NATIONAL STRATEGIC FRAMEWORK FOR THE ELIMINATION OF OBSTETRIC FISTULA IN NIGERIA

2011 - 2015

FEDERAL MINISTRY
OF HEALTH

FOREWORD

Obstetric Fistula (OF) particularly Vesico-vaginal Fistula (VVF) is a major public health problem in the developing world. In Nigeria, it is estimated that about 400,000 to 800,000 women are living with the problem and about 20,000 more women develop obstetric fistula every year. Currently, there are twelve dedicated centres offering surgical care to less than 4000 fistula women annually at different levels of expertise. At this rate it will take about 100 years just to deal with the backlog, ignoring new cases. With renewed global attention to the problem of obstetric fistula championed by UNFPA,and Fistula Care Project in line with the National Strategic Framework and Plan for VVF Elimination in Nigeria, surgical management and rehabilitation of women with fistula will become central in addressing the obstetric fistula problem.

It is therefore, obvious that there is a need to intensify training of more Surgeons and other health workers that will deal with the backlog and provide care closer to the women silently suffering from obstetric fistula. Besides training, there is also the issue of quality of care and hence the need for a standardized clinical protocol.

The goal of this document is to provide a standard reference material that can be used to train health workers and also guide them in the provision of holistic, respectful, simple, affordable, quality and evidence-based care for obstetric fistula women that will guarantee improved quality of life for these women and their families.

I therefore, approve the use of this document which has been carefully articulated by the VVF Technical Working Group with the hope that it will ensure good quality and uniformity in the care of women with obstetric fistula in Nigeria.

Prof. C. O Onyebuchi Chukwu
Honourable Minister of Health
February, 2012.

CONTENTS

ACRONYMS

BCC	Behaviour Change Communication
CBO	Community Based Organization
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
DQA	Data Quality Assurance
EmOC	Emergency Obstetric Care
FGC/M	Female Genital Cutting/Mutilation
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FMWA	Federal Ministry of Women Affairs
FWCW	Fourth World Conference on Women
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IAG	Inter-Agency Group
ICPD	International Conference on Population and Development
IMNCH	Integrated Maternal, Neonatal and Child Health
IPPF	International Planned Parenthood Federation
LGA	Local Government Area
MDGs	Millennium Development Goals
MMR	Maternal Morbidity and Mortality
MOV	Means of Verification

NARHS	National HIV/AIDS Reproductive Health Survey
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organization
NHMIS	National Health Management Information System
NISS	National Integrated Supportive Supervision
OF	Obstetric Fistula
OVI	Objectively Verifiable Indicator
PHC	Primary Health Care
PMF	Performance Measurement Framework
RBM	Results Based Methodology
RH	Reproductive Health
RVF	Recto-Vaginal Fistula
SMI	Safe Motherhood Initiative
SMOE	State Ministry of Education
SMOH	State Ministry of Health
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VVF	Vesico-Vaginal Fistula
WHO	World Health Organization

I. EXECUTIVE SUMMARY

Obstetric fistulae (vesico-vaginal and recto-vaginal fistulae) are serious reproductive health problems for women in Nigeria, even as fistulae have been practically eliminated in developed countries. It occurs as a result of obstruction from whatever cause during childbirth, leading to tissue damage and the typical clinical presentation of continous leakage of urine or faeces or both through the vagina. The constant leakage of urine and/or faeces through the vagina and the unbearable smell it causes leads to social isolation of the victims, and attendant severe physical and mental ill-health. It is estimated that Nigeria accounts for 40% of the worldwide fistula prevalence with approximately 20,000 new cases occurring each year, although recent studies put estimates at approximately 12,000 new cases per year.[1] Complications of pregnancy and delivery are the main cause of obstetric fistula. There is a strong association between reproductive risk and high fertility, illiteracy, poverty and lack of or poor quality medical care.[1,2,3]

Obstetric fistula (OF) is a burden mostly affecting the poor, the illiterate and young women who live in rural areas devoid of access to information and services. Furthermore, some socio-cultural beliefs and practices are known to be harmful to the health of women. In spite of all this, obstetric fistula can be prevented, by awareness creation, removing ideological norms that impede uptake of services and emergency obstetric care.

Prevention is therefore the key to stemming the tide of fistula. Strategies have to be evolved to include strengthening political commitment that creates a supportive

[1] Strengthening Fistula Prevention and Treatment Services in Nigeria; An Environmental Scan. EngenderHealth, May 2010

[2] Mahler H. The Safe Motherhood Initiative: A Call To Action. The Lancet 1987, 21:1(8534):668-70.
[3] Royston E, Armstrong S. Preventing maternal deaths. Geneva, World Health Organization, 1989.

enabling environment, and addressing harmful socio-cultural practices that serve as impediments. Improving service delivery by increasing the uptake of family planning, delaying marriage and early births, increasing access to quality maternal health services are also important in the national response. Rehabilitation and reintegration are also very important components of care where appropriate.

Although obstetric fistulae can be repaired successfully, patients' non awareness of availability of treatment facilities, and the cost of the repair have made access to the much needed care unobtainable for many. In recent times, there has been an emergence of a new scenario of the OF profile with older multi-parous women in their twenties and thirties, who have previously successfully delivered vaginally, developing obstetric fistulae. These are largely attributed to declining access to skilled obstetric care and increasing recourse to alternative health care systems, including some faith-based organizations for assistance during delivery and the unethical practice by some poorly qualified/equipped physicians and midwives; a situation that has perpetuated the bleak poverty spiral; one of disease, despair and death for many women in the country.

Since 2002, the Federal Government of Nigeria, through the Federal Ministry of Health (FMOH) in collaboration with development partners recognized that fistula efforts should not be addressed in isolation, but as part of an integrated effort to improve sexual and reproductive health in the country. The FMOH then commenced exercises that culminated in the development of the National Strategic Framework for Eradication of Fistula in Nigeria (2005-2010). It was developed to ensure a holistic approach to implementation of fistula interventions across a broad continuum of prevention, treatment and care as well as rehabilitation and reintegration. At the end of this period, a rapid appraisal of the situation led to the development of this current National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria for

2011-2015. It is premised on the first priority intervention of the National Reproductive Health Policy (2008), Healthy Pregnancy and Childbearing; and aligns completely with key crosscutting and sectoral priorities of the National Strategic Health Development Plan.

The framework has identified primary, secondary and tertiary prevention interventions and key rehabilitation and social reintegration strategies that will ensure that the incidence of OF is reduced by 50% from its current level.

1.0: Introduction

1.1 Obstetric Fistula in Nigeria

Obstetric fistula is an abnormal communication between the vagina and bladder (vesico-vaginal fistula) and/or the rectum (recto-vaginal fistula), related to childbirth. They are serious reproductive health problems for women in the developing world, although obstetric fistulae have been practically eliminated in developed countries. It results from prolonged obstructed labour from whatever cause during childbirth. It is this obstruction that underscores the typical features of obstetric fistulae; where the sustained pressure from the presenting part of the baby, affects the vaginal walls, the bladder, the rectum, the nerves and blood supply, leading to tissue damage, disability, and in many cases, death. The fistula that results presents with continuous dribbling of urine and sometimes faeces (urinary and/or faecal incontinence). Dripping urine wets clothing of the victims and also leads to excoriation of the already damaged vulva and vagina in addition to emitting a foul smell. Victims of obstetric fistulae are usually the lucky survivors of traumatic prolonged childbirth, but oftentimes without the joy of a baby which often dies during childbirth. They become social outcasts, some divorced and rejected by their families.They travel long distances in search of treatment, which often eludes them. Some have to take to begging or prostitution for survival[4].

Obstetric fistulae can be repaired surgically unless the fistulae are too large or there is associated damage to other tissues which makes repair impossible. Fistulae can often be prevented by the insertion of an in-dwelling catheter (for 4 to 6 weeks) to relieve pressure on the bladder following prolonged obstructed labour. Estimates of between

[4] Report of the Rapid Assessment of Obstetrics Fistula in Nigeria: The National Foundation on VVF, August 2003

40% and 95% of small fresh fistulae heal spontaneously with Foley's catheter insertion for 4 to 6 weeks[5].

1.1.1 Obstetric Fistula in the Context of Maternal Mortality and Morbidity

Complications of pregnancy and delivery are the main cause of morbidity and mortality in women of reproductive age (WRA)[6,7]. The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. Each year more than half a million healthy young women die from complications of pregnancy and childbirth. Virtually all such deaths occur in developing countries[8]. The World Health Organization (WHO) estimates that over 300 million women currently suffer from short/long-term complications arising from pregnancy or childbirth globally, with around 20 million new cases occuring every year[9]. Problems include infertility, severe anaemia, uterine prolapse and fistula. Worldwide, obstructed labour occurs in an estimated 5% of live births and accounts for 8% of maternal deaths[10]. Adolescent girls are particularly susceptible to obstructed labour, because their pelvises are not fully developed.

Throughout the world, but mainly in parts of sub-Saharan Africa and Asia, it is conservatively estimated that more than 2 million young women live with untreated OF. It has also been estimated that between 50,000 and 100,000 new women are affected each year[11]. The majority of maternal health problems occur in low income

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[5] EngenderHealth: Fistula Reduction in Nigeria, Strategy Recommendations, August, 2010

[6] World Health Organization. Revised 1990 estimatesof maternal mortality. A new approach by WHO and UNICEF. WHO/FRH/MSM/96.11. Geneva, WHO, 1996.

[7] World Bank. World Development Report: Investing In Health. Oxford, Oxford University Press, 1993.

[8] *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA*,Geneva, World Health Organization, 2003, www.who.int/reproductive-health/publications.

[9] *The World Health Report, 2005–Make every mother and child count*, 2005, Geneva,World Health Organization, www.who.int/whr.

[10] AbouZahr C. Global burden of maternal death. *British Medical Bulletin.*Pregnancy: Reducing maternal death and disability. British Council. OxfordUniversity Press. 2003. pp.1-13. www.bmb.oupjournals.org., WHO analysis of causes of maternal deaths: a systematic review. K.S. Khan and al. *Lancet* 2006;367: 1066-74

[11] Columbia University sponsored *Second Meeting of the Working Group for the Prevention and Treatment of Obstetric Fistula.* UNFPA, FIGO, Addis Ababa, 2002.

countries, where there is a strong association between reproductive risk and high fertility, illiteracy, poverty, lack of or poor quality medical care.[1,12,13] Unless they have access to a hospital that provides subsidized treatment and care, women may live with the fistula until they die, often at a very young age, from complications of their fistula. Such women often receive no support from their husbands or family members. At the Addis Ababa Fistula Hospital, 53% of the women had been abandoned by their husbands, and one woman in every five said that she had to beg for food to survive[14]. In India and Pakistan, some 70% to 90% of women with fistula had been abandoned or divorced, according to limited hospital studies[15]. It is not surprising therefore, that few women in some communities who can no longer cope with the pain and suffering, resort to suicide[16].

According to recent data the maternal mortality ratio for Nigeria has reduced marginally and estimates put at 487.1[17] - 545[18] per 100,000 live births. Even at this, Nigeria still has one of the highest rates in the world. The NDHS estimates that about 4 maternal deaths occur in Nigeria per hour, 90 per day, and 2,800 per month totalling about 34,000 deaths annually, with wide regional and local variations. It is also estimated that for every maternal death, at least 30 women suffer short to long term disabilities such as obstetric fistula (OF).

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[12] Mahler H. The Safe Motherhood Initiative: A Call To Action. The Lancet 1987, 21:1(8534):668-70.

[13] Royston E, Armstrong S. Preventing maternal deaths. Geneva, World Health Organization, 1989.

[14] Wall, LL et al. *Urinary incontinence in the developing world: The obstetric fistula. Proceedings of the Second International Consultation on Urinary Incontinence*, Paris, July 1-3, 2001. Committee on Urinary Incontinence in the Developing World, pp. 1-67. Available from Url: www.wfmic.org/chap12.pdf.

[15] Cottingham J, Royston E. *Obstetric fistula: A review of available information.* World Health Organization, Geneva, 1991.

