including obstetric fistula

2.1.2.3 Solicit input and disseminate fistula reports to key partners

2.1.2.4 Collaborate with development partners and civil society in advocacy, resource mobilization and delivery of services.

2.2 PRIORITY AREA 2: TREATMENT

OBJECTIVE: TO REDUCE PREVALENCE OF OBSTETRIC FISTULA

For the vast majority of girls and women with obstetric fistula, treatment remains unattainable. Treatment services under this objective will address increasing awareness on the availability of treatment; reducing access barriers to facilities; identification and referral of cases; reducing the cost of treatment and addressing the backlog. Critical to achieving the objective, obstetric fistula treatment must become a routine hospital service countrywide starting with regional referral hospital.

2.2.1 TREATMENT STRATEGY I: STRENGTHEN HEALTH SYSTEM CAPACITY TO PROVIDE ACCESSIBLE HIGH QUALITY OBSTETRIC FISTULA TREATMENT

KEY ACTIVITIES

2.2.1.1 Establish functional obstetric fistula management sites especially at national and all regional referral hospitals

- Strengthen National and regional centres of excellence:At national level, the national referral, and teaching Hospitals of Mulago, Mbarara and Gulu will act as national referral centres capable of handling simple and complex fistula cases, training, support supervision and research. Each should have dedicated obstetric fistula care teams with a minimum of at least two surgeons. The regional hospitals will provide leadership, training and technical management of surgical camp activities within their regions. Each regional hospital will have least one fistula repair team capable of repairing simple and complex fistula cases.
- Increase number of fistula repair outreaches: Mobilize district hospitals to serve as outreach posts for regional hospitals. District or general hospitals will carry out simple fistula repairs and fistula surgical outreach camps. Outreach camps will be organized at least once every quarter in these hospitals to repair simple fistula, identify complex cases, and offer apprenticeship to general doctors.

2.2.1.2 Build district and HSD capacity to plan and mobilize communities for fistula prevention and care

District health offices will provide leadership, planning and coordination of fistula programs. HC IVs will be supported to perform their functions including referral and mobilisation of cases for treatment within the health sub-districts (HSDs) systems. Focal point persons will be identified to mobilise and coordinate obstetric fistula activities within the HSDs.

2.2.1.3 Establish an effective fistula client identification and referral system.

Capacity will be built for an increased identification of cases and effective referral system from community/VHT and lower facilities to treatment sites. Feedback will be supported for clients to receive follow up care like FP and physical rehabilitation at lower facilities.

Where available, the referring support organisation will make appointments with hospital clinical teams on the client's behalf. The referring facility will help families by providing appropriate information and referral, and help the client achieve workable and timely management. Where support organisations are not available, the lowest HC will serve as the referral point. VHTs will be expected to refer obstetric fistula cases through existing structures, with support by CBOs where appropriate.

2.2.1.4 Provide standardized training for obstetric fistula care teams

Develop national training standards/guidelines and plan to rapidly increase competence and coverage of obstetric fistula care teams. National Referral and Teaching Hospital will be training centres, while regional hospitals with a substantial patient load will be apprenticeship centres for medical officers, midwives, nurses and social workers. In addition, obstetric fistula will be strengthened in pre-service curricula for health personnel

2.2.1.5 Institute Quality Improvement Practices in repair facilities

The Ministry of Health will develop and disseminate Quality Assurance protocols and tools to support hospitals implement quality improvement processes in obstetric fistula treatment. There will be support to mentorship, supervision and continuous medical education for surgical skills improvement.

