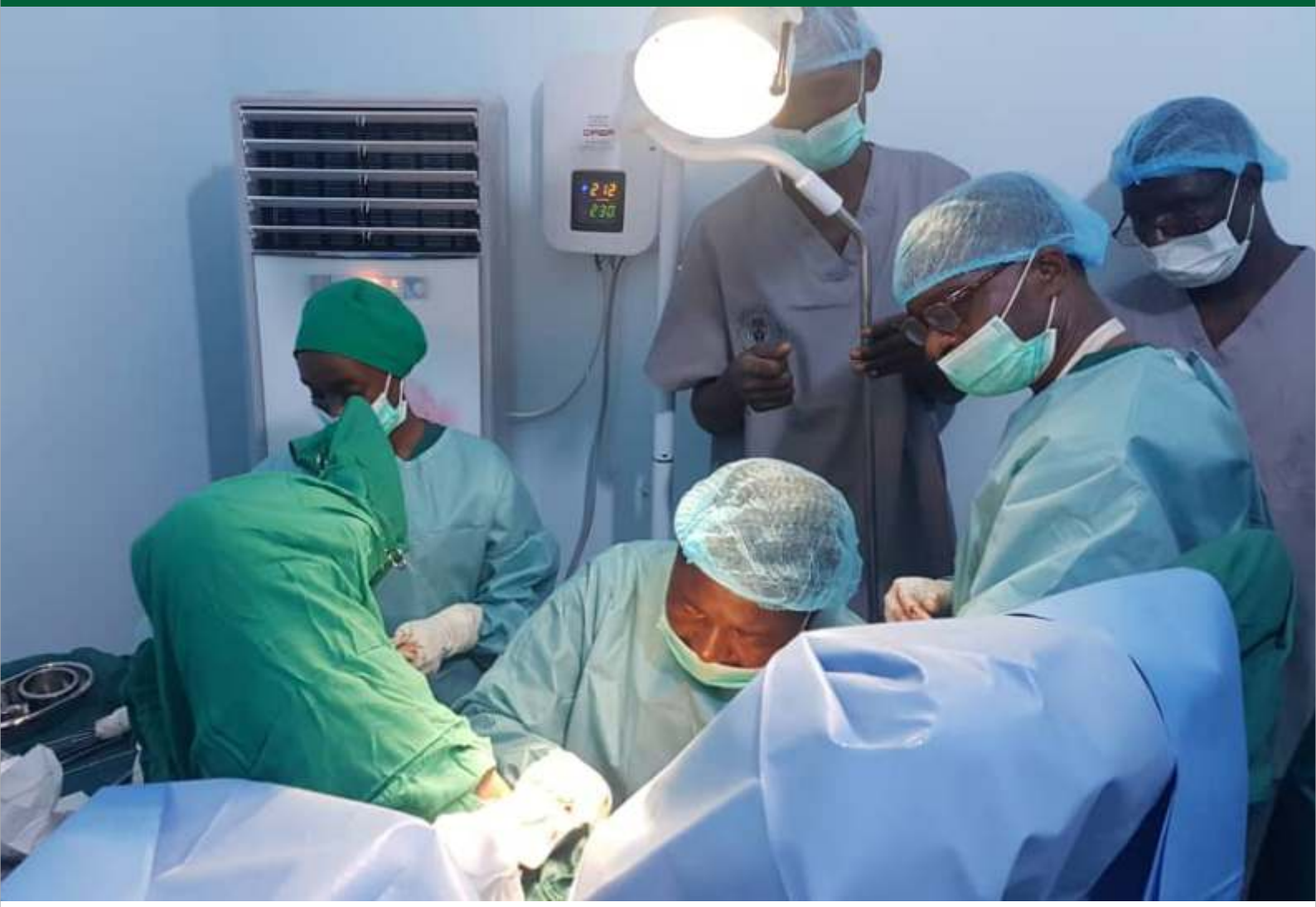
Federal Ministry of Health



NATIONAL STRATEGIC FRAMEWORK FOR THE ELIMINATION OF OBSTETRIC FISTULA IN NIGERIA

2019 - 2023

UNFPA

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Foreword

The occurrence of Obstetric Fistula (OF) is directly linked to obstructed labour, which is a major cause of maternal morbidity and mortality in Nigeria. It affects the poorest of the poor and has severe physical and psychosocial consequences that significantly impact the quality of life of women of childbearing age. OF is therefore, a major public health problem with an estimated global burden of 2, 000,000 cases (Geneva: World Health Organization; 2014) of which Nigeria contributes about 150,000 cases. Furthermore, about 12,000 new cases of obstetric fistula occur every year in Nigeria (EngenderHealth: 2010).

Obstetric fistula is preventable if all women that develop prolonged obstructed labour have timely access to surgical intervention to relieve the obstruction and deliver the baby. Functional health systems providing universal quality obstetric interventions has virtually eradicated obstetric fistula in the developed world and the preventive, curative as well as rehabilitative interventions can also be replicated in Nigeria.

To this end, the Government of Nigeria is committed to eliminating obstetric fistula and had developed and implemented two five-year strategic plans (2005-2010; and 2011-2015) towards achieving this goal. Examples of notable progress made include the development of policies in support of safe motherhood, establishment of fistula specific budget subheads, training of health care workers, establishment of fistula treatment centres and about 3,000 surgical treatment performed annually. At the current pace however, it is obvious that the country would not achieve its goal of eliminating obstetric fistula within a generation.

The revised and costed National Strategic Plan (2019-2023) provides a road map for intensification of efforts towards realising a fistula-free Nigeria. This revised fistula strategic plan aligns with the National Strategic Health Development Plan II (2017-2021) that strives to ensure Universal Health Coverage for All Nigerians. I am convinced that full implementation of the strategies outlined in this document will lead Nigeria to "a fistula- free generation".

I therefore call on all stakeholders to support the dissemination and use of this strategic document at all levels for harmonization and alignment of efforts to ensure optimal results and achievement of our ultimate goal of eliminating obstetric fistula in Nigeria.

Professor Isaac F. Adewole, FAS, FSPAP, FRCOG, DSc (Hons)
Honourable Minister of Health

Acknowledgements

The development of this third edition of the National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria (2019-2023) went through a due process including series of stakeholders' meetings to build consensus and ensure that it is in line with global standards and practice. The rigorous effort was premised on the firm believe that this document will serve as a guide to ensuring universal coverage of preventive, curative and rehabilitative obstetric fistula interventions.

I therefore wish to sincerely acknowledge and appreciate the contributions of our Development Partners: UNFPA, USAID-supported Fistula Care *Plus* Project and Medicins Sans Frontieres (MSF) towards the actualisation of this respires material. UNFPA is specifically commended for the time, interest, technical and financial support for the entire work of the costed National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria; we are grateful.

The painstaking input of the Consultants: Dr Clara Ladi Ejembi of the Department of Community Medicine, Ahmadu Bello University (ABU), Zaria, Dr Sunday Lengmang of the Evangel VVF Centre, Bingham University Teaching Hospital, Jos, Plateau State, the Costing Consultant Ezeh Uche of Oxford MN Consulting Limited, the National Obstetric Fistula Technical Working Group as well as the National Reproductive Health Working Group and key National stakeholders on obstetric fistula who actively participated in developing, revising and refining this document is deeply appreciated.

The Federal Ministry of Health particularly appreciates the immense contributions of Prof Oladosu Ojengbede of Centre for Population & Reproductive Health, University College, Ibadan, Prof Sunday Adeoye, Medical Director, National Obstetric Fistula Centre, Abakaliki, Prof. M.Aderemi Ijaiya of University of Ilorin and Dr Musa Elisha, National Programme Officer, Reproductive Health/Obstetric Fistula, UNFPA, especially for their critical review and technical input into the document.

I must thank other notable stakeholders especially our religious leaders, representatives of the Nursing and Midwifery Council of Nigeria (NMCN), Community Health Practitioners' Registration Board of Nigeria (CHPRB), the Nursing Division, Federal Ministry of Health, Federal Ministry of Women Affairs & Social Development, Federation of Muslim Women Association of Nigeria, Christian Association of Nigeria (CAN) and Islamic Development Bank for their robust participation in reviewing this document. Every individual who contributed at any level in developing this document is also well appreciated. Without you, this work would not have been completed.