[16] Wall, LL et al. *Urinary incontinence in the developing world: The obstetric fistula. Proceedings of the Second International Consultation on Urinary Incontinence*, Paris, July 1-3, 2001. Committee on Urinary Incontinence in the Developing World, pp. 1-67. www.wfmic.org/chap12.pdf.

[17] www.thelancet.com,Vol 378 September 24, 2011

[18] NDHS, 2008: Nigerian National Demographic and Health Survey

1.1.2 Implementation of the National Strategic Framework for Eradication of Fistula in Nigeria (2005 to 2010)

The Federal Government of Nigeria in 2002, through the Federal Ministry of Health (FMOH) in collaboration with development partners recognized that fistula efforts should not be addressed in isolation, but as part of an integrated effort to improve sexual and reproductive health in the country; commenced exercises that culminated in the development of the National Strategic Framework for Eradication of Fistula in Nigeria (2005 to 2010). It was developed to ensure a holistic approach to implementation of fistula interventions across a broad continuum of prevention, treatment and care as well as rehabilitation and reintegration. The strategy noted that reintegration of women with fistula post-repair was needed. The developers of the strategy noted a general desire to move from a medical paradigm for addressing fistula to a more multi-disciplinary and multi-sectoral approach. The complexity of the problem of obstetric fistula in Nigeria and the multi-factorial determinants of the condition called therefore, for a more multi-disciplinary and multi-sectoral approach to tackle the social concerns and address the status of Nigerian women's rights, the availability of and access to quality maternal health services.

In the last 5 years of implementation of this lapsed strategy, the Federal Ministry of Health remained in the lead in coordinating the work of multiple actors at the Federal, State, Local levels, Civil Society and international partners. Within this period, a Standard of Practice (SOP) for the management of OF for doctors and nurses was developed and some surgeons and nurses were trained on fistula management. Surveys and needs assessments were conducted to inform prevention, treatment and reintegration strategies with an estimated 2000 to 4000 OF patients repaired each year.

During this period, fistula was included in the Nigeria Demographic and Health Survey (NDHS) for the first time[19].

In the wake of the Millennium, the Federal Government made strident policy initiatives to ensure the implementation of activities to meet the MDG targets as part of NEEDS (National Economic Empowerment and Development Strategy). In line with this, the 2005 and 2006 budgets incorporated provisions for addressing health and social initiatives. Yet, social indicators improved only marginally. Nigeria ranked 158 out of 177 countries in the United Nations Development Programme (UNDP) Human Development Index (HDI) in 2005. The country's HDI, at 0.453 was lower than the average HDI for sub-Saharan African countries (0.515) and marginally above the average for countries in the ECOWAS (0.434). This relatively low level of human development became a source of policy concern and was indicative of the additional efforts needed to achieve the MDGs.

Now, in the 2010 ranking, Nigeria still remains among countries with low human development rating of 142 out of the 169 countries rated.

Despite government's efforts at raising the status of women and guaranteeing their reproductive health rights, the obstetric fistula scenario has remained a persistent scourge. Declining quality of maternal health care and rising poverty levels are indicted in causing a rise in the incidence of fistula all over the country.

1.2 Commitments to Reduction in Maternal Morbidity and Mortality (MMR) due to Obstetric Fistulae and other Causes

1.2.1 International and Regional Conventions and Soft laws

[19] UNFPA: Stakeholder Review of Obstetric Fistula in Nigeria Wednesday, April 21, 2010
Nicon Luxury Hotel

i. *Safe Motherhood Initiative (SMI)*

In 1987 the World Bank, in collaboration with World Health Organization (WHO) and United Nations Population Fund (UNFPA), sponsored a conference on safe motherhood in Nairobi, Kenya to help raise global awareness on the impact of maternal mortality and morbidity. The conference launched the **Safe Motherhood Initiative** (SMI), which issued an international call to reduce maternal mortality and morbidity by one half by the year 2000. It also led to the formation of an Inter-Agency Group (IAG) for Safe Motherhood, which has since been joined by the United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), International Planned Parenthood Federation (IPPF), and the Population Council[20].

In 2005, partners came together in a landmark meeting held in Johannesburg to review progress and adopt programmes and plans of action aimed at ending the scourge of obstetric fistulae. Participants at the Johannesburg Meeting captioned "To Make Motherhood Safer by Addressing Obstetric Fistula" included over 100 senior officials of Ministries of Health, International agencies, and Non-governmental organizations (NGOs), whose call was to urge governments of Africa - in particular Ministries of Health, Women Affairs, Education and Finance - to urgently address the issue of obstetric fistula and maternal health. In the notable *Johannesburg Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula,* they called on governments to ensure the rapid implementation and scale-up of national programmes to address maternal health and obstetric fistula, including National Road Maps for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa. The 2005 regional meeting also led to the development of a Regional Strategic Framework for the Elimination of Fistula in Africa.

[20] http://www.safemotheReproductive Healthood.org/

ii. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)

This Convention affirms not only that overall development requires the recognition and the exercise of basic human rights, such as the right to reproductive health, but also that women must benefit from and participate in development activities as equal partners with men.

In the 1990s, a series of global conferences organized by the United Nations identified maternal mortality and morbidity as an urgent public health priority and mobilized international commitment to address the problem. Governments from around the world pledged to ensure access to a range of high quality, affordable reproductive health services, including safe motherhood and family planning, particularly to vulnerable and underserved populations.

iii. The 1994 International Conference on Population and Development (ICPD)

This was held in Cairo and governments agreed to reduce the number of maternal deaths by half by the year 2000 and by another half, by 2015;

iv. The Fourth World Conference on Women (FWCW)

This was held in Beijing (1995), paid substantial attention to maternal mortality and reiterated the commitments made at the ICPD.

v. Millennium Development Goals

In September 2000, 189 countries at the United Nations (UN) Millennium General Assembly in New York endorsed a series of Millennium Development Goals that aim at reducing poverty worldwide. These goals build upon the agreements and commitments made by governments at the series of world conferences held in the 1990s (e.g. ICPD, FWCW). Among the international development goals set by the

United Nations is a reduction of maternal mortality ratio by three-quarters by the year 2015; providing access to reproductive health services by 2015 and reducing infant and child mortality rates by two-thirds by 2015.

vi. Protocol on the Rights of Women in Africa

On July 11, 2003, the African Union, the regional body charged with promoting unity and solidarity among its 53 member nations adopted a landmark treaty known as the Protocol on the Rights of Women in Africa (a.k.a the protocol) to complement the Regional Human Rights Charter and the African Charter on Human and People's Rights (the African Charter). The treaty affirms the reproductive choice and autonomy of women as a key human rights issue and called for the prohibition of harmful practices such as female circumcision.

vii. *Strategic Framework for the Elimination of Fistula in Africa: 2006-2015*

This strategic framework provides programmatic direction for eliminating fistula in the region as part of an integrated agenda to improve reproductive health outcomes. The framework is built on best practices and learning experiences from centres across the region and provides due attention to all the key preventive elements to effect timely elimination of obstetric fistula.

viii. *WHO Guidelines for Vesico-Vaginal Fistula Elimination*

1.2.2 The Enabling Legislative and Policy Environment for Elimination of Obstetric Fistulae in Nigeria

The Constitution of the Federal Republic of Nigeria provides for a social order founded on the principles of freedom, equity and justice and provides the national context for delivering services to reproductive health services to all Nigerians. Domestic and International instruments relevant to reproductive health and

applicable to Nigeria contain state obligations and specific actions required of stakeholders in order to give meaningful effect to the various components of reproductive health and rights. The Nigerian Constitution makes some provisions under sections 17 and 33-45 that are relevant to the promotion and protection of reproductive health rights. In addition, section 54 of the Nigerian Labour Law, Chapter 21 and Part 5 of the Criminal Code, and sections 18 of the Marriage Act as well as section 3 of the Matrimonial Act contain relevant but controversial provisions related to reproductive health and rights[21].

There is a plethora of policies directly and indirectly related to obstetric fistulae in Nigeria. They include: Behaviour Change Communication Strategy for the National Reproductive Health Policy and Framework (2005-2010), Federal Ministry of Health, 2005; Integrated Maternal, Newborn and Child Health Strategy, Federal Ministry of Health, 2007; National Family Planning/Reproductive Health Policy Service Protocols, Federal Ministry of Health, 2002; National Gender Policy, Federal Ministry of Women Affairs and Social Development, 2006; National Health Promotion Policy, Federal Ministry of Health, 2006; National Health Sector Strategic Plan for HIV & AIDS, Federal Ministry of Health, National AIDS & STI Control Programme, 2005; National Human Resources for Health Policy, Federal Ministry of Health, 2006; National Policy and Plan of Action on Elimination of Female Genital Mutilation in Nigeria, Federal Ministry of Health, 2002; National Policy on the Health & Development of Adolescents and Young People in Nigeria, Federal Ministry of Health, 2007; National Policy on Population for Sustainable Development, Federal Government of Nigeria, 2004; National Strategic Framework on the Health & Development of Adolescents and Young People in Nigeria, Federal Ministry of Health, 2007; National Strategic Health Development Plan 2010 – 2015; National

[21] Same as above

Strategic Plan for International Conference on Population & Development Programme of Action (2005-2014), National Planning Commission, 2005; Revised National Health Policy, Federal Ministry of Health, 2004; Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Nigeria, 2005.

The development of the National Strategic Health Development Plan (NSHDP) or simply the National Health Plan, is a developmental milestone in the enabling environment for the health sector in Nigeria, as it provides a uniform national health development framework and has been adopted as the ONE health plan to guide health system recovery and development. It was developed in a fully participatory manner that involved all the key stakeholders in health – Federal, State, LGA, international and domestic partners, and civil society organizations, and adopted results based management principles with an associated Results (Targets/Indicators) Framework that aligns and is consistent with the targets and goals of the Vision 20:2020. It will provide the framework for implementation and performance measurement in the period 2010 to 2015, in the first instance, and beyond, in the march towards Vision 20:2020.

The various laws in force in Nigeria address different aspects of reproductive health. However, many poorly reflect the current concept of reproductive health and are inadequate for addressing reproductive health concerns and issues as related to the Millennium Development Goals. Several glaring gaps exist in instruments that have been in existence for decades. These instruments have not been reviewed or updated

to reflect the current posture[22]. These gaps are clearly manifest in the Constitution laws, in human rights law, in family laws relating to marriage, divorce, inheritance and family planning and in criminal laws relating to rape and reproductive rights of pregnant women.

[22] Ladan Tawfiq: Discussion paper on 'Review of Existing Policies and Legislations in Nigeria' Presented at the IPG Stakeholders Consultative Forum held in Kano

2.0: Situation of Obstetric Fistula in Nigeria

2.1 Prevalence, Incidence and Determinants of Obstetric Fistula in Nigeria

It is estimated that Nigeria accounts for 40% of the worldwide fistula prevalence. Recent prevalence of obstetric fistula is estimated as 150,000[23]. Previous estimates put the prevalence between 800,000 and 1,000,000[24]. In recent times, there has been an emergence of a new scenario of the OF profile with older multi-parous women in their twenties and thirties, who have previously successfully delivered vaginally, developing obstetric fistulae. These are largely attributed to a low level of skilled birth attendance at delivery, inadequate access to emergency obstetric care and increasing recourse to deliveries at home and alternative health care system[25].

According to the 2008 National Demographic Health Survey (NDHS), the prevalence of obstetric fistula is 0.4%. Fistula prevalence is higher in zones in Northern Nigeria than in Southern Nigerian zones. For instance, the prevalence of fistula in North Central Nigeria is 0.8%, followed by 0.5% in the North East and 0.3% in North West Nigeria. In contrast, the highest prevalence in the Southern zones was found in South South Nigeria (0.5%), followed by South East Nigeria (0.3%) and South West Nigeria (0.2%). The prevalence for all Northern zones combined is 0.5%, compared to 0.3% for the Southern zones. Almost one-third of women surveyed (30.7%) had heard of fistula symptoms, with knowledge considerably higher in the North East and North West zones (49.6% and 66.2%, respectively) than in other zones of the country. Applying the 0.4% lifetime prevalence to the estimated number of women of reproductive age in Nigeria (37,425,000)[26]; 149,700 (approximately 150,000) women of

[23] Report on The Meeting for The Prevention And Treatment of Obstetric Fistula. UNFPA. Addis Ababa, November 2002. Nigeria: page 29.
[24] Wall LL. Fitsari `dan Duniya: an African (Hausa) praise song about vesicogavinal fistulas. Obstet Gynecol 2002; 100:1328-32.
[25] FMOH: National Strategic Framework and Plan for VVF Eradication in Nigeria, 2005-2010
[26] http://data.un.org/Data.aspx?d=GenderStat&f=inID%3A36

reproductive age in Nigeria either currently have obstetric fistula, or have experienced fistula symptoms in the past.