2.2.1.6 Ensure consistent supply of repair commodities and equipment.

Develop a standardised equipment and surgical supplies list for obstetric fistula and repair, and equip repair centres. Therefore, there is need to:

- Equip all Regional hospitals with necessary surgical furniture and equipment
- Integrate obstetric fistula treatment supplies in the national essential list and ensure distribution through the NMS and JMS
- Establish an emergency supply system of surgical supplies for obstetric fistula camps
- Regularly update the obstetric fistula data base to inform the supply and equipment needs

2.2.2 Treatment Strategy II: Strengthen community capacity to support women living with fistula to access treatment

Key Activities

2.2.2.1 Define the community obstetric fistula package

The purpose is to identify the range and nature of current and potential services which should be provided for women with fistula countrywide, such as: awareness creation, mobilisation for repair, transport, support of patients in hospital with food, re-integration and economic empowerment and registration of obstetric fistula clients at community level

2.2.2.2 Build capacity for VHTs to meet their role in obstetric fistula prevention, treatment and reintegration

VHTs are mandated to link to lower level health facilities and through the home-based care approach, they can seek out and support women with fistula to seek care. VHTs will be trained and facilitated to adapt and implement the community obstetric fistula package to their local socio-cultural contexts.

2.2.2.3 Use of community resources such as peer and/or family support groups, social and transportation resources

The strategy is to establish a system for Fistula survivors to reach out to others with testimonies of the impact of treatment on maternal morbidity and the quality of women's lives. Fistula survivors will be trained and supported to work as peer educators and ambassadors. This will help reduce stigma and increase response to obstetric fistula repair.

2.2.3 Treatment Strategy III: Establish a sustainable national fistula treatment support system

Key activities

2.2.3.1 Integrate obstetric fistula repair supplies, drugs, equipment and repair costs into the national Ministry of Health budget

2.2.3.2 Mobilisation of additional resource for obstetric fistula management as part of clinical services

Resources will be mobilised from the government, partners and other sources such as the planned national health insurance schemes. In addition, all partners will implement a single harmonised annual plan and reporting system to leverage and avoid duplication of resources.

2.2.3.3 Monitoring annual budget allocations for fistula treatment within hospitals

Priority area 3: Reintegration

Obstetric fistula has social, economic and psychological consequences for affected women. The sequels of these are stigmatization, isolation and loss of social support for both treated and untreated women with fistula.The strategy will address the reintegration problem by building referral capacity after treatment to community based social support groups and promote partnerships with civil society organizations.

2.2.4 Reintegration Strategy I Provide rehabilitation and support services to all women presenting with fistula

Key activities

2.2.4.1 Integrate Counselling in patient care

Develop and implement standards and guidelines for obstetric and psychosocial counselling of fistula clients. Strengthen fistula repair services to offer or refer women for counselling during the preoperative and postoperative period (i.e. during the hospital stay).

2.2.4.2 Facilitate Community Based Organizations (CBOs)

Health Facilities offering treatment services will be linked to CBOs and NGOs within their catchment areas. These CBOs, NGOs, Self-help groups (SHG) will be encouraged and supported to offer reintegration services including psycho-social counselling, economic empowerment, community and family support, community based patient tracking and data collection. CBOs will also conduct health education to increase community acceptance of fistula patients and prevention of obstetric fistula.

2.2.4.3 Build the capacity of VHTs and Fistula Survivors to re-integrate fistula clients

VHTs and Fistula Survivors will be involved in identifying women with obstetric fistula, referral, health education and community support after repair.

2.2.4.4 Provide physical rehabilitation services

Provide or refer fistula clients to physical rehabilitation services like physiotherapy, nutrition, orthopaedic aids and other medical specialities

PRIORITY AREA 4: ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION

2.2.5 STRATEGY 4.1 DEVELOP AND IMPLEMENT A COMMUNICATION PLAN

Fistula is a powerful advocacy case to highlight and engage stakeholders on the weaksexual and reproductive health services in the communities. Obstetric fistula provides an opportunity to raise consciousness about actual impact of gender inequality, illiteracy, nutrition and early marriage on health of women. Successful treatment and reintegration of women with obstetric fistula requires deliberate effort to address associated stigma, ostracism and misconceptions.

A fistula Communication plan will be developed to guide advocacy and BCC activities of all partners in the country within this strategy. Fistula survivors are highly effective and will be engaged in raising awareness and adding a new voice to reproductive health advocacy.