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Dr Adebimpe Adebiyi, mni
Director/Head, Family Health Department

Acronyms

ANC	Antenatal care
BCC	Behaviour Change Communication
CAN	Christian Association of Nigeria
CBO	Community-Based Organization
CHEW	Community Health Extension Worker
CHPRBN	Community Health Practitioners Registration Board of Nigeria
DfID	Department of International Development
DHS	Demographic and Health Survey
DQA	Data Quality assurance
EmOC	Emergency Obstetrics Care
FBO	Faith-based Organization
FC+	Fistula Care Plus
FMoE	Federal Ministry of Education
FMoH	Federal Ministry of Health
FMoY&C	Federal Ministry of Youths and Sports
FMWASD	Federal Ministry of Women Affairs and Social Development
FOMWAN	Federation of Muslim Women Associations of Nigeria
FP	Family Planning
GWIN	Growing Girls and Women in Nigeria
HMIS	Health Management Information System
IAG	Inter- Agency Group
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IMNCH	Integrated maternal, newborn and child health
IT	Information Technology
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMR	Maternal mortality ratio
MOV	Means of Verification
MSF	Medicins Sans Frontieres
MSS	Midwife Service Scheme
NGO	Non-governmental Organization
NHMIS	National Health Management Information System
NISS	National Integrated Supportive Supervision
NMCN	Nursing and Midwifery Council of Nigeria
NOFIC	National Obstetric Fistula Centre
NPHCDA	National Primary Health Care Development Agency
OF	Obstetric Fistula
PHC	Primary Health Care
RH	Reproductive Health
RVF	Recto-vaginal fistula

SDG	Sustainable Development Goals
SMI	Safe Motherhood Initiative
Smo	EState Ministry of Education
SMoH	State Ministry of Health
SMoH	State Ministry of Health
SOML P4R	Saving One Million Lives Programme for Result's
SOP	Standard Operating Procedures
SURE-P	Subsidy Reinvestment and Empowerment Programme
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAPP	Violence Against Persons Prohibition
VVF	Vesico-Vaginal Fistula
WHO	World Health Organization

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Executive Summary

With an annual incidence of 12, 000 cases and a backlog of 150000 cases, obstetric Fistula (OF) is a major public health problem in Nigeria. The disease is one of the worst childbirth injuries. Prolonged obstructed labour is the leading cause of OF, accounting for up to 95% of the cases seen in Nigeria. However, the reported rising prevalence of iatrogenic fistula is becoming a source of concern in the country. OF is a challenge in all parts of the country, but it is more prevalent in the northern part of the country because of a higher prevalence of the underlying determinants of the disease in the North. These determinants are the same as the factors causing maternal mortality.

Informed by the global call by UNFPA in 2003 to eliminate OF and committed to eradicating the menace of OF, Nigeria, since 2005 has articulated and implemented two National Strategic Plans aimed at addressing the problem. Reviews of implementation of past strategies have shown some progress in the quest to address the scourge of Obstetric Fistula in the country: budget lines have been created at National-level and in some states, some Development Partners have begun to collaborate with the Federal Government to support the OF eradication effort,. Centres for the treatment of Obstetric Fistula have been expanded; health care workers have been trained in OF repair surgery and post-operative care and the number of women being treated for OF has increased. Some prevention and rehabilitation strategies have also been implemented. However, the gains have not been ultimate as desired because of constraints of funding, poor investment in OF preventive activities, lack of synergy and integration of OF with maternal and family planning programmes, poor multi-sectoral collaboration and limited community participation. Other limitations include poor buy-in by states, heavy donor dependence, dearth of skilled health personnel, inequitable distribution of capacities and inability to unlock the potential resources for OF response that abound in tertiary hospitals across the country.

The current gains lag behind the desire for the elimination of obstetric fistula and with the current rate of surgical repair, it will take almost nine decades to clear existing backlog. Without the requisite investments and commitment to OF prevention, we will continue to have incident cases. Consequently, it is imperative that the strategy for the elimination of obstetric fistula in Nigeria be reviewed with a view to ending fistula within a generation.

The Obstetric Fistula strategic plan for the period 2019 to 2023, with a vision of an obstetric fistula free Nigeria has the objectives of contributing to 30% reduction in the incidence of OF, 30% reduction in the prevalence of OF and rehabilitation and re-integration of 30% of needy treated fistula patients within the planned period.

Proposed strategic interventions aimed at achieving the stated objectives of this plan include promoting inter-sectoral collaboration, behaviour change communication and scaling up access to comprehensive maternal health services for the primary prevention of OF. Furthermore, creating more Federal Government owned treatment Centres with at least one Centre per geo-political zone and establishing OF treatment facility in each state would expand availability of treatment services.

To ensure functionality of such centres, there will be greater investment in human capacity development for provision of OF-services, unlocking OF treatment potentials in tertiary health facilities and improvement in OF commodities supply chain management. A referral system will be established for the management of complex OF cases in identified OF facilities. Strategies to promote rehabilitation and reintegration of treated OF patients into their communities will be strengthened. Additionally, the governance architecture of the OF programme will be strengthened to ensure improved capacity and coordination. This plan proposes greater investment in OF research and enhanced monitoring and evaluation.

This revised document has seven (7) well-costed priority thematic areas, with defined interventions and activities. These areas include:

a. Priority Area 1: Prevention;
b. Priority Area 2: Treatment;
c. Priority Area 3: Rehabilitation & Reintegration;
d. Priority Area 4: Strategic Communication;
e. Priority Area 5: Research;
f. Priority Area 6: Leadership and Governance; and
g. Priority Area 7: Monitoring and Evaluation.

The total cost of the strategic plan for the five-year period is estimated to be NGN **18,381,637,000.00. The breakdown by priority area is shown below**

Summary of Cost Estimate of OF Elimination Strategic Plan by Priority Area

Priority Area	Description	Amount
Priority Area1:	Prevention of Obstetric Fistula	9,453,583,000:00
Priority Area 2:	Treatment	3,982,755,000.00
Priority Area 3:	Rehabilitation	2,974,063,000.00
Priority Area 4:	Communication	470,860,000:00
Priority Area 5:	Research	1,114,316,000.00
Priority Area 6:	Leadership and governance	128,944,000.00
Priority Area 7:	Monitoring and Evaluation	257,116,000.00
GRAND TOTAL		18,381,637,000.00

1 INTRODUCTION

1.1 BACKGROUND

Obstetric Fistula (OF), which is directly linked to maternal mortality, is an abnormal connection between the vagina, rectum and/or bladder that may develop after prolonged obstructed labour and is marked by incontinence of urine, faeces or both. The main types are vesico-vaginal fistula (connection between the bladder and the vagina) and recto-vaginal fistula (connection between the rectum and the vagina). Women with obstetric fistula undergo extreme physical, emotional, and psychological suffering, which persists until it is surgically corrected. It is the worst maternal morbidity affecting women and girls in developing countries, making it an important international public health concern.

The most common cause of OF is prolonged obstructed labour. When labour persists for days, it becomes obstructed and the presenting part of the foetus exerts sustained pressure on surrounding maternal pelvic soft tissue structures like the bladder, vaginal wall, rectum, blood vessels and nerves against the pubic /sacral bone anteriorly and posteriorly. Without access to timely, high quality medical intervention, various degrees of injury of the affected structures ensue leaving the woman continuously dribbling urine and or faeces. The constant wetness irritates the vulva leading to painful excoriations and dermatitis. Women with fistula often respond to these symptoms by drinking less fluid with the hope of reducing the amount of urine. Ironically, this results in the formation of concentrated urine, which is more irritating and offensive and could lead to further complications like bladder stone. Women with this condition isolate themselves, so as to avoid being shunned and socially stigmatized. If untreated they become social outcasts as they are rejected by their husbands and families. Other complications of prolonged obstructed labour include foetal loss, foot drop, infertility, depression or maternal death.

Women suffer the scourge of obstetric fistula for life unless it is treated. Some vesico-vaginal fistula of less than four weeks duration can be successfully treated by insertion of a urinary catheter for up to four weeks (EngenderHealth 2010). Although the majority of OF can be surgically closed, and continence regained, about 10% of vesico-vaginal fistula (VVF) remain incontinent in spite of the closure of the fistula because of involvement of the urinary sphincter (post-closure incontinence) (Hancock and Browning 2009). Furthermore, in very rare situations obstetric fistula persists in spite of skilled surgical interventions (Hancock and Browning 2009). Some of these might benefit from surgical urinary or faecal diversion to alleviate their suffering or live with the condition for life.

OF has virtually been eliminated in developed countries. The persistence of fistula in some countries and regions is an indicator of the failure of the healthcare services to provide accessible, timely and appropriate Intrapartum care (Tunçalp 2015)

1.1.1 Country Context

Nigeria is the most populous country in Africa with an estimated projected population of 189, 312, 912 million people. Annual population growth is 3.2 percent, and the total fertility rate is 5.5, with variations across states and regions (NDHS, 2013). Most projections place Nigeria as the third most populous country behind India and China by 2050. The country runs a federal system of government with 36 states and the Federal Capital Territory and 774 Local Government Areas. There is a total of 9572 political wards nationwide; which are increasingly becoming the focus of primary

health care development in the country.