There have been no large scale prospective studies done in Nigeria to provide reliable estimates of incidence of obstetric fistula. Projections have been made using age-specific NDHS estimates of lifetime prevalence, the average population size of each age group of women in the nation[27], and the average number of years since last birth, to arrive at estimates of incidence in Nigeria[28]. An accepted estimate of incidence is approximately 20,000 new cases a year because of large scale unreported births happening outside health facilities, although recent studies state lower estimates of approximately 12,000 new cases per year[29].

Possible factors in the formation of obstetric fistula include static gender norms that require women to seek approval from their husbands before seeking medical care during labour; poverty, ignorance, illiteracy, preference for home delivery and the desire to avoid Caesarean section[30], early childbearing (as opposed to early marriage); harmful traditional practices like "*gishiri cut*"[31], low social status of women coupled with poor access to and utilization of EMOC services are other reasons proffered for the higher incidence of obstetric fistula in Nigeria. The typical OF patient in Nigeria is best described as young, married at an early age, illiterate, poor, rural, and lacking access to ante-natal care.

[27] http://data.un.org/Data.aspx?d=GenderStat&f=inID%3A36

[28] Strengthening Fistula Prevention and Treatment Services in Nigeria; An Environmental Scan. EngenderHealth, May 2010

[29] Strengthening Fistula Prevention and Treatment Services in Nigeria; An Environmental Scan. EngenderHealth, May 2010

[30] UNFPA and EngenderHealth, 2003

[31] Local Hausa word that describes a form of the traditional practice of female genital mutilationin some communities in Northern Nigeria

2.2 Prevention of Obstetric Fistula in Nigeria[32]

Prevention of obstetric fistula is dependent on knowledge, participation and uptake of quality services.

2.2.1 Male participation

Male participation has been identified as key in addressing some of the delays in utilizing health services, thereby leading to negative reproductive health outcomes. In a recent study by UNFPA, male participation in project sites was noted to have generally improved[33]. At the Family Life Centre (Akwa Ibom), there is a hostel for men to support their wives with routine tasks pre and post surgery, because the centre does not have an adequate number of nurses. In Kano, it was reported that a high percentage of fistula patients are accompanied for treatment by husbands, fathers and brothers. In addition, in Kano, men's involvement in ANC in particular had increased, due to the government's policy of free maternal health care provision. In Cross River, it was reported that while husbands play a minimal role, fistula patients are often supported by fathers and brothers. Husbands were not seen to be supportive of family planning in most of the states visited. However, stakeholders in Kwara state reported seeing some improvement in this regard.

2.2.2 Family Planning

Family planning access and utilization according to statements of key informants in the recently conducted environmental scan is still relatively low in many places visited during the study. Several stakeholders interviewed indicated that lack of commodities is a factor contributing to low family planning use.

[32] Engenderhealth 2010: Strengthening Fistula Prevention And Treatment Services In Nigeria: An Environmental Scan

[33] UNFPA 2008: Report Of Evaluation Of Prevention, Treatment And Rehabilitation Of Obstetric Fistula In Northern Nigeria Project (Kankara And Nassarawa LGAs)

2.2.3 Early catheterization

Currently, little is being done to effect early catheterization for approximately 4 weeks for women who experience prolonged or obstructed labour as a premium intervention to prevent new fistula cases. Immediate catheterization can prevent or treat small, fresh fistula. After a couple of days of education regarding drinking regimens and catheter management, women can be sent home with instructions to return every week for monitoring.

2.2.4 Emergency Obstetric and Neonatal Care[34]

Emergency obstetric care has been identified as a key intervention required to attain the goals of the Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Nigeria, 2005.

Issues of availability of services within equitable geographic reach, costs expended to utilise the services; opportunities lost in actual uptake, attitudes of service providers and quality of service provided, are issues that affect service uptake. Access to emergency obstetric care was reported to have increased in Kaduna, Kano and Bauchi as a result of governmental policies providing free maternal health care. However, inability of women to pay for transportation was cited as a barrier to service uptake. Moreover, women's perceptions about the quality of health services were also cited as barriers to increased uptake of hospital delivery. One individual mentioned that the care women receive from facility staff is discouraging: "Ask any woman who has delivered in the hands of nurses their experience." In Cross River, stakeholders reported an insufficient number of doctors and midwives as a factor affecting quality of care.

[34] Engenderhealth 2010: Strengthening Fistula Prevention And Treatment Services In Nigeria: An Environmental Scan

2.3 Service Delivery[35]

Nigeria has established a national obstetric fistula centre in the South East zone of the country while plans are on the way to establish national obstetric fistula centres in other zones in Nigeria. Approximately 2,000 - 4,000 fistula repair surgeries are being carried out yearly in Nigeria. Although obstetric fistulae can be repaired successfully, poverty, lack of awareness of availability of treatment facilities and the high cost of the repair, has made access to the much needed care unobtainable for many.

According to a recently conducted environmental scan many workers at the state level in the country are not aware of the existence of a National Strategic Framework for Elimination of Obstetric Fistula. The poor awareness of the framework was said to be partly due to inadequate participation of state actors in formulation and review of the lapsed plan. During the assessment carried out, it was generally agreed that there had been an improvement in maternal mortality and morbidity indices in the recent years due to the implementation of the Road Map to the attainment of the MDGs related to Maternal and Newborn Health.

Of the states assessed during the scan, Kano State had conducted the most numbers of repairs (Laure VVF Centre) in the preceding year; while in the South, the South East Regional Fistula Centre in Abakaliki, Ebonyi State had conducted the most number. Overall, the largest numbers of repairs were conducted in the North West zone, spread across all of the seven states. The second largest numbers of repairs were conducted in the North Central Zone, the majority of which were conducted in a facility in Jos, Plateau State. The assessment identified no fistula repair services in the North East, and few in the South West zones. Fistula services in the South East and South South are provided almost exclusively at established fistula centres.

35 Engenderhealth 2010: Strengthening Fistula Prevention And Treatment Services In Nigeria: An Environmental Scan

Furthermore, findings from the scan showed that the relative non availability of trained fistula surgeons is a significant problem particularly, in state hospitals. In a few Teaching Hospitals in the North, there were pools of trained personnel; however the demand for their services was less than the demand for services at the state level where there were inadequate personnel. Staff retention and motivation were cited as serious problems by many stakeholders in the states visited. There was a recognized need to train people who are truly keen to provide fistula surgery and train more medical officers rather than Fellows to increase retention. Regarding referrals, the referral systems vary from state to state, with Ebonyi State providing exemplary coordination with regard to referrals from the community to the facility level, as well as referrals from the facility-level to community-based reintegration services. In the north, however, referrals between state hospitals were noted to be occurring, although no referrals were occurring between state hospitals and federal tertiary facilities.

2.4 Rehabilitation and Reintegration

In Kaduna and Kano, the Ministries of Women Affairs participate actively in reintegration of women with obstetric fistula providing support for reintegration and skills building activities for fistula patients. The same was not the situation in Bauchi,, although key informants mentioned that reintegration of fistula patients could be integrated into other activities currently being led by the ministry. A more complex system was in place in Ebonyi state, where women were referred from the health facility to the development centre and the coordinators within LGAs for "individualized reintegration" at the community level. In Kano, stakeholders felt that women's associations could be harnessed to pool resources to build a reintegration centre. No reintegration activities were reported in Kwara, Cross River, Nasarawa and Akwa Ibom (the latter since community outreach funding has been

discontinued)[36]. Majority of the women who were able to access treatment in states supported by UNFPA, passed through the government rehabilitation facilities in these states. However, the rehabilitation process did not follow a uniform pattern in each state[37], supporting a notion that there was no uniform understanding of what constitutes rehabilitation and reintegration.

2.5 Social Context and Rights Issues Related to Obstetric Fistula

' …. *The following are the typical characteristics of the African system: great emphasis on the importance of ancestry and descent; a social system that, in its most complex form, places greater importance on intergenerational links than on conjugal ones and that gives great respect and power to the old. …In keeping with the aim of lineage perpetuation, emphasis is placed on fertility: Virtue is related more to success in reproduction than to limiting profligacy. The marriage bond is typically weak, with spouses retaining strong lineage links, and with a marked spousal separation of economic activities and responsibilities; …. the basic family unit is a mother and her children….'*John Caldwell, 1988

Nigeria is Africa's most populous country, with 148 million inhabitants in 2007. There were almost 6 million births in 2007 – the third highest number in the world, behind India and China – and a total fertility rate of about 5.4. With the high population, poverty is widespread. According to the World Development Indicators 2007, published by the World Bank, more than 70 per cent of Nigerians live on less than US$1 per day, which limits their ability to afford health care. Poverty, demographic pressures, and insufficient investment in public health care, to name but three factors, inflate levels and ratios of maternal and neonatal mortality[38].

[36] Engenderhealth 2010: Strengthening Fistula Prevention And Treatment Services In Nigeria: An Environmental Scan
[37] UNFPA 2008: Report Of Evaluation Of Prevention, Treatment And Rehabilitation Of Obstetric Fistula In Northern Nigeria Project (Kankara And Nassarawa LGAs)
[38] http://www.unicef.org/devpro/46000_46919.html

Nigeria has a young population compared to more advanced countries. More than two in five Nigerians are below 15 years old and will enter child bearing age. By 2015 the number of women in the reproductive age bracket will be about 45 million.

The implication of this high young population bracket is that Nigeria's dependency ratio is much higher and of course, high dependency ratios affect family and society in several ways including incidence of more children per adult to provide with food, clothing, education, and housing. In addition, there would be more non – working household members to cater for, exacerbating social problems. Only 36% of Nigerian women are in the adult work force and most of these women are employed in the informal sector that attracts less skilled labour and poor remuneration[39].

Cultural and social pressures also limit access to health care and uptake of available services in Nigeria. In Muslim-dominated parts of Nigeria, where the maternal morbidity and mortality rates are very high, women often need their husbands' permission to seek medical care, which if granted may (or may not) be impeded by inadequate funds to bear hospital costs. Lack of education has been the bane of women in many parts of Nigeria, fuelling a vicious cycle of '*ignorance, disease and death'*. The result is a compounding of the 'access factor' (geographic, economic and social) by the 'lack of education factor' which increases the risk of poor maternal outcomes in these societies.

[39] FMoH/WHO: REDUCE Maternal and newborn Deaths in Nigeria. Make Pregnancy Safer

3.0: Problem Statement and Priority Areas for Action 2011 -2015

3.1 Problem Statement

Obstetric fistula is a major public health problem in Nigeria. While the condition has disappeared in developed countries, it remains a source of concern in Nigeria and serves as a proxy indicator of the status of Nigerian women and of the availability and access to quality maternal health services. Young adolescents and women whose growth has been stunted by malnutrition stand a higher risk of developing obstetric fistula in labour. However, the possibility of occurrence of fistulae can be reduced if pregnancy is delayed till sexual maturity is attained; all deliveries are attended to by skilled birth attendants, and women with obstructed labour have access to timely caesarean section.