ACTIVITIES

2.2.5.1 Documentation of obstetric fistula

Evidence for advocacy and BCC will be generated through systematic documentation, reporting and operational research.

2.2.5.2 Develop and implement a multilevel communication plan

The strategy recognizes that obstetric fistula is as much a social problem as it is a biomedical. At the national level, the communication interventions will be organized to increase visibility of fistula in planning, resource allocation and accountability; mobilise other sectors and partners and address the underlying root causes of fistula.The communication plan will also define the appropriate behaviour change interventions targeting individuals, families, communities and health delivery system. It will not be a stand-alone plan but be incorporated within ongoing RH and clinical programs.

Table 1: Working framework for the CommunicationPlan

Targeted Level	Desired Intermediate Outcome	IEC/BCC Interventions
1. Individual/ family/ household	• Improved birth planning • Increased knowledge, altered attitudes and beliefs about OF; • Improved care seeking for OF and RH services; • Improved links to household and community resources for emergency obstetric referral	• Communication such as: • Face-to-face, or group training and counseling • Mass media, community media • Events • Centralized information and referral • Community mobilization • Negotiated behaviors and interventions
2. Community targeting VHT CBOs, private sector, celebrities e.t.c	• Reduction of stigma • Increase sense of community and shared responsibility for OF prevention and rehabilitation; • Supporting re-integration into society • Increased access to FP	• Negotiated behaviour and interventions; • Enabling community environment; • Strengthen existing and create new social networks; • Community dialogue • Empower fistula survivors to advocate, educate, and counsel
3. Health systems	• Improved provider skills and attitudes in use of the partograph; • Youth friendly services • Public and private partnerships • Bridges between traditional and modern practitioners; • Enhanced image of public facility RH services; • Availing repair in routine services • Civil society pressure from human rights groups as well as professional associations.	• Inter-personal communication training; • Motivation and team building activities; • Facility managers training • Supervision system • Quality Improvement • Horizontal diffusion of policy
4. Leaders, planners, religious leaders, political and religious leaders, celebrities	• Restructured priorities in care and prevention • Supportive policy environment • Reallocation of resources • Increased visibility of Fistula as a political priority and gender issue	• Advocacy to inform and promote RH and fistula repair program • Negotiation to reprioritize, reorganize systems, reallocate resources • Distribution, promotion and subsidizing OF repair services • Use of national and district level champions

3 MONITORING AND EVALUATION

Currently, there is no standard reliable data system for obstetric fistula whether from facilities or Population based. Consequently, reporting is weak and does not inform decision-making on prevention or care. It is also difficult to monitor impact of the structural interventions such as decreasing age of marriage, delaying the first birth, use of family planning commodities and quality of antenatal and birth care. The lack of accurate data on the prevalence, incidence and outcomes of repair regarding obstetric fistula is a challenge to informed decisions on support interventions for policy, planning and programming. There is need to establish a system to capture, analyse and disseminate performance data within the national monitoring and evaluation mechanisms and research.

Therefore the program monitoring system will be integrated within the HMIS but will also develop a separate programmatic database. Monitoring will be mainly based on data collected in health facilities and other structures involved in the implementation. The national HMIS strategy is the backbone for monitoring performance in obstetric fistulaactivity within the Reproductive Health and Surgical services delivery. Facility based HMIS tools will ultimately include indicators necessary to provide appropriate information to plan, monitor, supervise, and review the national obstetric fistulaprevention, treatment and re-integration services. These indicators will be used to monitor progress towards set targets in the strategy log frame. The obstetric fistula Technical Working Group will periodically monitor the performance in different areas of the plan.

Specific obstetric fistula program data will initially be compiled within the obstetric fistula referral network until the backlog is reduced to manageable. The district core teams will be responsible for the collection and processing of data at the local level through the health information system

At the national level, the resource centre and the clinical department structures will process the data to facilitate the making of policy and strategic decisions. It will be essential to establish an organization with experience and resources in epidemiology to collect and analyze the obstetric fistula data monthly for the health sector. Monthly reporting of fistula, tracking and comparing across districts will get the campaign's momentum going will direct actions.