Primary health care (PHC) is the fulcrum of Nigeria's National Health Policy (2016). The 2016 National Health Policy's (NHP) mission statement is "to provide stakeholders in the health sector with a comprehensive framework for harnessing all resources for health development towards the achievement of Universal Health Coverage, as encapsulated in the National Health Act, and in tandem with the Social Development Goal 3". The goal of NHP is "To strengthen Nigeria's health system, particularly the PHC sub-system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians" The policy provides for a health care system organized into primary, secondary and tertiary levels of care, with the public and private sectors providing the care. The public health care system is divided into three tiers, each associated with one of the administrative levels of government. The federal government has the responsibility for tertiary healthcare, policy formulation and technical support to the states; the states provide secondary level health care, coordinate primary health care and provide technical support to the LGAs which have responsibility for PHC services provision. Whereas the LGAs are designated providers of PHC, they are the weakest link in the health care system as they have the lowest capacity and commitment to health development in the country (National Strategic Health Plan 2010) The Ward Minimum Health Package for Nigeria (NPHCDA, 2006) proposed strengthening a primary care facility at the level of each ward to provide basic emergency obstetric care services, while it is proposed that there should be at least a general hospital in an LGA, which should be able to provide comprehensive emergency obstetrics care (Federal Government of Nigeria 2010) but implementation has been slow. In an effort to strengthen PHC services with a view towards attaining Universal Health Coverage (UHC), the current administration, at the federal level is investing in supporting the upgrading of 10, 000 primary health care centres, one PHC per political ward for qualitative PHC service provision, with a focus on maternal, newborn and child health. Geographic and economic access to health services remain major challenges, so also the quality of care (Federal Ministry of Health 2017).

Maternal health indices in the country are poor. Maternal mortality accounts for 32% of mortality of women in the reproductive age group (15-49 years). The maternal mortality ratio in Nigeria is 576/100,000 live births (National Population Commission and ICF Macro 2014). Obstructed labour accounts for 10% of maternal deaths; it is estimated that 6% of obstructed labour results in obstetric fistulae (Dolea and AbouZahr 2003).

Poor reproductive health behaviour is a major contributor to the poor maternal health outcomes. The national median age at marriage is 18 years and the national rate of teenage pregnancy is 23%; however, these values mask wide zonal variations with the North West and North East zones having median ages of marriage of 15.4 years and 16.2 years respectively with a teenage pregnancy rate of 36% and 32% respectively (National Population Commission and ICF Macro 2014). Use of modern contraceptives is low (10%) and access to emergency obstetric care services is very limited with only 38% of deliveries supervised by a skilled birth attendant (National Population Commission and ICF Macro 2014).

1.2 GLOBAL INITIATIVES AND POLICY CONTEXT

1.2.1 Millennium Development Goals & Sustainable Development Goals

The Millennium Development Goal 5 had as one of its targets reducing maternal mortality ratio by 75% between 1990 and 2015, through universal access to sexual and reproductive health services and maternal health care services. The United Nations report on the International Conference on Population and Development (ICPD) Beyond 2014 Global Report highlighted that OF represented the face of the global community's failure to protect the sexual and reproductive health and rights of women and girls and achieve equitable access to comprehensive sexual and reproductive health services. The report noted that obstetric fistula continued to affect the poorest of the poor: women and girls living in some of the most under-resourced regions of the world. Hence the **Sustainable Development Goal (SDG)** 3 has a more ambitious target of reducing maternal mortality to at most 70/100,000 live births by 2030. Since OF is caused by the same determinants as maternal mortality, strategies employed to reduce maternal mortality will contribute to the prevention of obstetric fistula. Prevention of OF and rehabilitation of survivors will also benefit from efforts on SDG 1, 4, 5, 10 and 17. In 2016, UN Secretary-General Ban Ki-moon called upon the world to end fistula within a generation. The UN general assembly in 2018 revised the global vision on fistula to ENDING FISTULA WITHIN A DECADE!

1.2.2 Global Campaign to End Fistula

Recognizing that OF, hitherto a neglected condition that affects a large number of marginalized women is preventable and treatable; noting that addressing it provides an entry point to respond to the many developmental issues that disempowered women and limit their access to reproductive health service, in 2003, UNFPA and its partners started a global **Campaign to End Fistula .**

The goal of the campaign is to make fistula as rare in developing countries as in developed countries. Over 50 countries, including Nigeria, have benefited from this initiative through support for the surgical treatment and reintegration of fistula patients, training of doctors, nurses, midwives and community health workers with support from the Maternal Health Thematic Fund. In 2013, the United Nations commemorated the first International Day to End Obstetric Fistula, on 23 May, to raise awareness of this issue and mobilize support around the globe. Annually, various partners around the world committed to ending fistula observe the International Day to End Obstetric Fistula.

1.2.3 National Policies and Initiatives

The 2016 revised National Health Policy seeks to achieve health for all Nigerians, with a focus on strengthening primary health care and ensuring financial risk protection for the attainment of Universal Health Coverage. Maternal, Newborn, Child and Adolescent Health have been prioritized in the policy, so also in the National Strategic Health Development Plan (2017 - 2021), which is currently under review.

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

- The Sustainable Development Goals
- Economic Recovery and Growth Programme
- The National Health Policy
- The National Reproductive Health Policy
- The National Policy for Health and

Development of Young People and Adolescents in Nigeria

- Nigeria Family Planning Blueprint (Scale-up Plan)
- Reproductive, Maternal, Child and Adolescent Health plus Nutrition Strategy

Reducing the incidence of obstetric fistula will be indicative of the performance of reproductive health services in the country while clearing the backlog will be a good assessment of the performance of hospital surgical services. Re-integration services will reflect the performance of referral system, comprehensive interventions and community-based structures.

2 THE SITUATIONAL ANALYSIS

2.1 OBSTETRIC FISTULA IN NIGERIA

Globally, it is estimated that 2,000,000 women live with obstetric fistula with the majority of the cases from Africa and South East Asia (Geneva: World Health Organization; 2014). The prevalence of obstetric fistula in Nigeria is 150, 000 cases, a disproportionate 7.5% of this global burden (EngenderHealth 2010). According to the 2008 Nigeria Demographic and Health Survey (NDHS), the prevalence history of leaking urine among women aged 15 – 49 years, which was approximated to represent the prevalence of fistula, is 0.4% (National Population Commission (NPC) and Macro. 2009). Using the 2008 NDHS data, Maheu-Giroux computed the prevalence rate of obstetric fistula in Nigeria to be 3.2 per 1000 (CI 2.1 – 4.3) (Maheu-Giroux et al. May 2015). The estimated number of annual incidence of obstetrics fistula is 13,000 (EngenderHealth 2010).

Obstetric fistula may result anywhere women with prolonged obstructed labour lack access to emergency obstetric services. Since access to emergency obstetric care services is limited across Nigeria, obstetric fistula is found in all parts of the country. However, the prevalence is higher in the northern zones than the southern zones, a reflection of differentials in the distribution of health services and socio-cultural risk factors associated with the disorder.