3.2 Rationale

Obstetric fistula is a living reminder of a country's glaring failure to address the basic human rights and health service needs of the teeming population of women and children in the country. It is a striking indication of persistent socioeconomic and gender inequities and disparities in access to maternal health care. These include exposure to harmful socio-cultural beliefs and practices towards women and girls, such as early childbirth; lack of access to family planning services as well as skilled care during pregnancy and childbirth. More than two-thirds of African women do not have access to family planning and to Emergency Obstetric and Neonatal Care (EmONC) services[40]. The result of failure to access such services and health facilities that provide Caesarean section is either death or a major injury and disability to women's health. With a variety of related reproductive health policies in the country; little has been done to address the underlying root causes of obstetric fistula. There remains a need to move from policy commitments to action, to ensure safety of all

[40] Strategic Framework for the Elimination of Fistula in Africa: 2006-2015

women during delivery, to repair all obstetric fistula cases and prevent new ones by taking concrete steps to deal with the underlying determinants of obstetric fistula. Efforts to eliminate obstetric fistula are related to four of the eight Millennium Development Goals: Goal 1: Eradicating extreme poverty and hunger; Goal 3: Promoting gender equality and empowering women; Goal 4: Reducing child mortality and Goal 5: Improving maternal health. This strategic framework is also in concert and fully aligned with the current National Strategic Health Development Plan 2010 to 2015[24,] that calls for comprehensive and strategic programming.

3.3 Overarching Principles

The following principles and values underpin the new National Strategic Framework and Plan for Elimination of Obstetric Fistula in Nigeria:

1. The principle of social justice and equity and the ideals of freedom and opportunity affirmed in the 1999 Constitution of the Federal Republic of Nigeria and restated in the National Strategic Health Development Plan 2010 -2020;
2. Health and access to quality and affordable health care as a human right;
3. Equity in health care distribution based on needs for all Nigerians;
4. Good quality health care assured through cost-effective interventions that are targeted;
5. Efficiency and accountability to be maintained in the development and implementation of this plan;
6. Effective partnership and collaboration between various stakeholders to be encouraged in the principle of inclusiveness and transparency in a coordinated manner[41];

[41] National Strategic HealthDevelopment Plan 2010 -2020

7. Since health is an integral part of overall development, inter-sectoral cooperation and collaboration between the different health-related Ministries, development agencies and other relevant institutions shall be strengthened;
8. A gender responsive National Strategic Framework and plan to be achieved by mainstreaming gender considerations at all levels of design, implementation and evaluation of this plan.
9. The use of Results Based Methodology (RBM) in planning, implementation and evaluation of strategic interventions.
10. Active community participation in OF interventions at all levels.

3.4 Strategic Priorities of the National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria[42]

The National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria is premised on the first priority intervention of the National Reproductive Health Policy (2010): *Healthy Pregnancy and Childbearing* and covers every priority area identified in the National Strategic Health Development Plan 2010-2015. The provision of quality antenatal, delivery, postpartum and newborn care is critical to achieving the objective of healthy pregnancy and childbearing. Availability of such services, however, is not sufficient. Wide geographical coverage that will ensure easy geographical access is very crucial. The healthcare and other social policies within the country should facilitate easy financial access of all pregnant women to quality comprehensive maternal and newborn care. For healthy pregnancy and childbearing to be a reality, the three levels of delay relating to accessing the needed maternal care have to be effectively addressed, namely: delay at the household level (relating to the health seeking decision making processes at the household level), delay in reaching the healthcare facility (relating to transportation and geographical access), and delay

[42] One of the Priority Interventions of the National Reproductive Health Policy; Also aligned with NSHDP

within the healthcare facility (relating to availability of skilled personnel and needed facilities and supplies).

3.4.1 Capacity Development

Capacity building requirements for improving maternal outcomes in pregnancy and reducing the incidence and clearing the backlog of obstetric fistula in Nigeria will require human, institutional/organizational, and infrastructural development (which includes social capacity)[43]. The initial step for building capacity for addressing reproductive health issues in Nigeria is to carry out a comprehensive needs assessment and situational analysis which would be to be updated periodically to incorporate changes and form the evidence basis needed for developing an efficient system to drive the OF elimination process.

The capacity building strategy will cover all seven major components of the health system vis:

i. Service delivery (preventive, promotive and curative);

ii. Support services (procurement and storage of drugs and supplies, record keeping, blood transfusion services, equipment management, finance and accounts);

iii. Health manpower and their deployment;

iv. Physical infrastructure;

v. Financing arrangements (insurance, aid, direct payment, etc);

vi. Regulation and licensing of the facility;

vii. Overall stewardship (setting policy, planning allocating resources);

[43] Marc Okunnu:Lead Paper ''Capacity Building needs for improving RH in Nigeria' presented at the Independent Policy Group forum held in Kano, 2006

In addition to the above, the development of social capital which is a driving force for sustainable change and redirection of reproductive health outcomes will be a key component of both the Capacity Building strategy and the Behaviour Change Communication strategy. Strategies to increase the awareness of community members to the identifiable risk behaviors will build the capacity of the community to demand for services and will lead to early screening and timely uptake of prenatal and post natal services. This NSF will support the formation of grass roots based Civil Society Organizations (CSOs) and encourage partnership and involvement (including partnership with faith based organizations and traditional rulers) in creating the needed ownership of the plan. In addition, rehabilitation of obstetric fistula patients into communities will be achieved by providing vocational training and micro loan schemes and will enable them serve as advocates and contribute steadily to improvements in the socio economic conditions of these vulnerable groups of women.

Reparative management of fistulae will require a differentiated approach to management at each of the 3 levels of service delivery. Even with this strategy there are still significant resource constraints, reinforcing recommendations regarding conservative treatment of OF by immediate catheterization for fresh fistula at the facility level that may, in some cases, make surgery unnecessary.[44]

3.4.2 Promotion of Healthy Reproductive Health Behaviour[45]

The main focus of the framework will be prevention of fistulae by the adoption of behaviour change interventions at all levels, using appropriate and innovative channels and messages identified by evidence based modalities to target not only the women,

[44] Waaldijk K. The Immediate Management of Fresh Obstetric Fistulas. American Journal of Obstetrics and Gynecology; 2004: 191 p.795-9
[45] National Reproductive Health policy,2010

but also their husbands, community leaders, and a significant others in decision making processes and health-seeking behavior of the populace.

Implementing the healthy reproductive health behaviour interventions of the National Reproductive Health policy is key to attaining the targets of safe motherhood and newborn health in Nigeria. The Behaviour Change Communication Strategy for the National RH Policy and Framework (2005-2010) will serve as the reference framework to be adopted.

One major intervention is to advocate for a separate budget line for obstetric fistula services at all levels and adequate allocation of funds to the budget line to effectively and adequately fund the implementation of services. Key partnerships will be encouraged with the media to continually mobilize the leaders and people to action for family planning, birth spacing and uptake of antenatal and perinatal services.

Protecting the fundamental rights of vulnerable people to life, education, health will need legislation and a policy environment that is supportive and specifically addresses issues that discourage rights abuse and inhibit equitable access to social services (such as education and health) of both girls and boys. Policy makers and Legislators will need to receive targeted messages to ensure the right approach is adopted in addressing the rights based issues related to obstetric fistulae. Community participation will be engendered by capacity development, advocacy, social mobilization and innovative social entrepreneurship to ensure that the OF programme bears the encumbered cost or opportunity (ies) missed for the adoption of the desired behaviour change.

3.4.3 Gender Responsive Programming and Rights Basis

This framework is to focus on analyzing immediate and underlying determinants of obstetric fistula as it pertains to the differential roles men and women play in the causation of this scourge; and adopt interventions which are designed to improve women's access to resources and opportunity in the context of prevention efforts. Ensuring effective participation of consorts, family heads and community leaders is also important to attain the goal of elimination. To this end, experts in gender based programming will ensure effective mainstreaming of gender perspectives in programming the design, planning, implementation, monitoring and evaluation of interventions at all levels. It is expected that these approaches will lead to gradual changes in behaviour in the short to medium term and ensure institutional empowerment of women in the long term, as regards access to and utilization of social services.

3.4.4 Improving the Information base for Priority-setting and Evidence-based Programming[46]

- **A Baseline Needs Assessment and Service Mapping**

Building on the information that is already available, and as part of developing a strategy for reducing the prevalence of obstetric fistula and improving treatment services, it is pertinent to perform a needs assessment of the situation within a particular country or region, because the data readily available may be scanty, incomplete, directed to maternal and newborn mortality and morbidity and not

[46] WHO Guiding principles for VVF Elimination

specifically designed to provide information on the prevalence and unmet need for obstetric fistula services.

Mapping existing services provides useful information to planners and policymakers by identifying any gaps in services, equipment and human resources for emergency obstetric care (basic and comprehensive) and fistula services.

- **Health Management Information System and Epidemiological Studies**

This involves the collection, collation and analysis of data routinely collected by health and other government departments, and other data such as community surveys to give an indication as to the 'unmet need' for fistula prevention and repair services for a particular community. Unfortunately, in many areas where fistula is prevalent, data-collection systems have either not been established or are not robust or reliable, as is also the case with data on other maternal morbidities. Most data on fistula are hospital based, which do not take into account the majority of women hidden in the community who are unable to seek medical care. It may therefore, be necessary to collect primary data. This may be done through community-based surveys using more qualitative approaches to estimate the unmet need. Proxy measures may also be available to estimate the prevalence and burden of obstetric fistula. For example high maternal mortality rates or high rates of uterine rupture are often associated with a high prevalence of obstetric fistula.

- **Community Based Study of the Magnitude and Distribution of Obstetric Fistula in the country**

Knowing the prevalence of women living with fistula and the incidence of new cases occurring each year is in itself not sufficient to develop a sustainable obstetric fistula elimination programme. It is, however, a necessary step in commencing strategic

interventions. It will provide a correct rendering of causal determinants and provide the benchmarks from which change can be measured.

4.0: Expected Results

The elimination strategy for obstetric fistula will be three -pronged:

I. *Primary prevention strategies*

This requires the creation of a political, legal and social environment that promotes improvement in the status of women and girls and therefore, the prevention of obstetric fistula. In particular, there is a strong need to address issues related to sociocultural factors, gender equality, and education of the girl child and to review law and policies that may be an obstacle for utilization of reproductive health services. In addition, there is a need to ensure that pregnancies are wanted, planned, and occur at an optimal time in a woman's life. They are based on principles of health promotion and education designed to ensure that all women, their families and communities, understand the need for good nutrition, delaying the age at first pregnancy, as well as the advantages of birth spacing and providing access to family planning as it impacts on the development of obstetric fistula.

Once a girl or woman is pregnant, she, her family members and the community need to be made aware of antenatal care, understand the necessity for skilled care at childbirth and the signs and symptoms of possible complications during childbirth, such as prolonged labour. This can be promoted by increasing community awareness, training traditional birth attendants, increasing women's knowledge of normal pregnancy and delivery and about when and where to seek help and why. However, easy access (including health financing options, transportation etc) to a local EmONC facility remains paramount and a functional referral system is key to linking secondary and tertiary level prevention interventions. Facilities with quality basic and

comprehensive emergency obstetric care services[47] must be available and accessible, including finances to manage complications when they occur.[48] Therefore, strategies must focus on strengthening health systems to improve timely access to maternal health services and in particular, strategically located and fully functional emergency obstetric care (EmONC) centres.

II. Secondary level prevention strategies

At the facility level, all skilled birth attendants will be trained to prevent fistula formation or to enable closure of very small fistula without surgery by the use of an indwelling urinary catheter for all mothers who have survived an obstructed labour. A multilevel/multi-tier national system for fistula care and service delivery is proposed and may be adapted from the best practices approach already existent in-country. This approach involves smaller local facilities performing more basic fistula prevention interventions as part of early diagnosis and management of fistulae. Repairs, depending on complexity will be carried out at higher levels and stand alone facilities

III. Tertiary level prevention including rehabilitation, reintegration and stigma reduction

Rehabilitation serves to bring back the opportunity to live again, renews hope and lays the foundation of a new dawn, thus dispelling the depression associated with the condition. This includes psychological counselling, microenterprise loans or grants, income generating activities, skills acquisition, literacy education, and physical competence to live a productive life of interdependence, including management of inoperable cases. However, even the most robust rehabilitation programme cannot secure complete reintegration into communal existence of women with obstetric

[47] Basic emergency obstetric care includes the following capabilities: administration of antibiotics, oxytocics, or anticonvulsants; manual removal of the placenta; removal of retained products following miscarriage or abortion; and assisted vaginal delivery with forceps or vacuum extractor. Comprehensive care includes the above plus Caesarean section and safe blood transfusion.