Key Activities

- Selection by the Fistula Technical Working Group of the data priorities for annual and quarterly indicators to be collected in the HMIS, by CBOs and NGOs and other sectors
- Establishment of an electronic database by the clinical department of Ministry of Health
- Production of an annual report prior to the annual Joint Review Mission
- Holding an annual review and planning meeting
- Conducting operational research based on priorities agreed upon in the Fistula Technical Working Group

4 IMPLEMENTATION ARRANGEMENTS

The country has been implementing obstetric fistula prevention and care activities but on a rather limited scale. Scale up is needed to integrate obstetric fistula within the routine services. To achieve countrywide access and limit unit costs, implementation of this strategy will continue to be based on existing service delivery structures. At the national level, the Ministry of Health has established a coordination desk for obstetric fistula located within the clinical services department. The focal point in the Ministry of health will link with related activities in the Ministry of Health, such as the Human resource development plan, reproductive health, community based health care, health education and Health Management Information System to ensure synergy and coordination of efforts within the ministry.

Overall, policy direction and standards will be provided within the MOH sector-working group, whose functions alsoincludecoordination, planning, monitoring and evaluation, of obstetric fistula initiatives within the health sector.

In order to ensure adequate national coordination, the already established Fistula Technical Working Group (FTWG) will ensure national technical and managerial support for the implementation of the obstetric fistula Strategy including provision of technical input for policy formulation and guidance for all Obstetric Fistula interventions and leadership at the Ministry of Health. This FTWG, chaired by the Commissioner clinical services will:

- Identify concrete terms of reference and membership criteria,
- Develop annual implementation plans forobstetric fistula services,
- Fundraising to ensure sustainability of different obstetric fistula interventions,
- Review, monitor, evaluate obstetric fistula interventions at country level.
- Coordinate partner activities and develop annual fistula service maps
- Determine data and operational research priorities
- Lead and guide advocacy initiatives

Thus, the management and implementation structures will be designed to

- Support and strengthen the leading role of government, and the MOH as the technical line ministry as regards policy, strategy, monitoring and evaluation, including quality assurance and quality control
- Support and strengthen the decentralised health services by ensuring that coordination is also done at district and HSD level
- Support a multi sectoral approach

The regional hospitals will provide technical support supervision to the hospitals within their community/ outreach programs. The clinical and facility based activities will be implemented within the district decentralization framework. The DHT will provide planning guidance as well as monitoring and support supervision including establishment of a district focal point person.

OF repair Annual Work plans will be developed within the overall hospital and district plans. These will be amalgamated to provide the Annual National Work Plan. Quarterly and annual implementers meetings will be organized to review status of implementation, achievements and results. Efforts will be made to include obstetric fistula reporting in the health sector annual performance reviews and general assembly.

In order to have successful implementation of this strategy, it will necessary to increase resources from the current levels. This strategy emphasizes shifting from individually funded projects to a program funding, that is, pooled resources and with less earmarked contributions towards a common implementation plan. Support to the Ministry of Health will as much as possible be aligned within the SWAP (Sector Wide Approach) funding modalities.

Table 2: Task Distribution of Fistula Repair by Level of the health care delivery system in Uganda

Level	New tasks
VHT	Case detection, awareness, community mobilisation and
HC II and III	Prevention, case detection, follow up and referral
HC IV	Prevention, case detection, follow up and referral
General Hospitals	Simple fistula repairs, Monitoring
District Health Office	Building appropriate facility, administrative and multi-sectoral capacity to adequately address obstetric fistula
Regional Referral Hospital	Complex fistula repairs, Out-reach, training and technical Supervision
National Referral Hospital	Repair of very complex fistula, Training and technical Supervision
Ministry of Health	Set rights and gender based policy framework, set standards OF clinical care and training programs, developing centres of excellence, input with supplies, equipment and training, develop related services