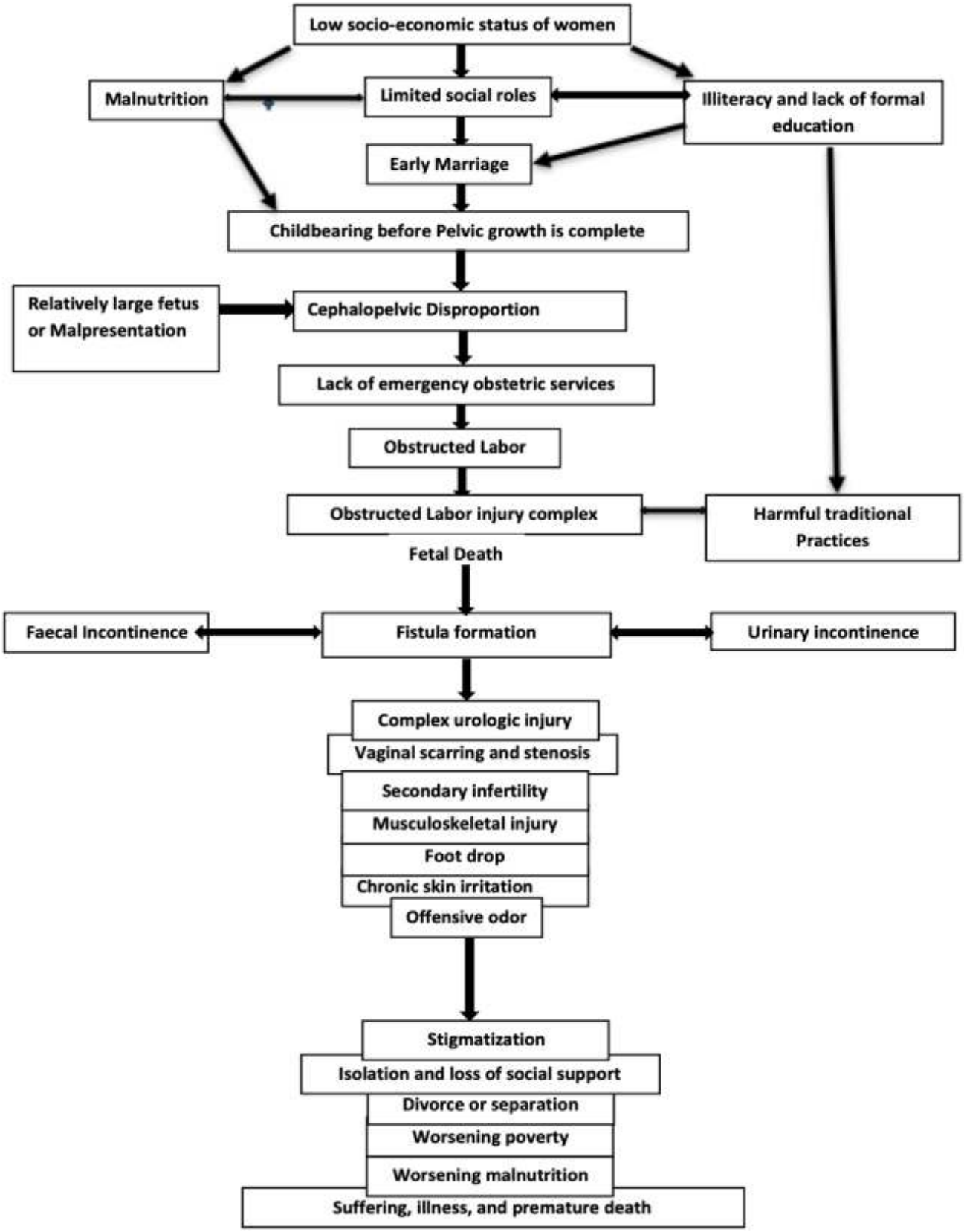
The most common cause of obstetric fistula in Nigeria is prolonged obstructed labour; this accounts for 65.9% - 96.5% of cases seen in various treatment centres in Nigeria (Ijaiya et al. 2010). The association between adolescent childbearing and obstructed labour has been well established in Nigeria. While the typical profile of an Obstetric Fistula patient is a young, poor, illiterate rural girl who had been given out in marriage at a very early age, became pregnant soon after, had no benefit of antenatal care, laboured at home for days and ended up with a stillbirth and obstetric fistula, this profile is changing. Even in the core northern areas of the country where it was the predominant mode of presentation, the pattern is also changing. Fistula surgeons report that the women who present with fresh fistula now cut across all age groups. This is because, in recent times, there has been an emergence of a new scenario of the Obstetric Fistula profile with older multi-parlous women in their twenties and thirties, who have previously successfully delivered vaginally, developing Obstetric Fistula (Ijaiya et al. 2010, Ezegwi and Nwogu- IKojo 2015). These are largely attributed to declining access to skilled obstetric care and increasing recourse to alternative healthcare systems, including the use of faith-based organizations' maternity facilities, for assistance during delivery. Fistula surgeons have reported a rising trend of iatrogenic fistula across the country. The majority are said to occur from caesarean sections performed by poorly skilled doctors and sometimes by quacks for relieve of obstructed labour and also from poorly performed hysterectomies.

Every childbirth should be supervised by skilled birth attendant (SBA), so that complications can be detected early and appropriate intervention or referrals instituted. Unfortunately, only 38% of deliveries in Nigeria are supervised by SBAs, with coverage levels ranging from as low as 5.4% in Sokoto State to 96.2% in Imo State (National Population Commission (NPC) and ICF Macro 2014). The immediate cause of the fistula is lack of access (geographic and economic) to quality caesarean section services to relieve obstruction during labour. Access to emergency obstetric care in Nigeria is limited. A study conducted in three northern states (Zamfara, Katsina and Yobe States), as part of a study in six developing countries, found only 2% and 0% of

facilities in the sampled states offering emergency obstetric care. None of the States met the criteria of the provision of basic and comprehensive emergency obstetric care signal functions respectively (Ameh et al 2012). While almost all states have proclaimed provision of free maternal and child health services so as to remove economic barriers to access, the scope and coverage vary; and oftentimes the pronouncements are not matched with resource provision to ensure implementation, thus limiting impact. Where free services are not provided, the cost of care becomes a major limitation; for example, in Kwara State, the N50, 000 being charged in government health facilities for caesarean sections was identified as one of the major factors increasing the risk of iatrogenic fistula. Aside access factors, ignorance, socio-cultural practices that impede timely decision-making in event of prolonged obstructed labour, transportation and communication difficulties and costs may further limit timely arrival at a health facility. In addition, cost of treatment, the dearth of skilled health personnel, drugs, equipment and commodities all contribute to poor and delayed care at the health facilities. All of these factors work in tandem to adversely affect maternal outcomes, including fistula.

Figure 1 shows the obstetric fistula pathway (Walls et al 2005). Most of these factors are preventable. Early marriage and early onset of childbearing increase vulnerability to OF. The 2013 NDHS showed that 23% of females aged 15 - 19 years had commenced childbearing or were pregnant at the time of the survey. Higher proportions were found in the North West and North-East Zones with the highest proportions of 52% and 53% recorded in Jigawa and Katsina States respectively. A review of fistula cases in Nigeria by Ijaiya et al (2010) found that most of the VVF patients in northern Nigeria had married early; 93.6% of Sokoto patients had married before the age of 18 years, while 81.5% and 52.3% of the patients in Kano and Maiduguri respectively were married by the age of 15 years. Poverty, lack of female education and gender norms that promote patriarchy, economic dependence and marginalization of women in decision-making, and, socio-cultural practices that encourage early marriage leading to early childbearing before the pelvis is fully developed, all work in synergy to increase odds of development of VVF.

Figure 1: Pathways to Obstetric Fistula



Reducing the risk of becoming pregnant through use of effective contraception contributes to reducing the risk of developing obstetric fistula. Unfortunately, the modern contraceptive prevalence rate in Nigeria is 9.8%, one of the lowest rates in Africa. Among adolescents, the group most vulnerable to obstetric fistula, the rate is 4.8 % (National Population Commission (NPC) and ICF Macro 2014).

2.2 PREVENTION OF OBSTETRIC FISTULA

Prevention of OF includes primary preventive interventions aimed at reducing the incidence of the condition, secondary prevention aimed at early diagnosis and effective treatment, while tertiary prevention focuses on the limitation of disability and rehabilitation. A number of initiatives are on going in the country that addresses the different levels of prevention, with varying levels of intensity and coverage.

Primary OF prevention in Nigeria is predicated on strengthening the health care system to provide accessible, affordable, quality maternal health care services, including family planning, skilled birth attendance, basic and emergency obstetric care in addition to strengthening social systems that empower women and providing them with safety nets.

2.2.1 Health Systems-related Initiatives

2.2.1.a Promotion of Family Planning Services

Family planning as a deliberate component of prevention of obstetric fistula helps vulnerable women to delay early childbearing, prevent unintended pregnancy, ensure healthy timing and spacing of pregnancy following a successful fistula repair and limit family size where desired family size has been achieved. The current effort of government is aimed at raising the current contraceptive prevalence rate to 36% by 2019 from the current rate of 10%. To achieve this, there have been significant investments by government and development partners in procuring and distributing free contraceptives, training of health workers and promotion of task shifting for lower cadre health care providers to provide long-lasting contraceptives.

2.2.1.b Increasing Skilled Birth Attendants Coverage

A number of initiatives are on going, aimed at increasing the number of midwives' recruitment, deployment and retention of midwives. These include:

Training Programmes

The Nursing and Midwifery Council of Nigeria has reintroduced the community midwifery-training scheme so as to rapidly increase the availability of midwives. A number of development partners are supporting midwifery-training institutions to improve the quality of training offered. In states with dire need of midwives, permission has been granted to them by the relevant regulatory bodies to introduce abridged training programs that will build the skills of their Community Health Extension Workers for midwifery service provision. A number of states in the core north have commenced the program. Also, the Nursing and Midwifery Council of Nigeria has given approval for the re-introduction of midwifery as a basic qualification, so as to boost availability of midwives. Additionally, the National Primary Health Care Development Agency (NPHCDA) and a number of development partners conduct training programmes for Life Saving Skills for CHEWs, nurse/midwives and doctors.