[48] For every 500,000 people, at least four facilities offering basic EmOC and one facility offering comprehensive EmOC are recommended.

fistula without establishing a social milieu where obstacles such as superstition, rejection, poverty, etc are eliminated at best, or reduced to the minimum. Obstetric fistula is associated with stigma; often self stigmatization underlies the associated depression many women with obstetric fistula suffer.

4.1 Goal

To eliminate fistula related to childbirth (OF) through improvements in reproductive health outcomes of girls and women in Nigeria.

4.2 Purpose

1. To determine the actual prevalence and incidence of obstetric fistula
2. To reduce the incidence and prevalence of obstetric fistula
3. To ensure rehabilitation and reintegration of women with fistula

4.3 Outcomes

1. Incidence and prevalence of obstetric fistula determined in Nigeria.

2. New cases and backlog of obstetric fistula reduced

3. Women with the need, access and utilize rehabilitation and reintegration services

4.4 Outputs

1: Strengthened political, socio-cultural and legal environment interventions related to reducing fistula formation

2: Enhanced community participation in the prevention of fistula formation

3: Improved availability of obstetric fistula prevention interventions and EmONC

4: Strengthened national capacity for treatment and care of obstetric fistula

5: Increased availability of rehabilitation and reintegration services for women treated for obstetric fistula

6: Quality rehabilitation and reintegration services provided

7: Increased community support of women with obstetric fistula

8: Documentation of learning and progress.

9: Enhanced coordination and management of OF programmes

4.5 Beneficiaries and Reach

- Direct Beneficiaries of implementation of activities in this National Strategic Framework are the OF patients who will benefit by programmatic interventions at both the output and outcome levels.
- Indirect beneficiaries are community members who will have improved access to care that improves their overall wellbeing; health care workers whose capacities would have been built to carry out reparative surgical interventions and care and other pregnant women

4.6 Targets

1. Reduce the incidence of Obstetric Fistula in Nigeria by 50%
2. Increase treatment of Obstetric Fistula by 50% from the current level
3. Increase reintegration by 50% for women requiring reintegration.
4. Increase by 30% the number of facilities offering rehabilation services.

4.7 Alignment of the National Strategic Framework for Elimination of Obstetric Fistula with the National Strategic Health Development Plan

1: Strengthened political, socio-cultural and legal environment interventions related to reducing fistula formation

2: Enhanced community participation in the prevention of fistula formation

3: Improved availability of obstetric fistula prevention interventions and EmONC

4: Strengthened national capacity for treatment and care of obstetric fistula

5: Increased availability of rehabilitation and reintegration services for women treated for obstetric fistula

6: Quality rehabilitation and reintegration services provided

7: Increased community support of women with obstetric fistula

8: Documentation of learning and progress.

Health Financing and Leadership and Governance priority areas of the NSHDP

Community Participation and Ownership priority area of the NSHDP

Service Delivery priority area of the NSHDP

Human Resource and Service Delivery priority areas of the NSHDP

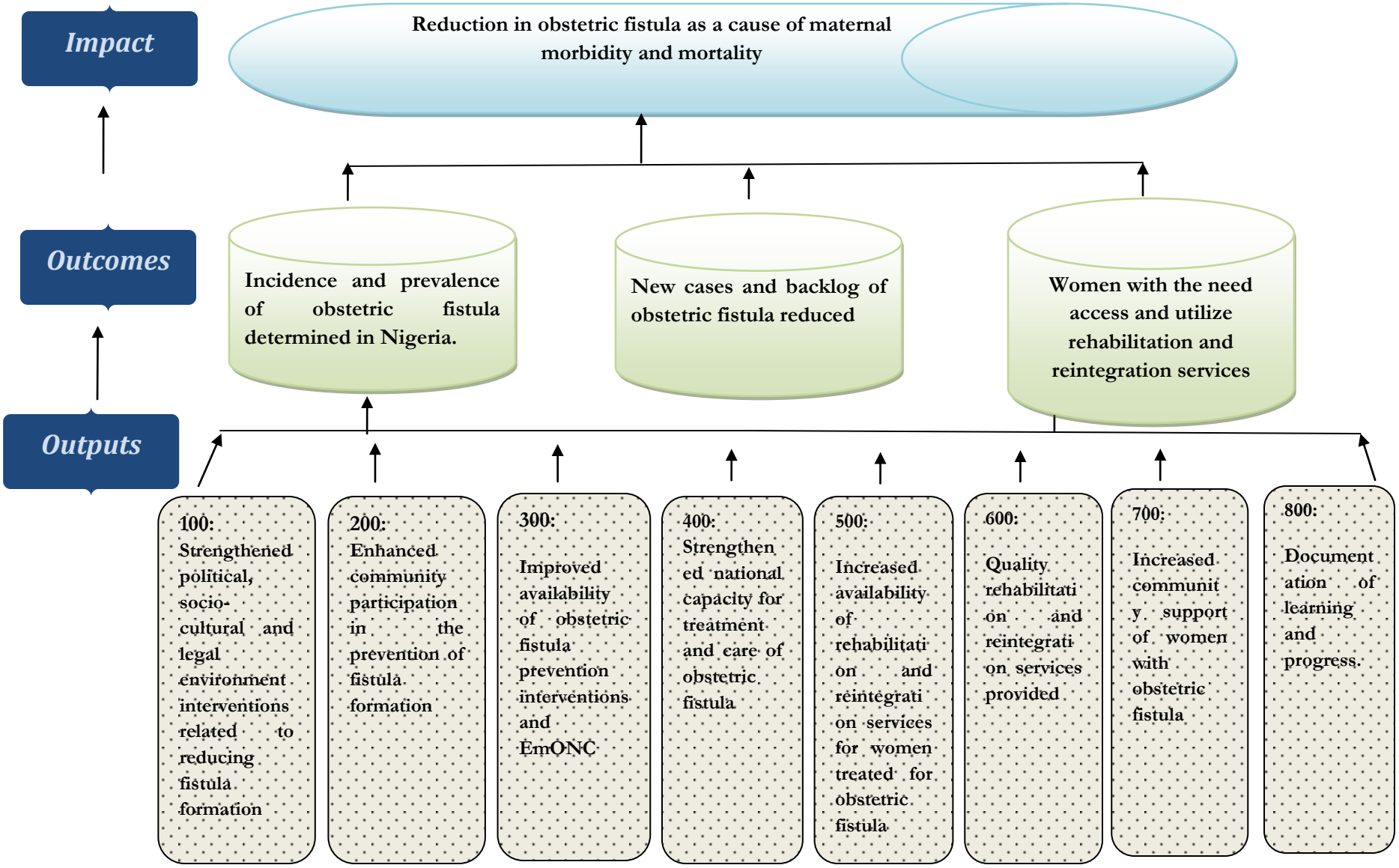
Human Resource and Service Delivery priority areas of the NSHDP

Human Resource and Service Delivery priority areas of the NSHDP

Community Participation and Ownership priority areas of the NSHDP

Research priority areas of the NSHDP

4.8 Work Breakdown Structure



4.9 Logical Framework Analysis

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
Goal: To eliminate obstetric fistula in Nigeria through improvements in the reproductive health outcomes of girls and women.	**Impact:** Reduction in obstetric fistula as a cause of maternal morbidity and mortality	MMR	**Assumption:** Political will and commitment to OF intervention programmes by all stakeholders sustained. **Risk rating:** High **Indicator:** Existence of political instability **Assumption**: i) Stable and committed government - FMOH and government at all levels. ii) Budget includes OF activities clearly budgeted for **Risk rating**: High **Indicator**: i) Existence of political instability ii) Total line budget as a component of total relevant budget for government agencies at all levels **Assumptions:** OF funds released for planned activities

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
			on time **Risk Rating:** High **Indicator**: Timing of release of funds
Purpose: 1.To determine the actual prevalence and incidence of obstetric fistula	**Outcomes:** Incidence and prevalence of obstetric fistula determined in Nigeria.	Incidence of OF Prevalence of OF	**Assumption:** Relevant government at all levels support OF elimination by channeling resources(commitment, funds, facility etc) to health systems strengthening **Risk rating:** Moderate
2. To reduce the incidence and prevalence of obstetric fistula.	New cases and backlog of OF reduced	Government at all levels with budget lines for OF elimination National and sub-national policies in place to increase the access of women to quality OF information and services Percentage of allocated OF Budget released for planned activities Percentage of government at all levels with health budget allocated to OF (recurrent and non-recurrent costs)	**Assumption:** Relevant government at all levels support OF elimination by channeling resources(commitment, funds, facility etc) to health systems strengthening **Risk rating:** Moderate **Assumption:** Adequate and timely funding budgeted and released by government and stakeholders. **Risk rating**: High

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		Contraceptive prevalence rate Proportion of births attended by skilled birth attendants National and sub-national laws and policies in place to address rights issues that predispose to OF Civil society partnership actively promoting gender equality, women and girls empowerment and reproductive rights nationwide Proportion of girls who complete secondary education or attend vocational schools Met need for EmONC	Communities' willingness to imbibe fistula prevention measures. **Indicator: i.)** Amount budgeted and released for specific OF interventions ii) Timely release of funds **Assumption:** Women will utilise services **Risk rating**: High **Indicator**: i. Harmful socio cultural practices ii. Type of Male involvement iii. Number of women seeking care **Assumption**: Availability of transport and communication infrastructure **Risk rating**: High **Indicator**:

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		Number of providers trained in fistula management Number of health facilities equipped to provide quality fistula management. Number of women treated for OF per year Number of women with fistula receiving pre- and post-operative counselling annually Number of women with fistula repaired annually	Funding available for the survey Willingness of government and partners to undertake the survey **Assumption:** Health workers available for training at facility level. **Risk rating**: Moderate **Indicator:** Number trained at facility **Assumption**: Availability of motivated trained personnel **Risk rating**: High **Indicator:** Appropriate enabling environment
3. To ensure rehabilitation and reintegration of women with fistula	3. Women with the need access and utilize rehabilitation and reintegration services	Proportion of women treated for fistula using rehabilitation and reintegration services annually Reduction of stigma associated with obstetric fistula at the community level	**Assumption:** Community Leaders, family Heads support OF elimination and allow wives to utilise services **Risk rating**: Moderate **Indicator:** i) Number of

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		Proportion of women fully reintegrated* in the community annually	Community Leaders, Family Heads providing support ii) Type of male involvement iii) Timeliness of support
	Outputs 100: Strengthened political, socio-cultural and legal environment interventions related to reducing fistula formation	Existence of policies on reproductive health that integrate obstetric fistula prevention Annual amount expended on obstetric fistula Existence of policies or programming frameworks related to girl child education, male involvement, early child bearing etc	**Assumption:** Relevant Government at all levels support OF elimination by channeling resources(commitment, funds, facility etc) for health systems strengthening **Risk rating:** Moderate **Indicator:** i) Number of government at all levels committing resources to OF ii) Type of State support iii) Timeliness of support
	200: Enhanced community participation in the prevention of fistula formation	Existence of community committees (in partnership with the health facilities) for maternal health, informed and aware of OF (mechanism of cost sharing, referral, etc.) KAP studies on community knowledge, attitude and practices Community screening of OF Number and type of media organizations, Faith Based	**Assumption:** Leaders support for elimination of Fistula and commit resources in a sustained manner. **Risk rating**: High **Indicator**: Number of Leaders committing resources ii) type of support/commitment iii) Timeliness of support

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		*Organizations (FBOs), Community Based Organizations (CBOs) etc involved in community mobilization Number of community members involved in advocacy, social mobilization and programme communication efforts Type of community involvement in preventive interventions e.g girl child education, early child bearing, nutritional and financial support initiatives	
	300: Improved availability of OF prevention, interventions and EmONC	Number of EmONC (BEmONC) and CEmONC) facilities available for a population of 500,000 Proportion of EmONC facilities strengthened according to the standard guidelines for OF management Constellation of services available for early prevention of fistula Proportion of facilities with skilled personnel to provide 2^{o} and 3^{o} levels OF prevention services	**Assumption**: Amount budgeted and released for strengthening EmONC services and early prevention interventions. **Risk rating**: High