5 ROLES AND RESPONSIBILITIES

Ministry of Health

- Policy guidance and technical support for Obstetric Fistula
- Strengthening reproductive health care especially increasing access to fully functional emergency obstetric care services
- Overall coordination and monitoring national Obstetric Fistula activities
- Training and Quality assurance
- Advocacy and Resource mobilisation

Ministry of Agriculture, Animal Husbandry, and Fisheries

- Food security to meet nutrition needs of girl child

Ministry of Gender Labour and Social Development

- Develop a strategy to systematic, comprehensive sexuality education for out-of-school adolescents.
- Raise public awareness about the dangers of early marriage and obstetric fistula, and monitor adherence to laws on early marriage and adolescent pregnancy.
- Ensure that the current child protection strategy includes measures to protect girls from stigmatization and abuse due to early pregnancy or fistula.
- Reduction of stigma towards women with Obstetric Fistula
- Reintegration and rehabilitation of women on Obstetric Fistula care

Parliament

- Enact the bills and legislation that ensure SRH&R for adolescents are upheld
- Ensure National Social Health Insurance Bill, and other proposed prepayment schemes cater for fistula prevention, care and reintegration

Ministry of Education and sports

- Strengthening Obstetric Fistula in pre-service curricula of health professionals
- Strengthening Obstetric Fistula in school health program

Ministry of Works Housing and Communication

- Support communication technology for EmOC and emergency referral
- Support availability and sharing of information

Ministry of Local Government

- Disseminate guidelines
- Community mobilisation
- Plan and monitor local government service in delivering Obstetric Fistula
- Creation of synergistic partnerships with civil society in Obstetric Fistula prevention and care

- Establish effective referral system for women living with fistula

Civil society/ traditional community/NGOs/FBO/Media

- Advocacy for protecting the rights of the girl-child to basic education and proper nutrition
- Countering harmful traditional and socio-cultural beliefs and practices,

Development Partners

- Championing Obstetric Fistula as an entry point in accelerating MNH programmes at country level
- Provide resources to different sectors in strengthening strategy implementation especially in clearing backlog and developing reintegration programs
- Support Research
- Support establishment of Data base
- Support fistula repair

6 LOGFRAME

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
PRIORITY AREA 1: PREVENTION					
OBJECTIVE: To reduce the incidence of obstetric fistula	• Reduced number of new cases/1000 live births	• number of news cases of obstetric fistulas per year	• 848	• Survey, UDHS	• Road map is implemented
PREVENTION STRATEGY 1: Improve access and utilization of quality Sexual & Reproductive Health and Family Planning services to prevent Obstetric fistula	• Adolescents and women have access to quality Sexual & Reproductive Health and Family Planning services				
KEY ACTIVITIES					
2.1.1.1 Provide skilled attendance at births	• Pregnant women are delivered by skilled attendants	• Proportion of deliveries conducted by skilled attendants	• 60%	• Supervision report, HMIS, UDHS	• Implemented within the Road map to accelerate the reduction of maternal and neonatal mortality and morbidity (2007-2015)
2.1.1.2 Scaling up goal oriented antenatal care and emergency obstetric care	• Pregnant women attending at least 4 antenatal care visits	• Percentage of pregnant women attending antenatal care at least four times	• 90%	• Annual health sector reviews reports	
2.1.1.3 Increase access to accurate and quality family planning information and servicesespecially for adolescents	• Adolescents utilize family planning services	• Adolescent Contraceptive Prevalence Rate	• 45%	• UDHS in depth reports, Annual panel survey	• Road map to accelerate the reduction of maternal and neonatal mortality and morbidity (2007-2015)
2.1.1.4 Establish appropriate and effective obstetric emergency referral system	• All HSDs have a multilevel obstetric emergency referral system	• Proportion of HSD with functioning ambulance systems	• 100%	• District reports	• Cooperation with other transport subsystems
2.1.1.5 Promote adolescent sexual and reproductive health services	• Adolescents access contraceptive services	• Proportion of sub counties with at least 1 facility offering YFHS	• 70%	• District reports	• Implemented within the Road map to accelerate the reduction of maternal and neonatal mortality