Midwife Service Scheme

The Midwife Services Scheme was introduced in 2009 by the National Primary Health Care Development Agency. In recognition that the dearth of skilled health care providers in rural areas is a major limitation to use of maternal health services, the Agency introduced the scheme with the objective of increasing access to skilled attendance at delivery. The strategy deployed is posting retired and unemployed midwives to primary health care facilities in underserved rural communities in the country. This was to ensure round the clock provision of delivery services in these communities. An evaluation of the scheme in 2017 found that the gains were only marginal, as the uptake of ANC

increased by only 7.3%, while the change in skilled attendance at delivery uptake was inconclusive (Okeke 2017). Access to the services eroded with time as challenges of retaining and recruiting the midwives due to inadequate housing arrangements and irregular payment of salaries frustrated the scheme (Okeke 2017)

Saving One Million Lives Initiative (SOML)

It is estimated that one million under-five and maternal deaths occur annually in Nigeria. The Saving One Million Lives Initiative (SOML) aims to avert these deaths, through the implementation of a package of high impact cost-effective interventions that include Integrated Maternal Newborn and Child Health (IMNCH) services. Consequently, SOML is strengthening the capacity of one PHC facility per ward to provide skilled supervision of deliveries; basic emergency obstetric care services and ensure availability of essential maternal and child health commodities, while intensifying behaviour change interventions to increase service demand. The programme builds on the conditional cash transfer introduced during the SURE-P MCH project, the MSS and the free IMNCH carried out under the National Health Insurance Scheme and Millennium Development Goal with the aim of strengthening the capacity of 4300 PHC to deliver on its IMNCH agenda. Each State has received the World Bank funds and execution of the programme is on going.

Table 1: Interventions for Prevention of Obstetric Fistula in Nigeria

Prevention of Obstetric Fistula	
Health system-based strategies	**Population-based strategies**
· Removal of financial barriers to access maternal health services · Expanding access to skilled birth attendants · Promoting the use of partograph · Scaling up availability of, accessibility to and provision of Emergency Obstetrics Care (EMOC) · Provision of affordable emergency transport services for women with obstetrics emergencies · Demand creation of interventions to improve uptake of institutional deliveries and use of EMOC · Promotion of family planning Catheterization	· Promote the education of the girl child · Delaying early marriage and early childbirth · Community education and sensitization on the recognition of labour complications · Educating communities of socio-cultural factors that contribute to obstetric fistula

Source: FMoH Data Bank

Laws and Policies

Most States have policies for the provision of free MCH services. In addition, some states, like Ebonyi have enacted laws that make it mandatory for pregnant women to book in antenatal clinics and deliver in health facilities; breaching of the law attracts sanctions. Advocacy should be intensified to have such laws enacted in other states.

2.2.1.c Catheterization for Prolonged Labour

As part of the strategy to avert the development of OF in a woman that develops prolonged obstructed labour, the Federal Ministry of Health's guideline on catheterization for the prevention and treatment of obstetric fistula recommends the insertion of Foley's catheter for 10 days for these women (National Guidelines on Catheterization for Prevention and Management of Obstetric Fistula 2016.). Since the development of the guideline, some health workers have been trained and implementation is on going in various health facilities across the different levels of care.

2.2.1.d Increasing Access to Emergency Obstetric Care

In line with the National Strategy for Integrated Maternal Newborn and Child Health, a number of interventions have been put in place to expand access to basic and emergency obstetric care services. These include the development of SOPs, training of health personnel, support to States to develop their IMNCH strategic plans, training of various cadres of health workers on the use of partograph and in the provision of basic and emergency obstetric care, commodities provision, developing emergency transport systems etc. Also, it is envisioned that the one PHC facility per ward, being upgraded to serve as the PHC referral centres in each ward, will be strengthened to provide both skilled attendance at delivery and basic emergency obstetric care.

While some improvements have been recorded, challenges still remain. In all the states visited as part of generating evidence for this situation analysis, the use of partograph to monitor the progression of labour was very limited. In many of the states, partograph were not being used in secondary health facilities, let alone primary health care facilities. A large proportion of primary health care facilities designated as providing basic emergency obstetric services are not providing the full complement of services due to shortages in skilled personnel; financial resources also limit the capacity of most public health facilities to provide comprehensive emergency obstetric care. One of the consequences is the rising incidence of iatrogenic fistula because of the activities of poorly trained personnel and quacks.

Access to Delivery Care for Treated Fistula Patients

Some VVF treatment centres observed that a number of repaired women with obstetric fistula encounter a number of challenges and are thus unable to attend ANC and deliver by elective caesarean section when they subsequently become pregnant. They resort to attempting vaginal deliveries, which result in the breakdown of the repairs. To avert this, some VVF centres have started their own antenatal and delivery services.

2.2.2 Population-based Interventions

A number of population-based interventions are on-going that address the social determinants of obstetric fistula and promote appropriate obstetric fistula risk behaviours reduction. It is noteworthy that some of these interventions are being undertaken in other sectors outside the health sector, especially the Ministries of Education, Women Affairs and Communication.

Within the health sector, there is an increasing recognition of the reproductive health benefits of promoting girl-child education. These include delaying the age at marriage and onset of childbearing, adequate spacing of children, limiting the number of children and appropriate reproductive health care seeking behaviour. To this end, a number of development partners working in the area of reproductive health are promoting the education of the girl-child as a strong strategy for reduction in maternal mortality and morbidity through increasing girl-child school enrolment, retention and graduation at a secondary school level. UNFPA, MacArthur Foundation, DfID are some of the partners providing support to local NGOs for this intervention.

2.3 TREATMENT OF OBSTETRIC FISTULA

2.3.1 Catheterization

The Federal Ministry of Health developed a guideline on the use of the urinary catheter for primary prevention and early treatment of vesico vaginal fistula in 2013 and was launched in 2016(National Guidelines on Catheterization for Prevention and Management of Obstetric Fistula 2016). Most fistula centres have trained their staff on the new guideline and the practice has been implemented in most centres across the country. During the national response assessment, all the centres visited in the six zones of Nigeria had mainstreamed implementation of catheterization for early treatment of vesico vaginal fistula into their OF management plans. This offers some women the opportunity of a simple, safe and cost- effective alternative to surgical repair. It is also expected that when other primary and secondary health facilities are trained, and they put into practice the use of urinary catheter, this treatment mechanism will potentially save hundreds of women the need to undergo surgical repair of their fistula with significant financial savings.

2.3.2 Surgical Treatment

Most of the fistula surgeries are currently being performed in designated fistula centres, some stand-alone fistula hospitals, while others are attached to general hospitals. It is noteworthy that some of the Obstetricians/Gynaecologists and Urologists trained in fistula surgery are based in the teaching hospitals and the potential for fistula surgery abound in these facilities. Unfortunately this potential remains majorly unlocked as many challenges, including the cost of services and competing demand for beds limit fistula surgery provision in these facilities. Hardly any fistula surgery is provided in private health facilities except in the stand-alone Fistula facility owned by the Catholic Church in Akwa Ibom state

The FMOH and development partners expanded training services for fistula surgery for different categories of health care providers. Following that, rapid surgical interventions with various service delivery approaches were introduced such as pooled effort, routine care or both in the different centre across the country. Few centres provide advanced fistula surgical interventions including University College Hospital Ibadan, National Obstetric Fistula Centre Abakaliki, National Obstetric Fistula Centre Katsina, and Evangel Fistula Centre Jos. In 2013 the Federal Ministry of Finance in collaboration with Federal Ministries of Health and Agriculture, launched the Growing Girls and Women in Nigeria (GWIN) initiative. One of the areas supported through this intervention, which focused on marginalized women and girls, was the provision of free fistula repairs in 13 centres between 2014 and 2015. In addition, three major partners have been supporting OF repair work in the country, they are UNFPA, Fistula Care Plus and MSF.

The number of surgeries performed in the 18 fistula centres from 2014 to September 2017 is shown in Table 2. Some achievements were noted during the national response assessment of the six geo-political zones with regard to fistula treatment in an effort to reduce the prevalence in the country.

Between 2014 and 2017, a total of 8047 repairs were carried through routine and pool effort in 18 centres, an average of 2012 per annum. Of note is the annual increase in the number of repairs, with the figures almost doubling between 2014 and 2015. The annual mean number of repairs per centre offering routine care ranged from 10 in University College Hospital Ibadan to 360 in NOFIC Katsina, with a mean of 129.