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		Use of early catheterization for prevention Geographic coverage of EmONC facilities	
	400: Strengthened national capacity for treatment and care of obstetric fistula	Number/location of facilities providing simple fistula treatment services Number/location of centres providing specialist fistula services Number/location of doctors and nurses able to undertake simple repairs (M:F) Number/location of surgeons able to undertake complex repairs (M:F) Proportion of patients waiting for surgery for more than 2 months* Fistula repair team in place (M:F) Equipment and supplies for fistula repair in place Availability of guidelines and	**Assumption:** Health workers available for training at facility level. **Risk rating**: Low **Indicator:** Number trained at facility **Assumption**: Availability of motivated trained personnel **Risk rating**: High **Indicator:** Number of motivated workers

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		standards on fistula management and training in place Proportion of women with obstetric fistula who have a successful first repair by each facility[49]. Proportion of women who have had two or more unsuccessful repairs Number/location of training facilities (pre-service and in-service) including OF prevention and treatment as part of the core syllabus Number of surgeons undertaking simple fistula repair training per year Number of in-country surgeons undertaking specialist fistula training (either in country or elsewhere) per year	

[49] Ideally the closure rate should be 85%, of which 90% should be without incontinence disaggregated into different types of fistula

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		Number of paramedical personnel trained in fistula treatment and care (M:F)	
	500: Increased access to rehabilitation and reintegration services for women treated for obstetric fistula	Number of fistula treatment services which include social reintegration activities Proportion of women treated for fistula who have access to rehabilitation & reintegration services Number of partnerships established with income generating activities or micro credit institutions Number of CBOs providing gender sensitive livelihood programmes for women who have lived with fistula	**Assumption:** Availability of resources including manpower committed to VVF related rehabilitation/reintegration work. **Risk rating**: High **Indicator**: i) Number of M:F involved in rehabilitation/reintegration work **Assumption:** Availability of private sector organization, NGOs and civil societies committed to OF work. **Risk rating**: High **Indicator**: i) Number of NGOs/CSOs doing OF work
	600: Quality rehabilitation and	Number of functional rehabilitation & reintegration centres	**Assumption:** Women will utilise services **Risk rating**:

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
	reintegration services provided	Number of women fully reintegrated[50] into their communities Number of centres offering life skills education to women who have experienced fistula Proportion of women who experienced OF who actually started small businesses Proportion of women who have experienced OF in the community who received life skills trainings	High **Indicator**: i Harmful socio cultural practices ii. Type of Male involvement iii. Number of women seeking treatment. **Assumption:** Health personnel and social workers available and willing to be trained. **Risk rating**: Low **Indicator**: Number of HWs /SWs trained
	700: Increased community support of women with obstetric fistula	Proportion of community leaders who support community initiatives for social reintegration of women who have experienced OF Proportion of community leaders who support reintegration programmes in the community Proportion of former fistula clients who serve as peer educators or	**Assumption:** Leaders support elimination of fistula and commit resources in a sustained manner. **Risk rating**: High **Indicator**: Number of leaders committing resources ii) type of support/commitment iii) Timeliness of support

[50] ***Living with husband/ family, participation in community gatherings***

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		advocates in their communities Resources mobilized at the community level Number of Media, FBOs, CSOs, CBOs etc topicalizing OF	
	800: Documentation of learning and progress.	Number of consultation meetings (coordination, knowledge sharing, etc.) held Quarterly release of OF News Bulletin Biannual Conference on OF Elimination carried out Number/type of clinical and operational research Number of research grants on OF funded annually National reports on progress of OF Elimination Number/type of publications on OF	**Assumption:** Availability of NGOs and civil societies committed to OF work. **Risk rating**: High **Indicator**: i) Number of NGOs/CSO **Assumption:** Availability of Resource personnel committed to OF work. **Risk rating**: High **Indicator**: i) Number of resource personnel conducted research ii) Type of researches conducted

Summary	Expected results	Objectively Verifiable Indicators	Assumptions and risks
		written in national and international journals	
	900: Enhanced coordination and management of obstetric fistula programmes	Coordination/partnership forum for MNH/OF programmes established and functional Number of annual planning monitoring and review reports. Number of annual work plans developed for implementation of the NSF Joint monitoring and evaluation plan costed and in existence Number of national review and planning meetings held Timeliness of programme evaluation	**Assumption:** Partners support elimination of fistula and commit resources in a sustained manner. **Risk rating**: High **Indicator**: Number of partners committing resources to OF. ii)Type of support/commitment iii) Timeliness of support

4.10 Results Matrix

Output	Activities	Target Audience	Responsible	Cost
100: Strengthened Political, Socio-Cultural and Legal Environment Interventions Related To Reducing Fistula Formation Aligns with the Health Financing and Leadership and Governance priority areas of the NSHDP				
Strategy 1: Advocacy, Social Mobilization and Resource Mobilization:	110: Ensure OF elimination interventions fully integrated into national policies/strategies	State Executives, Policy Makers, Health Workers, Programme Officers	FMOH/FMWA/Partners/CSOs	
	120: Intensify advocacy and policy dialogue for increased resource allocation to strengthen health systems	Decision Makers, State Executives, Media	FMOH/FMWA/Partners/NGOs/CSOs	
	130: Develop or support policies and laws that promote free MCH services, accelerated access to girl child education etc at all levels	State Executives, Policy Makers, Health, Education and Social Workers	State Executives, LGA Chairmen	
	140: Develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy	State Executives, Policy Makers, Health Workers, Programme Officers	State Executives, LGA Chairmen	
Strategy 2: Capacity Development and Health care financing:	150: Create budget line item for fistula at Federal, State and LGA levels	State Executives, Policy Makers, Health Workers, Programme Officers	State Executives, LGA Chairmen	
	160: Provide system for health budget execution, monitoring and reporting	State Executives, Policy Makers, Health Workers, Programme Officers	Programme Officers, State Executives, LGA Chairmen	

Output	Activities	Target Audience	Responsible	Cost
	170: Develop, cost and adequately finance maternal health National Road Maps that highlight OF interventions	Health Workers, Programme Officers	FMOH/FMWA/SMOH/Community Leaders/Partners/CSOs	
	180: State and LGA to institute stakeholder interactive forums for review and feedback	Health workers, Programme Officers, Partners	FMOH/FMWA/SMOH/Community Leaders/Partners/CSOs	
200: Enhanced community participation in the prevention of fistula formation. Aligns with the Community Participation and Ownership priority area of the NSHDP				
	210: Provide an enabling framework for community participation and ownership	Policy Makers, Health workers, Programme Officers	FMOH/FMWA/SMOH/LGA/Partners/CSOs	
	220: Develop community level assessment tool on OF and MNH, including relevant socio-cultural beliefs and practices	Policy Makers, Health Workers, Programme Officers	FMOH/FMWA/SMOH/LGA/Partners/CSOs	
	230: Establish and/or strengthen partnership and coordination mechanism for resource mobilisation, programming and M and E e.g. CDC, WDCs	Decision Makers, State Executives, Media	FMOH/FMWA/SMOH/LGA/Media/Partners/NGOs/CSOs /FBOs	
	240: Foster the participation of men in fistula elimination and maternal health	Community Leaders, Religious Leaders, Adolescents, Household Leaders	FMOH/FMWA/SMOH/LGA/Media/Partners/NGOs/CSOs /FBOs	
	250: Support community mobilization to contribute to emergency funds and transport; evaluating and reducing harmful cultural practices and beliefs; creating linkages with the health system community-based surveillance systems; health financing schemes for the poor etc	Community Leaders, Religious Leaders, Adolescents, Household Leaders/Health Workers	FMOH/FMWA/SMOH/LGA/Media/Partners/NGOs/CSOs /FBOs	

Output	Activities	Target Audience	Responsible	Cost
	260: Develop appropriate BCC and IEC tools and deploy	Community Leaders, Religious Leaders, Adolescents, Household Leaders/Health Workers Programme Officers	FMOH/SMOH/Partners	
	270: Train TBAs to engender safe practices and beliefs and create linkages with the health system to improve utilization	TBAs	FMOH/SMOH/Partners	
300: Improved availability of OF prevention interventions and EmONC. Aligns with Service Delivery priority area of the NSHDP				
Strategy 1: Capacity Development (Service Provision)	310: Availability of a constellation of services at facility level	Programme Officers/Health Workers	FMOH/SMOH/LGAs/ Partners	
	320: Establish a reliable referral system	Programme Officers/Health Workers	FMOH/SMOH/LGAs/ Partners	
	330: Provide services free of charge	Programme Officers/Health workers	FMOH/SMOH/LGA	
	340: Strengthen NHIS, NPHCDA to integrate fistula at relevant levels	Programme Officers	FMOH/SMOH/NHIS/Partners	
	350: Support community mobilization to contribute to emergency funds and transport and explore health financing schemes for the poor	Programme Officers/Community	FMOH/SMOH/LGAs/ Partners	
Strategy 2: Capacity Development (Human):	360: Improve pre-service graduate training in medical, nurses and midwives training institutions	Teaching Hospitals and other Training Institutions	Consultants/ Government	
	370: Map and analyze regional and global capacities and needs in training	States, LGAs	Programme Officers/Consultants	

Output	Activities	Target Audience	Responsible	Cost
Strategy 3: Research (Formative and Operational)	380: Conduct gender disaggregated studies on access to education and health	Communities	Programme officers/Consultants	
	390: Conduct formative research and household survey to develop BCC tools and interventions	Communities	Programme Officers/Consultants	
	3100: Conduct operational research on accessibility, adequacy and utilization of RH especially OF services	Hospitals, PHCs	Programme Officers/Consultants	
400: Strengthened National Capacity For Treatment and Care of Obstetric Fistula. Aligns with Human Resource and Service Delivery priority areas of the NSHDP				
Strategy 1: Service Delivery and Standards	**4**10: Identify, renovate/construct and equip centres/units providing fistula treatment and ensure dedicated operating theatres.	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	420: Provide pre and post-operative care and counseling including services to women on the waiting list	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	430: Training of the EmONC providers in areas of basic and comprehensive emergency obstetric care including standard Caesarian Section and Family Planning	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	440: Provide and maintain equipment, supplies and drugs needed for treatment of OF	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	450: Provide adequate staffing for fistula treatment and care, ensuring appropriate motivation for staff	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	

Output	Activities	Target Audience	Responsible	Cost
	460: Develop quality assurance models such as audits, clinical protocols and standards for practice guidelines for detection, management and follow-up	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	470: Maintain a register to capture fistula patients' attendance and service uptake	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
	480: Institutionalize integrated supportive supervision mechanisms	PHCs, General and Specialist Hospitals	FMOH/SMOH/LGAs/ Partners	
Strategy 2: Social Mobilization:	490: Awareness campaigns for hospital staff working in outpatients to provide priority assistance to women with OF	Hospital Staff	FMOH/SMOH/LGAs/ Partners	
	4100: Conduct awareness campaigns in collaboration with media institutions to reduce backlog	Women with OF, Community Members	FMOH/SMOH Programme Officers/Media/NGOs/CSOs	
Strategy 3: Human Capacity Devt:	4110: Carry out rapid assessments of available resources and training needs	Programme Officers/Consultants	FMOH/SMOH/LGAs/ Partners	
	4120: Support the development of a National Human Resource Plan for OF	Programme Officers/Consultants	FMOH/SMOH/LGAs/ Partners	
	4130: Adapt/develop training curricula/manuals	Programme Officers/Consultants	FMOH/SMOH/LGAs/ Partners	
	4140: Mainstream fistula in the training curriculum of undergraduate and postgraduate medical programs (includes nursing and midwifery programmes, social workers and community health extension workers)	Teaching Hospitals. General Hospitals, Specialist Hospitals, PHCs and other OF Centres		