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
					and morbidity (2007-2015)
PREVENTION STRATEGY II Strengthen Intersectoral Collaboration in obstetric fistula prevention	**Collaboration for prevention of obstetric fistula established in other sectors**	• **Visibility of OF in sectoral plans and policy documents** • **Number of sectors collaborated with**	• **3 sectors**	• **Minutes, reports from sectors**	
2.1.2.1 Collaborate with Ministry of Gender Labour and Social Development to integrate obstetric fistula prevention and reintegration	• **Obstetric fistula prevention and reintegration incorporated in MoGLSD programs**	• **Number of programs in MoGLSD incorporating obstetric fistula prevention and reintegration**	• **2**	• **Sectoral reports**	**Obstetric fistula prevention and reintegration main streamed in sector programs**
2.1.2.2 Collaborate with Ministry of Education and Sports to sensitize in-school adolescents on complications of teenage pregnancy including obstetric fistula	• **Obstetric fistula prevention and reintegration incorporated in MoES programs**	• **Number of programs in MoES incorporating obstetric fistula prevention and reintegration**	• **2**	• **Sectoral reports**	**Obstetric fistula prevention and reintegration main streamed in sector programs**
2.1.2.3 Solicit input and disseminate fistula reports to key partners	• **Input from other sectors**	• **Number of sectors /agencies explicitly including OF prevention in their annual plans**	• **2**	• **MoH Reports**	**Partner send reports**
2.1.2.4 Collaborate with development partners and civil society in advocacy, resource mobilization and delivery of services	• **Increased participation of local partners and civil society in fistula prevention and management**	• **Number of local partners and civil society participating in advocacy**	• **One partner per district**	• **District Reports**	**Civil society interest**

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
PRIORITY AREA 2: TREATMENT					
OBJECTIVE REDUCE the prevalence of obstetric fistula in Uganda	• Reduced number of OF cases	• Prevalence of fistula symptoms	• Less than 50,000 cases	• UDHS	• Reduced incidence • Partner support
TREATMENT STRATEGY I Strengthen health system capacity to provide accessible high quality obstetric fistula treatment	• Reduced backlog	• Number and proportion of fistula cases successful fistula closed	• By 90%	• Annual report	• Quality of records • Women don't come back
KEY ACTIVITIES					
2.2.1.1 Establish national centres of excellence	• National centers offering routine fistula repair services • National centers offering training services	• Number of national centres offering routine fistula repair services • Number of national centers offering training services	• 4	• Annual reports	• Funding available
2.2.1.2 Build district and HSD capacity to plan and mobilize communities for fistula prevention and care	• Integration of OF in district leadership, planning, monitoring and supervision	• OF prevention, treatment and reintegration included in district health planning and reporting	• All HSD plans	• Quarterly district plans and reports	• Quality of records
2.2.1.3 Establish an effective fistula client identification and referral system	• Functional referral system	• Average Fistula referral rate of identified cases by level of health facility	• 80%	• HSD and district reports • MoH Reports and records	• Quality of records
2.2.1.4 Provide standardized training for doctors, midwives, nurses, and social workers.	• Skilled staff available for repair at district and regional hospitals	• Number of individuals/teams trained	• 60 facility teams	• Training report	• Teams deployed appropriately after training
2.2.1.5 Institute Quality Improvement Practices in repair facilities	• Improved treatment outcomes	• Proportion of women who have a successful first repair at each facility.	• 90% closure rate	• Hospital reports	• Data disaggregated into different types of fistulas)
2.2.1.6 Ensure consistent supply of repair commodities and equipment.	• System for routine and emergency OF clinical supplies system in place	• Number of regional hospitals with no stock outs of key supplies for fistula repair	• No stock outs	• Hospital reports	• Links to RH and clinical services commodity plans