Table 2: Distribution of Fistula Repairs in Obstetric Fistula Treatment Centres in Nigeria, 2014 - 2017

NAME OF FACILITY	ZONE	2014	2015	2016	2017	Conservative treatment 2017	Total
National Obstetric Fistula Centre, Ningi	NE	54	131	164	157	28	**534**
VVF Centre, Damaturu	NE	0	0	100	30	0	**130**
VVF Centre, Maiduguri	NE	0	0	100	100	0	**200**
VVF Centre, Yola	NE	0	0	100	100	0	**200**
General Hospital Ogoja	SS	14	17	17	62	0	**110**
VVF Centre, Calabar	SS	0	0	50	100	0	**150**
Family Life Centre &VVF Hospital, Uyo	SS	89	134	97	118		**438**
National Obstetric Fistula Centre, Abakiliki	SE	230	246	194	183	0	**853**
Hajiya Gambo Sawaba VVF Center Zaria	NW	38	123	102	103	6	**372**
Laure VVF Centre Kano	NW	122	386	270	276	55	**1109**
National Obstetric Fistula Centre, Babbar Rug a Katsina	NW	352	371	357	245	59	**1384**
Gesse VVF Centre Birnin-Kebbi	NW	55	140	171	152	16	**534**
Maryam Abacha Women and Children Hospital Sokoto	NW	93	183	103	134	60	**573**
Faridat General Hospital Gusau	NW	21	49	95	77	15	**257**
Sobi Specialist Hospital Ilorin	NC	0	44	13	49	3	**109**
Evangel Hospital, Jos	NC	315	305	336	322		**1278**
University College Hospital Ibadan	SW	18	6	6	20	0	**50**
Adeoyo General Hospital Ibadan	SW	0	18	18	29	0	**65**
Wesley Guilds Hospital, Ilesha	SW	0	0	0	23	0	**23**
TOTAL		**1401**	**2153**	**2293**	**1958**	**242**	**8,047**

Source: FMoH Data Bank

Very few centres have personnel with the competence to treat complex fistula cases. Thus, surgeons from these centres go to centres with less skilled personnel to help treat these complex cases; sometimes the patients are referred. However, the referral pathways are not well defined. In some cases, the fistulae may be deemed inoperable and urinary diversion may be the only solution, although, there are socio-cultural reasons for declining diversion

2.4 REHABILITATION

Rehabilitation and reintegration of women living with obstetric fistula in Nigeria are supported by the Federal Ministry of Women Affairs, some State Ministries of Women Affairs, Development partners like UNFPA, MDG, and international NGOs like Fistula Foundation USA. The interventions were implemented by local NGOs and dedicated fistula centres.

In 2015, the Federal Ministry of Women Affairs in collaboration with the Federal Ministry of Health provided some training equipment for several fistula centres spread across the country. Sewing machines, knitting machines and grinding machines were provided, along with supplies for fistula centres in order to encourage the centres to provide rehabilitation and reintegration services.

Fistula Foundation, Nigeria is the main NGO in the country involved with rehabilitation for many years. Between 2014 and 2016, Fistula Foundation Nigeria rehabilitated 595 women living with obstetric fistula in five states in North West Zone of Nigeria. In recent years, they have provided six months institution-based rehabilitation skill acquisition training programme. After successfully acquiring the skills, beneficiaries are given a start off support of basic equipment like a sewing machine or knitting machine in accordance with the skill acquired. Fistula Foundation Nigeria reintegrates the treated fistula women back to their communities and conducts follow-up to monitor progress.

Table 3: Rehabilitation Data from some Rehabilitation Centres Supported by Fistula Foundation Nigeria from 2014 - 2017

State	Number of women rehabilitated by Year				
	2014	2015	2016	2017	Total
Kano	50	0	25	0	**75**
Jigawa	100	100	100	100	**400**
Sokoto	0	100	10	0	**110**
Kebbi	0	50	0	0	**50**
Kaduna	0	50	10	0	**60**
Ebonyi	0	0	72	60	**132**
Akwa-Ibom	4	0	20	36	**60**
Katsina	100	0	0	53	**153**
Borno	51	20	0	12	**83**
Total	**305**	**320**	**237**	**261**	**1123**

Source: FMoH Data Bank

Dedicated fistula centres offer variable rehabilitation and reintegration interventions. Most fistula centres provided guidance and counselling to women living with obstetric fistula. Very few centres actively provided institutional based socio-economic rehabilitation and reintegration interventions, like skill acquisition training with follow up of a seed fund to set up; and coordination of cooperative societies for women living with obstetric fistula. Very few centres also have dedicated ward and training halls or workshop for rehabilitation. None of the centres provided community-based rehabilitation and very little is being done in reintegration and community follow up.

The dedicated fistula centres appear to have difficulty in establishing support for rehabilitation and reintegration of women living with obstetric fistula. There is no involvement of social workers in rehabilitation and reintegration. Services are epileptic and subject to availability of fund. Furthermore, there is no comprehensive national plan for rehabilitation and reintegration of women living with obstetric fistula.

2.5 RESEARCH IN OBSTETRIC FISTULA

A number of the fistula centres conduct OF-related researches, but the volume of publication in peer-reviewed journals is low. Most of the researches are review of routine data and quantitative studies. Overall, it is noteworthy that the researches are not driven by any national agenda. Also, most of the researches were self-funded with scant funding for research in Nigeria, which limits robust engagement in research in obstetric fistula.

2.6 THE 2011 - 2015 STRATEGIC PLAN ACHIEVEMENTS

To date, the Federal Ministry of Health has developed and implemented two National Strategic Frameworks and Plan of Action for Obstetric Fistula Elimination in Nigeria (2005 - 2010, 2011-2015). The focus of the second strategic plan, which was in tandem with the first one, was to determine the prevalence and incidence of obstetric fistula in Nigeria as a basis for national planning. Furthermore, it sought to promote the prevention of the occurrence of new cases of OF through the implementation of primary preventive interventions, clear the backlog of existing cases through expansion of OF treatment centres and human capacity development and reintegrate OF patients into their communities through the execution of rehabilitative interventions. Successful implementation of the Plan was due to the collaboration of other sectors and the ability to address the social determinants of OF and buy-in by the states to create the enabling policy and funding environment to guide OF work in their states; forging of partnerships, fostering of community participation and improved coordination of OF-related work.

Within the period of implementation, the following have been accomplished:

- A budget line for Obstetric Fistula was created at the FMoH and by a few state governments.

- Efforts are on going to finalize the research being conducted to determine the prevalence and incidence of obstetric fistula in Nigeria. Financial constraints have limited the scope of the work.

- Interventions for primary prevention of fistula within the health sector are largely carried out by other departments and units of the Department of Family Health. Partners are increasingly investing in the education of the girl child as a strategy for improved reproductive health outcomes,

including reducing the incidence of fistula.

- There has been an expansion of obstetric fistula repair services with a resultant reduction in the prevalence of OF.

- Three National OF Centres were established out of the six planned. These centres are National Obstetric Fistula Centre in Katsina, Katsina State, North West Nigeria, which has also been designated as a FIGO international training centre, the National Obstetric Fistula Centre in Ningi, Bauchi State, North East Nigeria, and the pioneer National Obstetric Fistula Centre in Abakaliki, Ebonyi State, South East Nigeria. In addition to these three national centres, there are 14 other OF treatment centres, all belonging to different state governments, except two that belong to faith-based organizations. These centres have continued to provide OF repair services, either as routine services, pooled effort or both. However, gross inequities were observed in human resource distribution, skills, funding and output across the different centres assessed as part of the national response assessment.

- **Other accomplishments within the framework under review include:**

i. Improvement in the skills of health workers in OF management. FMOH and their key partners have conducted a number of training for doctors and nurses.

ii. A guideline for use of catheterization for primary and secondary prevention was developed in 2013 and launched in 2016. The guidelines have been disseminated and training of health workers in its use has commenced.

iii. Available data shows that between 2014 and 2017, a total of 8047 repairs were done in the routine fistula centres and outreach sites

iv. The third key objective of the strategic plan was the rehabilitation and social re-integration of OF patients. In 2014, the Federal Ministry of Women Affairs bought and distributed skills acquisition equipment to eight centres. A few States and fistula centres have supported rehabilitative work. Only one local NGO appears to be working in the area of OF rehabilitation.

v. Some community-related interventions were undertaken, but mainly, donor-driven.

vi. Standardized data capture registers in support of strengthening OF monitoring were developed.

vii. The National Obstetric Fistula Technical Working Group continue to coordinate the OF response in the country.

viii. In established treatment centres where repairs have been going on for some time, fistula surgeons reported that the proportion of old cases of VVF presenting for treatment is reducing.

2.6.1 Challenges Implementing 2011-2015 Strategic Plan

- The limited interest of key development partners involved in reproductive health and poor participation of states and key sectors, frustrated optimal implementation of key components of the plan, notably prevention and rehabilitation. It is noteworthy that the

same factors that cause maternal mortality are the same ones that lead to OF, as OF patients are the women that escaped maternal death from obstruction of labour. The need for integration and ensuring the provision of a continuum of care by the plethora of partners supporting MNCH cannot be overstated.

- While the plan was to ensure that states develop their state-specific plans for OF elimination and provide budget lines, this was hardly done. None of the key state level actors in the six states visited to assess the states' response were aware of the existence of a national strategic plan for OF elimination. Also, none of the states had any OF specific policies or plans and very few states had budget lines, though limited, and desk officers for OF.

- Non-inclusivity in the process of development of the Strategic Plan and poor dissemination of the document were identified by state stakeholders as major factors for their limited involvement in the implementation of the Strategic Plan. This should be addressed during the development of the third Strategic Plan.