Output	Activities	Target Audience	Responsible	Cost
	4150: Conduct in-service training and retraining of service providers to improve their knowledge and skills in management of OF	General Practice Doctors, Surgical Registrars and Consultants; Nurses	FMOH/SMOH/LGAs/ Partners	
	4160: Establish 6 zonal training centres (one in each of the geo-political zones of Nigeria) to serve as fistula training, referral and research centres	Contractors, State and LGA Executives	FMOH/SMOH/LGAs/ Partners	
500: Increased Access To Rehabilitation And Reintegration Services For Women Treated For Obstetric Fistula. Aligns with Human Resource and Service Delivery priority areas of the NSHDP				
Strategy 1: Advocacy	510: Develop Advocacy Kit	Community Heads, Husbands, Traditional and Religious Leaders	FMOH/SMOH/LGAs/ Partners	
	520: Advocate for integrating fistula rehabilitation & reintegration programmes in policies and plans	Decision makers at State level	FMOH/SMOH/ Partners	
	530: Advocate for increased political/financial support by political leaders, First Ladies and donors	First Ladies, Political leaders, Donors	FMOH/SMOH/LGAs/ Partners	
Strategy 2: Research	540: Design and conduct comprehensive socio-cultural research on instituting social reintegration interventions	Communities	FMOH/SMOH/LGAs/ Partners	
Strategy 3: Capacity Building	550: Build NGO capacities to design, implement, monitor and evaluate gender sensitive livelihoods programmes for women who have lived with fistula	NGOs, CSOs, CBOs and other Civil Society Groups	FMOH/SMOH/LGAs/ Partners	
600: Quality Rehabilitation and Reintegration Services Provided. Aligns with Human Resource and Service Delivery priority areas of the NSHDP				
Strategy 1: Capacity Building	610: Establish/strengthen fistula rehabilitation centres	State Governments and LGAs	FMOH/SMOH/LGAs/ Partners	

Output	Activities	Target Audience	Responsible	Cost
	620: Provide support and services for social reintegration of women, irrespective of the treatment results	Rehabilitation Centers	FMOH/SMOH/LGAs/ Partners	
	630: Create referral systems between rehabilitation centres and institutions that provide micro-finance and livelihood skills development	Rehabilitation Centers	FMOH/SMOH/LGAs/ Partners	
	640: Adapt specific counselling package for rehabilitating women with special needs (young, old, HIV+, disabled, with irreparable fistula)	Social Workers	FMOH/SMOH/LGAs/ Partners	
	650: Train social workers and health providers in the integration of rehabilitation/reintegration services into national programmes,	Health and Social Workers	FMOH/SMOH/LGAs/ Partners	
	660: Provide loans or grants to help women start an economic activity	Women with Fistula	FMOH/SMOH/LGAs/ Partners/NGOs	
700: Increased Community Support Of Women With OF. Aligns with the Community Participation and Ownership priority area of the NSHDP				
Strategy 1: Social Capital	710: Promote partnerships at community level to ensure continuous availability of resources and technical assistance	CBOs, Community Leaders	SMOH/LGAs/ Partners/NGOs	
	720: Adapt community mobilization strategy based on evidence from research	CBOs, Family Heads, Traditional and Religious leaders	SMOH/LGAs/ Partners/NGOs	
	730: Provide direct counselling to family heads, husbands and key family members	CBOs, Family Heads	SMOH/LGAs/ Partners/NGOs	
	740: Build capacity of previous fistula patients to serve as peer educators	Women with Fistula	SMOH/LGAs/ Partners/NGOs	

Output	Activities	Target Audience	Responsible	Cost
	750: Empower former fistula patients to act as powerful advocates for change	Women with Fistula	SMOH/LGAs/ Partners/NGOs	
	760: Establish PHC Community Mobilization Team	CHEWs, VVF Focal persons, TBAs, Ward Leader, In charge at PHC	SMOH/LGAs/ Partners/NGOs	
	770: Create support networks/groups	Women with Fistula	SMOH/LGAs/ Partners/NGOs	
	780: Train Community Based Organizations (CBOs) on advocacy and lobbying skills at all levels	CBOs	SMOH/LGAs/ Partners/NGOs	
800: Documentation of Learning and Progress. Aligns with the Research priority area of the NSHDP				
	810: Document progress and feedback through OF News Bulletin	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	820: Sponsor participation of researchers to local and international conferences to share findings.	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	830: Define OF related research priorities and develop a research agenda.	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	840: Support 6 Research grants on OF annually	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	850: Convene research dissemination workshops.	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	860: Conduct clinical and operational research	TWG/RDMC/Consultants	FMOH/SMOH/LGAs/	

Output	Activities	Target Audience	Responsible	Cost
			Partners/NGOs	
	870: Engage in policy advocacy based on research.	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	880: Support publications of research findings.	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
900: Enhanced Coordination and Management of Obstetric Fistula Programmes. Aligns with Partnership for Health and the Health Management Information System priority areas of the NSHDP				
Strategy 1: Coordination	910: Establish intersectoral coordination/partnership forum for MNH/OF programmes	Programme Officers	FMOH/SMOH/LGAs/ Partners/NGOs	
	920: Define roles and responsibilities of each partner based on comparative advantage and deploy ????	Programme Officers	TWG	
	930: Set up Research and Data Management Subcommittee of the TWG (RDMC)	Programme officers	TWG	
	940: Maintain a functional webpage on Fistula Elimination on FMOH website	Programme Officers	TWG	
	950: Hold regular consultation meetings (coordination, knowledge sharing, etc.)	TWG FMOH/SMOH/LGAs/ Partners/NGOs	Programme Officers,	
Strategy 2: Planning	960: Develop AWP at Federal and State level	TWG FMOH/SMOH/LGAs/ Partners/NGOs	Programme Officers,	
Strategy 3: Monitoring and Evaluation	970: Implement a joint monitoring and evaluation plan	RDMC	FMOH/SMOH/LGAs/ Partners/NGOs	
	980: Carry out a baseline assessment	RDMC	FMOH/SMOH/LGAs/ Partners/NGOs	

Output	Activities	Target Audience	Responsible	Cost
	990: Produce biannual national reports on OF	RDMC	FMOH/SMOH/LGAs/ Partners/NGOs	
	9100: Hold annual national review and planning meeting	TWG/RDMC	FMOH/SMOH/LGAs/ Partners/NGOs	
	9110: Evaluate the programme at midterm and end of programme.	TWG/RDMC/Consultants	FMOH/SMOH/LGAs/ Partners/NGOs	
	9120: Conduct clinical and operational research	TWG/RDMC/Consultants	FMOH/SMOH/LGAs/ Partners/NGOs	
	9130: Produce periodic IMNCH/Fistula bulletins	TWG/RDMC/Consultants	FMOH/SMOH/LGAs/ Partners/NGOs	

5.0: Coordination and Feedback Mechanisms for Implementation of Framework

Coordination between relevant Ministries, Departments, Agencies, International Partners, Training and Obstetric Fistula Repair Centres and Non-Governmental Organizations (NGOs) involved in Obstetric fistula repair is a key strategy for resource mobilization and utilization, synergy creation, and efficient programme implementation and remains the key role played by the Federal Ministry of Health. The Paris Declaration for Aid Harmonization encourages International Development partners to align their funding priorities with national priorities to effect coherence and consolidation in a bid to attain results. Mechanisms for coordination and for forging strategic partnership will be developed between relevant development partners within and across sectors including communities and community-based organizations, Government, the organized private sectors, and Faith-Based Organizations, among others.

The National Taskforce will consist of a Technical Working Group constituted by Federal and State Ministries of Health, Education and Women Affairs resource persons and International development partners. The taskforce will be expected to sit and deliberate on all key technical issues, providing a strengthened capacity to effect acceptable programming. In addition, a Research and Data Management Committee will be set up to oversee all aspects of the research grant making component of the framework. It will consist of programme specialists in the area of research and monitoring and evaluation.

6.0: Monitoring and Evaluation Plan

The Monitoring and Evaluation plan of the NSFOF consists of the Performance Management Framework and the Monitoring and Evaluation (M and E) calendar. It underscores the importance of strategic information management to reflect the attainment of targets and expectations.

The current reawakening of focus on fistula as a preventable condition in the country should lead to increase in interventions aimed at tackling its underlying causes. Monitoring of programmes and interventions will then ensure that plans are complied with, ethical issues are respected and that all efforts are directed towards achieving the goal as stated in the strategic plan. It will also support cross-fertilization of ideas, thereby enhancing the quality of care and maximizing resources. Each level of care is responsible for generating the report of their activities as a form of feedback to the next level of authority. A synthesis of these reports may dictate periodic review of plans and actions. The plan will utilize existing national structures during the implementation of the M & E activities thereby, contributing to ongoing systems strengthening efforts in the country. Routine monitoring of program implementation and financial execution would be by the relevant department in the Federal and State Ministries of Health with support from development partners and other implementing agencies through integrated supportive supervision.

6.1 Data Collection

Collation of routine data would be at the service delivery points by trained service providers at the health facility level. LGA M & E persons would then collate data from all supported facilities and share with the state HMIS officers who would be mainly responsible for sending the data to the national level and sharing with the relevant government ministries and agencies at all levels through the use of the National Health Management Information Systems (NHMIS) software (DHIS). This data flow is in line with the NHMIS policy (2006). Data from surveys and assessments would also be collated using existing mechanisms within the country.

6.2 Data Quality Assurance (DQA)

Data collated from this process, being part of the national NHMIS process would be subject to routine DQA exercises on a 2-monthly basis by LGA M & E persons while the state HMIS officers

with other programme officers would conduct Quarterly DQA on facilities benefitting from programme funds. Data quality assurance would be assured in the process of data collation by checking submitted data using the completeness and timeliness checklist at both the LGA and State levels and running gap analysis on electronic data with feedbacks provided to the health facility level accordingly.

6.3 Information Products

The information collected from the project activities would be analysed and produced into statistical charts that would be shared at stakeholders' meetings including the statutory State Health Data Consultative Committee and the IMNCH technical committee at the state level. The products would also be shared publicly through periodic IMNCH/Fistula bulletins at the state and national levels.

6.4 Capacity Building for Monitoring and Evaluation

The project will rely mainly on existing human resource available in the country. Capacity building activities would include technical assistance and trainings by M & E specialists from the implementing agencies. Relevant M&E staff would be trained on DQA, data analysis and use. Routine capacity building activities would be included in the regular M & E meetings at the LGA level and the HDCC meetings at the state level.

6.5 Programme Evaluation

The projects executed in the programmatic areas of this strategic plan would be evaluated at intervals to check how the projects are contributing to the stated outputs through the select indicators. The evaluation would take place at mid-term and end of the project. Evaluation of fistula work across the country will assess the level of performance of all activities against desired objectives of the interventions and that of the strategic plan. Conventionally, evaluation is carried out at mid-term and end of the plan period, which in this case will be 2013 and 2015.

6.6 Monitoring and Evaluation Budget

An estimate of about 10% of the total budget allocated or mobilised for the implementation of the strategic plan would be allocated to monitoring and evaluation activities in line with international best practices.

6.7 Integrated Supportive Supervision

The strategic plan recognizes the need to ensure that the quality of service being delivered to beneficiaries of such services need to be in line with internationally acknowledged best practices and that health workers as well as other service providers at every stage of service delivery adhere strictly to national guidelines, protocols and Standard Operating Procedures designed and adapted to the Nigerian context. To ensure that clients get optimal levels of care and that health workers are supported to adequately provide quality health services, this plan would ensure that routine supportive supervision activities for this strategic plan are conducted at all levels. The supportive supervision would be integrated into existing National Integrated Supportive Supervision for health facilities using the National ISS tools developed for that purpose.

6.8 Research

Operations research is required for obtaining evidence-based data for improved performance of the health system and optimizing programme implementation approaches. It should therefore, always inform policy, programmes, project development and reviews. A Research and Data Management Committee will be set up with membership across partner agencies to provide the platform to coordinate research and data management activities.