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
STRATEGY **Strengthen community capacity to support women living with fistula to access treatment**	• **Increased in number of women with fistula seeking treatment**	• **Number of women with fistula seeking treatment**	• **200,000**	• **Facility records**	
KEY ACTIVITIES					
2.2.2.1 Define the community obstetric fistula package	• **Community obstetric fistula package defined**	• **Community obstetric fistula package**	• **1**	• **District reports**	• **Package fits within VHT**
2.2.2.2 Build capacity for VHTs to meet their role in OF prevention, treatment and reintegration	• **VHTs incorporating Fistula services in routine work**	• **Proportion of VHTs retrained**	• **80%**	• **Training records, District reports**	• **VHTs are functional especially in communities with highest need**
2.2.2.3 Use of community resources such as peer and/or family support groups in social and transportation resources	• **Repair sites with links to community resources**	• **Number of repair sites with links to community resources**	• **100%**	• **Supervision reports and treatment centre reports**	• **Organized community resources available**

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
STRATEGY **Establish a sustainable nationalfistula treatment support system**	• **Reduction in waiting time for fistula repairs**	• **Proportion of women with fistula waiting >3 months for repair at hospitals**	• **< 5%**	• **Facility records**	
KEY ACTIVITIES					
2.2.3.1 Integrate obstetric fistula repair supplies, drugs, equipment and repair costs into the national Ministry of Health budget	• **Fistula repair commodities explicitly considered within Ministry of Health budget**	• **Proportion of facilities without stock outs of key Fistula repair commodities**	• **90%**	• **Annual health expenditure reports for hospitals**	• **Adequate sector budget performance**
2.2.3.2 Mobilisation of additional resource for obstetric fistula management as part of clinical services	• **Increased funding for repair and preventive services**	• **Proportion of facilities with increased operational funding for repair**	• **40%**	• **Hospital Financial reports**	• **Prioritization of fistula repair by partners**
2.2.3.3 Monitoring annual budget allocations for fistula treatment within hospitals	• **Efficient allocation and expenditure of surgery and OBGY funds in hospitals**	• **Increased annual expenditure on fistula repair in the five tears of the strategy**	• **10%**	• **Financial reports**	• **Fistula costs computed within hospital work**

Objectives/Strategies/Activities	Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
PRIORITY AREA 3 REINTEGRATION					
OBJECTIVE: To ensure that all women affected by fistula are reintegrated into social life	• **All women affected by fistula are reintegrated into social life**	• **Percentage of women successfully reintegrated in their community following treatment**	• **80%**	• **Hospital reports** • **NGO and CBO reports**	
REINTEGRATION STRATEGY Provide rehabilitation and support services to all women presenting with fistula	• **Women with obstetric fistula receiving rehabilitation and support services**	• **Percentage of repaired women receiving rehabilitation and support services**	• **80%**	• **VHT reports, CBO reports and Midterm evaluation report**	○
KEY ACTIONS					
2.2.4.1 Integrate counselling in fistula patient care	• **All fistula cases seen in facilities receive obstetric and psychosocial counselling**	• **proportion of treated fistula clients receiving post operative counseling**	• **80%**	• **Supervision reports** • **Treatment center reports**	• **Adequate staffing in hospitals**
2.2.4.2 Facilitate Community Based Organizations (CBOs)	• **CBOs and associations facilitated**	• **Number of CBOs following up and supporting repaired cases** • **CBO, district reports**	• **>100 (or 1 per district)**	• **District reports**	• **Willing CBOs are available**
2.2.4.3 Build the capacity of VHTs and Fistula Survivors to re-integrate fistula clients	• **Improved reintegration outcomes**	• **Proportion of sub-counties having VHTs with capacity to re-integrate fistula clients**	• **60%**	• **Support supervision** • **District reports**	• **VHTs revitalized in all districts**
2.2.4.4 Provide physical rehabilitation services	• **Increased access to physical rehabilitation services**	• **Proportion of hospitals linked or providing physical rehabilitation services for fistula cases**	• **60%**	• **Hospital reports**	• **Physical rehabilitation services functioning**