- The poor synergy between the different actors in the continuum of OF preventive interventions and among various stakeholders at different levels limits optimization of outcomes. It is noteworthy that maternal mortality has similar determinants as OF, but within the FMOH, while interventions to prevent maternal mortality and promote family planning, key interventions for the prevention of OF, are undertaken by different units, within the same department, there is no evidence of service integration or synergy of their efforts. Ways of overcoming this lack of synergy and integration within the department during program planning and execution should be explored in the next plan.

- Community-level interventions, including behaviour change communication, continue to receive limited attention in most of the OF programming.

- The country is replete with policies and plans, but the translating the policies to action remains a major challenge.

- The cost of treatment in teaching hospitals, some state and faith-based hospitals makes the services unaffordable to many OF patients in need of the services, thus they only access the services when a pooled free OF repair activity is provided in such hospitals.

- Poor political will, gross under funding, the dearth of skills, gaps in skills of the health workforce, disconnect between actors at some of the NOFICs and State level actors, non-availability of dedicated VVF treatment facilities were identified as some other constraints that limit the fistula response at the state level.

- While some progress has been made, the interventions put in place for the improvement of maternal health during the MDG period resulted in a reduction of Maternal Mortality Ratio from an estimated figure of 800/100,000 live births in 1990 to 576/100,000 live births in 2013. However, this does not appear to have translated into a significant reduction in the incidence of OF as the continued presentation of incident fistula cases

indicates that our primary preventive interventions are not having the desired effects.

- The prevalence and incidence of fistula remain unknown. Financial constraints frustrated the complete implementation of the planned nationwide research to provide empirical evidence about the magnitude, distribution and determinants of fistula in the country. Lack of this information is also militating against evidence-based planning.

- There is currently no national database for OF and monitoring and evaluation of the fistula program in the country remains weak, fragmented and essentially donor-driven.

2.7 RATIONALE FOR THE 2019-2023 STRATEGIC FRAMEWORK

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 girls in the country. Despite the realization of its debilitation and the significant marginalization and social exclusion it causes, it remains a largely neglected and 'hidden' disease. Consequently, it is not prioritized in reproductive health issues and information is not readily available to guide decision-making at all levels of the health system and among stakeholders. There is a need to prioritize obstetric fistula response for the following reasons:

- Enjoying a healthy life, free from OF is a basic human right.

- Obstetric fistula is an eminently preventable condition. The continuous presentation of new cases of the disease in the country is indicative of continuing gaps in the ability of the health system to provide universally accessible, affordable, acceptable, and appropriate and quality sexual and reproductive health services. If our goal is the elimination of obstetric fistula, then there is a need to strengthen and scale up our interventions to reduce the incidence of obstetric fistula to zero.

- At the current rate of repair, with an estimated 150,000 prevalent cases, it is projected that it will take 83 years to clear the backlog of cases. There is thus an urgent need to develop a strategy to accelerate the rate of repair for attainment of the goal of elimination of OF in this generation.

- For a proportion of the obstetric fistula women, reintegration into their communities is a problem because of stigma and discrimination, social exclusion and poverty. Yet rehabilitative interventions remain largely unaddressed in our current efforts. There is a need for the buy-in of other key stakeholders, which should be clearly articulated in this plan.

- Current efforts at addressing obstetric fistula remain fragmented, weakly uncoordinated and driven at the Federal level with limited buy-in by the states, MNCH partners and communities. The plan will provide an investment case for the promotion of buy-in of all relevant stakeholders.

- The huge human resource potential in Departments of Obstetrics and Gynaecology and Urology need to be

unlocked for expansion of coverage with fistula treatment services.

- Efforts to eliminate obstetric fistula aligns with seven of the Sustainable Development Goals. SDG Goal 1: End poverty in all its forms everywhere; SDG2: End hunger and achieve food security and improved nutrition and agriculture; SDG 3: Ensure healthy lives and promote the well-being of all people at all ages; SGD 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; SDG 5: Achieve gender equality and empower all women and girls; SDG 10: Reduce inequality within and among countries; and SDG 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.

3 STRATEGIC DIRECTION ON ENDING OBSTETRIC FISTULA 2019-2023

Nigeria's Obstetric Fistula Strategy for the period 2019 to 2023 is premised on the need to promote universal access to obstetric fistula prevention, quality treatment and rehabilitative services in line with the global campaign to end obstetric fistula by 2030.

3.1 VISION

Nigeria becomes a country free of obstetric fistula.

3.2 MISSION

Strengthen the health care system so that women have access to quality, effective and affordable maternal health care services and address the development and human rights issues affecting women and girls: poverty, gender inequality, lack of education and early childbearing through sustainable collaborative efforts with partners and stakeholders at all levels

3.3 GOAL

The goals of the strategy are:

- To prevent women from developing fistula through health promotion and behaviour change communication and universal access to high quality comprehensive maternal health services;
- To ensure that all women with fistula have access to quality treatment services, including treatment of complex cases; and
- To ensure that women with obstetric fistula are reintegrated into their communities
- In addition, the wider social determinants that increase the vulnerability of women and girls to OF are addressed through collaboration with other relevant sectors.

3.4 STRATEGIC OBJECTIVES

In order to contribute effectively to the attainment of the health sector goals, the main focus of the OF strategic plan will be to:

- Eliminate the incidence of obstetric fistula through ensuring universal access to sexual and reproductive health services and maternal health services for women in the reproductive age group;
- Strengthen and expand OF treatment centres nationwide for reducing the prevalence of VVF;
- Foster community participation, inter-sectoral and inter-disciplinary collaboration for the re-integration of OF patients and for addressing the social determinants of OF; and
- Promote reproductive health care seeking behaviour

3.5 TARGETS

Between 2019 and 2023:

- To promote the reduction of the incidence of Obstetric Fistula by 30%
- To reduce the backlog of untreated Obstetric Fistula cases by 30%; and
- To promote and facilitate the rehabilitation and reintegration of 30% % of needy treated fistula patients into their communities.

3.6 GUIDING PRINCIPLES

This Strategy shall be guided by the principles enunciated in the National Health Policy, which are:

- Health is a basic human right

- Mutual accountability and shared responsibility
- Equity in access to health care services
- Gender responsiveness and sensitivity and social accountability
- Political commitment
- Inter-sectoral actions and partnerships
- Community participation
- Integration into sexual and reproductive health programs and services
- Effective leadership and governance

3.7 PRIORITY AREAS AND INTERVENTIONS

The strategy prioritizes the following areas:

- Prevention of obstetric fistula
- Treatment of obstetric fistula
- Rehabilitation and re-integration
- Strategic Communication
- Promotion of Research
- Leadership and Governance
- Monitoring and evaluation

Figure 2: Priority Areas and Key Interventions and Actions of OF Strategy

PRIORITY AREA 1: PREVENTION

Objective: To promote the reduction of the incidence of Obstetric Fistula by 30% between by 2023

The intent is to prevent women from developing fistula through health promotion and behaviour change communication and universal access to high quality comprehensive sexual and reproductive health services

Prevention Strategy 1: Increase access to quality sexual and reproductive health services

The risk of OF, maternal death and disability can be averted with universal access to three key interventions: family planning, skilled birth attendance at every delivery, and access to emergency obstetric and newborn care. To this end, OF prevention should be integrated into on-going primary health care and maternal health interventions.

Key activities:

- Accelerate the development of one PHC per ward, with a focus on MNCH
- Promote availability and accessibility to family planning services at all levels.
- Ensure all deliveries are supervised by a skilled birth attendant
- Train health providers at all levels on ANC and safe labour management and ensure support for use of partograph
- Expand coverage with basic and comprehensive emergency obstetric care in line with the National Maternal and Newborn Strategy
- Ensure all women have access to affordable, quality and safe Caesarean section.
- Train health care providers to conduct urethral catheterization for all women with prolonged obstructed labour and referral of cases of obstetric fistula to designated fistula centres.

Prevention Strategy 2: Promote inter-sectoral collaboration to address the root causes of OF

The social determinants of maternal morbidity and mortality that disempowered women and compromise their health should be adequately addressed. These factors include the dearth of female education, early marriage and childbearing, poor nutrition of girls and women, female subjugation etc. This is best addressed by effective collaboration with relevant sectors and stakeholders.

Key activities:

- Collaboration with Ministries of Women Affairs, Education and Youth Development, National Primary Health Care Development Agency.
- A Network of Religious and Traditional Leaders.

PRIORITY AREA 2: TREATMENT

Objective: Reduce the prevalence of untreated OF by 30% by 2023

Achieving this goal will require ensuring all women with fistula have access to quality treatment services, including treatment of complex cases.