RESULTS	PERFORMANCE INDICATORS	BASELINE DATA	TARGETS	SOURCE OF DATA	METHOD OF COLLECTION	FREQUENCY	RESPONSIBLE
IMPACT Reduction in obstetric fistula as a cause of maternal morbidity and mortality	MMR	545/100,000 Live births	15% decrease	NDHS	Survey	Every 3 – 5 years	National Population Commission,
OUTCOMES							
Incidence and prevalence of obstetric fistula determined in Nigeria.	Incidence of OF	12,000 - 20,000 new cases annually	Available	NDHS, Population Study	Survey	• Every 3 – 5 years • Every 2 years for Pop. study	FMOH, National Population Commissio
	Prevalence	150, 000	Available	Population study	Survey	Every 2 years	FMOH
New cases and backlog of OF reduced	Government at all levels with budget lines for OF elimination	Not known	30% annual increase	Baseline data and State Reports	Routine data collection	Annual	SMOH
	National and sub-national policies in place to increase the access of women to quality OF information and services	Not known	Available	Baseline data and State Reports	Routine data collection	Annual	SMOH
	Percentage of allocated OF Budget released for planned activities	Not known	60%	Baseline data and State Reports	Routine data collection	Annual	SMOH
	Percentage of government at all levels with health budget allocated to OF (recurrent and non-recurrent costs)	Not known	60%	• Baseline data and State Reports • National Health Accounts and Expenditure Reviews • Budget Office	Routine data collection	Annual	SMOH

				Report.			
	Contraceptive prevalence rate	9.7%	5% increase	NDHS	Survey	Every 3 – 5 years	National Population Commission
	National and sub-national laws and policies in place to address rights issues that predispose to OF	Not known	Available	• Federal and State Reports • Media reports	Routine data collection	Annual	FMOH, SMOH
	Civil society partnership actively promoting gender equality, women and girls empowerment, and reproductive rights nationwide	Not known	Available	• State Reports • NGO reports • Media reports	Routine data collection	Annual	SMOH
	Proportion of girls who complete secondary education or attend vocational schools			National surveys	Routine data collection	Annual	FMOE
	Proportion of births attended by skilled birth attendants	39%		NDHS	Survey	Every 3 – 5 years	National Population Commission
	Met need for EmONC	Not known	30%	NARHS	Survey		NBS
Women with the need access and utilize rehabilitation and reintegration services	Proportion of women treated for fistula using rehabilitation and reintegration services annually	Not known	Available	• State Reports • NGO Reports • Media Reports • National Surveys	Routine data collection	Annual	FMOH, SMOH
	Reduction of stigma associated with obstetric fistula at the community level	Not known	Available	• State Reports • NGO Reports • Media Reports • National Surveys	Routine data collection	Annual	FMOH, SMOH

	Proportion of women fully reintegrated* in the community annually	Not known	Available	• State Reports • NGO Reports • Media Reports • National Surveys	Routine data collection	Annual	FMOH, SMOH
OUTPUTS							
100: Strengthened political, socio-cultural and legal environment interventions related to reducing fistula formation	Existence of policies on reproductive health at all levels that integrate obstetric fistula prevention	Not known	Available	Federal and State Reports	Routine data collection	Annual	FMOH, SMOH
	Annual amount expended on obstetric fistula	Not known	Available	State Reports	Routine data collection	Annual	SMOH
	Existence of policies or programming frameworks related to girl child education, male involvement, early child bearing as related to OF etc	Not available	Available	Federal and State Reports	Routine data collection	Annual	FMOH, SMOH
200: Enhanced community participation in the prevention of fistula formation	Existence of community committees (in partnership with the health facilities) for maternal health, informed and aware of OF (mechanism of cost sharing, referral, etc.)	Not available/known	Available	• Federal and State Reports • NGO Reports	Routine data collection	Annual	FMOH, SMOH
	KAP studies on community knowledge, attitude and practices	Not available	Available	• Federal and State Reports • NGO Reports	Routine data collection	Annual	FMOH, SMOH
	Community screening of OF	Not known	Available	• Federal and State Reports • NGO Reports • Media	Routine data collection	Annual	FMOH, SMOH, LGAs

				Reports			
	Number and type of media organizations, Faith based Organizations (FBOs), Community Based Organizations (CBOs) etc involved in community mobilization	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
	Number of community members involved in advocacy, social mobilization and programme communication efforts	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
	Type of community involvement in preventive interventions e.g girl child education, early child bearing, nutritional/financial support initiatives	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports • Reports of Committees	Routine data collection	Annual	FMOH, SMOH, LGAs
300: Improved availability of OF prevention interventions and EmONC	Number of EmONC (BEmONC) and CEmONC) facilities available for a population of 500,000	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of EmONC facilities strengthened according to the standard guidelines for OF management	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Constellation of services available for early prevention of fistula	Not known	Available	• Federal and State Reports • Facility	Routine data collection	Annual	FMOH, SMOH

				Reviews			
	Women with at least 4 antenatal care (ANC) visit	45%	50%	NDHS	Survey	Every 3 – 5 years	National Population Commission
	Unmet need for Family Planning	20%	30%	NDHS	Survey	Every 3 – 5 years	National Population Commission
	Proportion of facilities with skilled personnel to provide 2^{o} and 3^{o} level OF prevention services	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Use of early catheterization for prevention	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Geographic coverage of EmONC facilities	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
400: Strengthened national capacity for treatment and care of obstetric fistula	Number /location of facilities providing simple fistula treatment services	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number/location of centres providing specialist fistula services	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number /location of doctors and nurses able to undertake simple repairs (M:F)	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH

	Number/location of surgeons able to undertake complex repairs (M:F)	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of patients waiting for surgery for more than 2 months*	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Fistula repair team in place (M:F)	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Equipment and supplies for fistula repair in place	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Availability of guidelines and standards on fistula management and training in place	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of women with obstetric fistula who have a successful first repair by each facility [1].	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of women who have had two or more unsuccessful repairs	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH

	Number/location of training facilities (pre-service and in-service) including OF prevention and treatment as part of the core syllabus	Not known	Available	• Federal and State Reports • Facility Reviews • Training Reports	Routine data collection	Annual	FMOH, SMOH
	Number of surgeons undertaking simple fistula repair training per year	Not known	Available	• Federal and State Reports • Facility Reviews • Training Reports	Routine data collection	Annual	FMOH, SMOH
	Number of in-country surgeons undertaking specialist fistula training (either in country or elsewhere) per year	Not known	Available	• Federal and State Reports • Facility Reviews • Training Reports	Routine data collection	Annual	FMOH, SMOH
500: Increased access to rehabilitation and reintegration services for women treated for obstetric fistula	Number of fistula treatment services which include social reintegration activities	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of women treated for fistula who have access to rehabilitation and reintegration services	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number of partnerships established with Income Generating Activities or Micro credit institutions	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number of CBOs providing gender sensitive livelihood programmes for women who have lived with fistula	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH

600: Quality rehabilitation and reintegration services provided	Number of functional rehabilitation & reintegration centres	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number of women fully reintegrated[1] into their communities	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Number of centres offering life skills education to women who have experienced fistula	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of women who experienced OF who actually started small businesses	Not known	Available	• Federal and State Reports • Facility Reviews	Routine data collection	Annual	FMOH, SMOH
	Proportion of women who have experienced OF in the community who received life skills trainings	Not known	Available	• Federal and State Reports • Facility Reviews • Training reports	Routine data collection	Annual	FMOH, SMOH, LGAs
700: Increased community support of women with obstetric fistula	Proportion of community leaders who support community initiatives for social reintegration of women who have experienced OF	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs

	Proportion of community leaders who support reintegration programmes in the community	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
	Proportion of former fistula clients who serve as peer educators or advocates in their communities	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
	Resources mobilized at the community level	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
	Number of Media, FBOs, CSOs, CBOs, etc topicalizing OF	Not known	Available	• Federal and State Reports • NGO Reports • Media Reports	Routine data collection	Annual	FMOH, SMOH, LGAs
800: Documentation of learning and progress.	Number of reviews, knowledge sharing (including dissemination) meetings held	Not available	Mid-year, End of year	Federal and State Reports	Routine data collection	Annual	FMOH, SMOH, LGAs, partn
	Quarterly release of OF News Bulletin	Not available	Quarterly release	Federal	Routine	Quarterly	FMOH, partners
	Biannual Conferences on OF Elimination carried out	Not available	Conducted	Conference Report	Routine	Every two years	FMOH, partners
	Number/type of clinical and operational research	Not available	6 per year	Reports	Routine	Annually	FMOH, partners, TWG

	Number of research grants on OF funded annually	Not available	6 per year	Reports	Routine	Annually	FMOH, partners, TWG
	National reports on progress of OF Elimination	Not available	Available	Report	Routine	Annually	FMOH, SMOH
	Number/type of publications on OF written in national and international journals	Not available	5 publications annually	Journals	Review	Quarterly	FMOH
900: Enhanced coordination and management of obstetric fistula programmes	Coordination/partnership forum for MNH/OF programmes established and functional	Not available	Strengthened, quarterly meetings	Federal reports	Routine	Annually	FMOH, SMOH, partners, TW
	Number of annual work plans developed for implementation of the NSF	Not available	30% annual increase	Reports	Routine	Annually	FMOH, SMOH, partners, TW
	Number of annual planning and monitoring meetings.	Not available	-	Reports	Routine	Annually	FMOH, SMOH, partners, TW
	Joint monitoring and evaluation plan costed and in existence	Available	30% annual increase	Reports	Routine	Annually	FMOH, SMOH, partners, TW
	Number of monitoring activities conducted (see monitoring calendar)	Not available	See Calendar	Reports	Routine	Annually	FMOH, SMOH, partners, TW
	Number of national review and planning meetings held	Not available	Quarterly	Reports	Routine		FMOH, SMOH, partners, TW
	Number of AWPs developed at all levels	Not available	Federal and State develop AWPs	Reports	Routine	Annually	FMOH, SMOH, partners, TW
	Timeliness of programme evaluation	Not available	See calendar	Reports	Routine	Annually	FMOH, SMOH, partners, TW

6.9 PERFORMANCE MONITORING FRAMEWORK

6.10 Monitoring Calendar

		YEAR 1 2011	YEAR 2 2012	YEAR 3 2013	YEAR 4 2014	YEAR 5 2014
Monitoring and Evaluation Activities	**Surveys/studies**	Conduct baseline survey and relevant research/studies for identified NSF baselines. Conduct study on incidence and prevalence of obstetric fistula	Operational Research Award Research Grants	Operational Research Award Research Grants Conduct study on incidence and prevalence of obstetric fistula	Operational Research Award Research Grants	Operational Research Conduct study on incidence and prevalence of obstetric fistula
	Monitoring systems	Establish committee to monitor indicators Conduct joint field visits with partners Harmonize data collection with National Health Management Information System	Conduct joint field visits with partners Report progress of programme implementation and expenditures in AWPs Operational research	Conduct joint field visits with partners Report progress of programme implementation and expenditures in AWPs Operational research	Conduct joint field visits with partners Report progress of programme implementation and expenditures in AWPs Operational research	Conduct joint field visits with partners Report progress of programme implementation and expenditures in AWPs Operational research

		YEAR 1 2011	YEAR 2 2012	YEAR 3 2013	YEAR 4 2014	YEAR 5 2014
	Evaluations			Conduct Mid Term Review /Evaluation of Framework		Conduct Final Review/Evaluation
	Reviews	Joint Programme Reviews	Joint Programme Annual Reviews	Joint Programme Annual Reviews	Joint Programme Annual Reviews	Joint Programme Annual Reviews
Planning references	**Strategic Plan evaluation milestones**	Conduct Annual Reviews and Annual Work Plan Development exercises	Conduct Annual Reviews and Annual Work Plan Development exercises Biannual Conference	Conduct Annual Reviews and Annual Work Plan Development exercises Conduct Mid-term reviews	Conduct Strategy final evaluation Biannual Conference	Conduct Strategy final evaluation
	M & E capacity development	Develop OF database at the National Population Commission	Develop database of technical personnel from MDAs as technical experts on OF	Upgrade Databases	Upgrade Databases	Upgrade Databases
	Use of information	Annual review of Strategy used for the Policy brief to Government Annual review of strategic programming of AWPs	Annual review of strategic programming of AWPs	Annual review of strategic programming of AWPs	Annual review of strategic programming of next cycle	

		YEAR 1 2011	YEAR 2 2012	YEAR 3 2013	YEAR 4 2014	YEAR 5 2014
C O S T		₦	₦	₦	₦	₦