Objectives/Strategies	Outcomes/Outputs	Indicators	5 yr Target	MOV	Risks/Assumptions
PRIORITY AREA 4: BCC STRATEGY: DEVELOP AND IMPLEMENT A COMMUNICATION PLAN	• **Increased commitment by government to fund obstetric fistula prevention and treatment services** • **increased commitment by partners to fund obstetric fistula services**	• **Annual fund allocation to reproductive health and surgical services** • **Annual increment in partner contribution to the obstetric fistula implementation plan**	20% 100%	• **Annual health sector performance report** • **Annual national fistula report**	• **Increased budgetary allocation to health and prioritization of rh and clinical services**
KEY ACTIVITIES					
2.2.5.1 Documentation of obstetric fistula	• **Fistula advocacy package**	• **Fistula advocacy package developed**	• **1**	• **Package**	
2.2.5.2 Develop and implement a communication plan	• **Multilevel advocacy and behavoiur change plan**	• **Proportion of communication activities implemented**	• **100%**	• **Monitoring plan**	

7 TARGETS

Assumptions for annual targets in 5 years	Target 2015				
Annual cases in a national training hospital	500	Cases annually	(An average of	10	Cases per week)
Cases repaired per 2 week fistula camp	88	Cases per camp	(An average of	8	Cases/camp day)
Annual routine cases repaired in functioning regional Hospital	300	Cases annually	(An average of	6	Cases per week)
Annual simple OF routinely repaired in district hospital	96	Cases annually	(An average of	8	Cases/month)
% of cases with OF mobilised	90%	Cases needing repair			

	Baseline 2010	Targets 2011	2012	2013	2014	2015
Total National population	31,784,600	32,939,800	34,131,400	35,357,000	36,615,600	37,789,440
Crude birth rate	0.0496	0.049	0.0486	0.0482	0.0477	0.0473
Annual births	1,576,516	1,614,050	1,658,786	1,704,207	1,746,564	1,787,441
Epidemiology						
New Cases /year (124/100,000 births)	1,955	1,901	1,954	2,008	2,057	2,106
Prevalence: Estimated number of women living with obstetric fistulas	200,000	200,641	198,815	191,255	179,356	162,354
Repair Targets						
Number of National Teaching Hospitals Repairing Fistula	1	2	3	3	3	3
Number of Regional hospitals plus PNFP hospitals (e.g Kitovu, Kagando, Lacor Kamuli Mission) providing fistula repair services at the same rate as regional hospitals throughout the five years	9	11	13	16	19	21
Number of district hospitals offering surgical camps/outreaches	4	10	15	20	30	40
Estimated number of camps per year	14	33	56	72	106	164
Estimated cases repaired at National Teaching Hospitals	200	400	600	900	1,200	1,500
Estimated cases repaired in Camps	840	1,320	4,928	6,336	9,328	14,432

Estimated routine repairs in Regional Hospitals	180	1,100	2,600	4,800	5,700	6,300
Estimated repairs of simple cases in District Hospitals	40	960	1,440	1,920	2,880	3,840
Total number of repairs	**1,260**	**3,780**	**9,568**	**13,956**	**19,108**	**26,072**
Mobilisation Targets						
Total number of Cases mobilised from community (demand)	4,500	20,064	39,763	57,376	71,743	81,177
Unmet demand	4,500	16,284	30,195	43,420	52,635	55,105
Prevention Targets						
Supervised deliveries	43%	45%	50%	60%	65%	75%
Ceaserean Section Rate	<5%	5%	>5%	>5%	>5%	>5%
Proportion of births managed with a partograph	Unknown					
Number of EmOC facilities providing tertiary fistula prevention services	<5%					