Treatment Strategy 1: Strengthen health system capacity to provide quality, appropriate and accessible fistula treatment services

For the vast majority of Obstetric Fistula patients, treatment is unattainable. Many of

them are not aware of the availability of treatment facilities, for those that are aware; access to treatment facilities may be limited by economic and geographic inaccessibility and dearth of skilled personnel. This objective will therefore address awareness of treatment services, training of personnel – doctors and nurses in OF repair and management, development of treatment centres, including sites for the treatment of complicated cases, identification and referral of clients and removal of economic barriers to access.

Key Activities

- Expand the number of dedicated National Obstetric Fistula Centres from 3 to 6. Each state should train a team of surgeons. In states without OF treatment facilities, one state hospital should be identified and supported for the repair of simple fistula cases so as to expand the total number of fistula treatment sites from 17 to at least 36. The National and other capable Fistula Centres will provide leadership, training and technical oversight for the state fistula treatment centres
- Increase the number of routines and pooled effort fistula repairs
- Develop an MOU with every department of OBGYN in all federal teaching hospitals to provide routine free fistula services
- Identify and empower at least one passionate OBGYN doctor that will be responsible for routine fistula surgeries in all federal and State teaching/Specialist hospitals.
- Expand the use of catheterization for the early management of obstetric fistula
- Develop a system for classification of fistula surgery and a system for referral of very difficult and complex cases to the very experienced surgeons for management.
- Exempt fistula clients from all charges relating to their management
- Establish a system for the identification and tracking OF patients to treatment centres.
- Provide standardized basic and specialist training for doctors, nurses and other professionals in OF prevention and management.
- Promote mandatory rotation of OBGYN residents from teaching hospitals/FMCs in designated fistula centres so as to rapidly scale up the number of surgeons available for fistula surgery.
- Strengthen the mainstreaming of OF into the pre-service training curricula of doctors, nurses, community health workers and social workers and physiotherapists
- Ensure a sustainable supply of commodities and consumables in OF treatment centres
- Ensure adequate provision of required instruments and equipment for fistula management
- Institute a system of quality assurance OF treatment centres.

Treatment Strategy 2: Strengthen community capacity to help women access VVF treatment services

Key Activities

- Support WDCs and CBOs to identify and support women with OF, access treatment centres
- Support media programs and jingles on OF for community awareness, sensitization and client mobilization.

Treatment Strategy 3: Establish a sustainable OF treatment support systems

Key Activities:

- Support establishment of fistula desk offices in all SMoH to coordinate fistula activities.
- Establish budget lines for OF prevention and treatment at state and federal levels
- Mobilize additional resources for OF interventions
- Integrate OF drugs, equipment and supplies into states' and federal budget.

PRIORITY AREA 3: REHABILITATION AND RE-INTEGRATION

Objective: To promote rehabilitation and reintegration of 30% of treated fistula patients into their communities by 2023

Obstetric fistula presents enormous psychological, social and economic challenges. While the situation appears to be changing, many of the patients still face stigma, discrimination, abandonment and neglect. However, anecdotal reports tend to suggest that increasingly, some of the women with OF are still supported by their husbands. There is the need to develop client-centred needs-based rehabilitation and reintegration strategies that meet the needs of individual clients.

Rehabilitation Strategy: Client-centred rehabilitation and reintegration

Key Activities

- Integrate counselling into patient management
- Assess the needs of individual fistula client
- Empower NGOs, CBOs and FBOs to conduct rehabilitative and re-integrative interventions including economic empowerment and psychosocial support
- Support communities and NGOs to re-integrate the women back into their communities.
- Strengthen State Owned Rehabilitation/Re-integration Centres to function properly.

PRIORITY AREA 4: STRATEGIC COMMUNICATION

Objective: To create enabling environment and promote behavioural change for OF prevention

Obstetric Fistula brings to the fore, the social determinants of maternal health and the weaknesses in the reproductive and health services available to them. Thus, an OF communication strategy is a very powerful advocacy tool for engaging policymakers, community leaders and members of the community around issues of safe motherhood. The communication strategy will include advocacy, social mobilization and behaviour change communication. In addition, learning and sharing platforms will be created and high

impact researches implemented.

Social and Behavioural Change Communication Strategy:

Key Activities:

- In collaboration with safe motherhood team, develop and implement an evidence-based comprehensive segmented advocacy and communication strategy.
- Create a learning and sharing platforms
- Conduct high impact researches and utilize findings to inform policy and practice

PRIORITY AREA 5: RESEARCH

Objective: To strengthen OF research and development and significantly contribute to the national fistula response

Noting the limited investment in organized, focused OF research in the country, it is imperative that in the current strategic focus, attention is given to strategies that will help to generate evidence for OF action. Consequently, the following implementation strategies are proposed:

Research Strategy 1: Strengthen National Capacity for OF research in Nigeria

Key Activities

- Constitute and fund meetings of a multidisciplinary National OF Research Working Group
- Develop a National OF research agenda
- Build capacity of OF stakeholders in resource mobilization and conduct of OF research (both qualitative and quantitative)

Research Strategy 2: Increase resource mobilization and allocation for OF research

Key Activities

- Allocate at least 2% of OF funds for research, at all levels
- Conduct training in proposal writing and resource mobilization
- Mobilize resources and competitive fund research proposals

Research Strategy 3: Enhance strategic partnerships for dissemination and utilization of OF research findings to inform policy and practice

Key Activities

- Establish collaborative and multidisciplinary multicentre researches within Nigeria and across countries
- Create a learning and sharing platforms for the dissemination of research findings
- Conduct research dissemination meetings and fund participation in conferences for the dissemination of research works
- Create a repository for OF-related research work in Nigeria
- Support research that will provide empirical evidence on the prevalence, incidence and distribution of OF in Nigeria
- Strengthen the utilization of research findings to inform policy and practice

PRIORITY AREA 6: LEADERSHIP AND GOVERNANCE

Objective: To provide effective leadership and enabling environment that ensures adequate oversight and accountability for delivery of quality OF care

Effective leadership and governance are central to the realization of the goals and objectives of the plan. The aim is therefore to provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality OF interventions for the elimination of OF. The following implementation strategies will be used.

Leadership Strategy 1: Provide clear policies and plans and regulatory framework

Key Activities

- Conduct advocacy meetings with key VVF actors and stakeholders, including representatives from other key sectors for buy-into OF and mainstreaming OF into their plans and activities
- Review and develop clear policies and guidelines relating to OF treatment and prevention
- Develop annual operational plans from the strategic plan, harmonizing plans with State Government and partners.
- Convene an annual meeting with state VVF desk officers to support their development of annual operational plans.

Leadership Strategic 2: Strengthen coordination at all levels and improve performance through regular reviews

Key Activities

- Build capacity of the OF staff in OF programming and programme management
- Convene a regular coordinating meeting of the National OF Working Group
- Support the establishment of Fistula desk in all the states
- Convene regular meetings of the fistula practitioners
- Hold regular OF partners meeting
- Conduct annual review meetings for all stakeholders
- Conduct annual meetings of state-level policy and program managers for review/advocacy/sensitization
- Hold regular planning and coordination meetings with other units involved in OF related preventive activities in the department.

PRIORITY AREA 7 MONITORING AND EVALUATION

Objective: To improve OF programme performance through enhanced OF programme M&E

While OF interventions have been going on for more than a decade and two Strategic Plans have been implemented, at the National level data capture is weak, even regarding treatment. Data to guide prevention and

treatment interventions is scanty. There is still no population-based data on the prevalence and incidence of OF, so also on key determinants of the problem. This is compounded by the fact that data from other relevant programs are not shared, as there is hardly any integration between family planning and safe motherhood programs and OF. Additionally, data from centres supported by partners are not regularly shared with the Federal Ministry of Health and there is variability in the tools used by the different partners. There is a need to capture, analyse and disseminate OF data within the national HMIS.

M&E Strategy 1: Strengthen routine data generation and flow from public/private facilities and community-based health providers for the National Health Management Information System (NHMIS).

Key Activities:

- Identify a core set of indicators for reporting OF activities
- Harmonization of data collection tools for use in public and private OF health facilities.
- Printing and distribution of the revised tools to promote usage.
- Training of assigned health providers on the revised tools.
- Strengthen mainstreaming of OF data needs into the HMIS
- Support regular analysis of data and reporting of OF activities nationally

M&E Strategy 2: Operationalize electronic database for OF

Key Activities:

- Create a maternal health module to include OF indicators
- Roll out mobile technology to health facilities.
- The use of mobile technology for Obstetric Fistula data collection and transmission shall be employed to improve effective and efficient reporting.

M&E Strategy 3: Strengthen human resources for M&E for OF

Key Activities:

- Train M&E Officers at the national, state and facility levels.
- Develop M&E plan and supervise State M&E Officers and Facility Officers in charge of data collection and transmission.

M&E Strategy 4: Strengthen national documentation of OF programme learning and progress

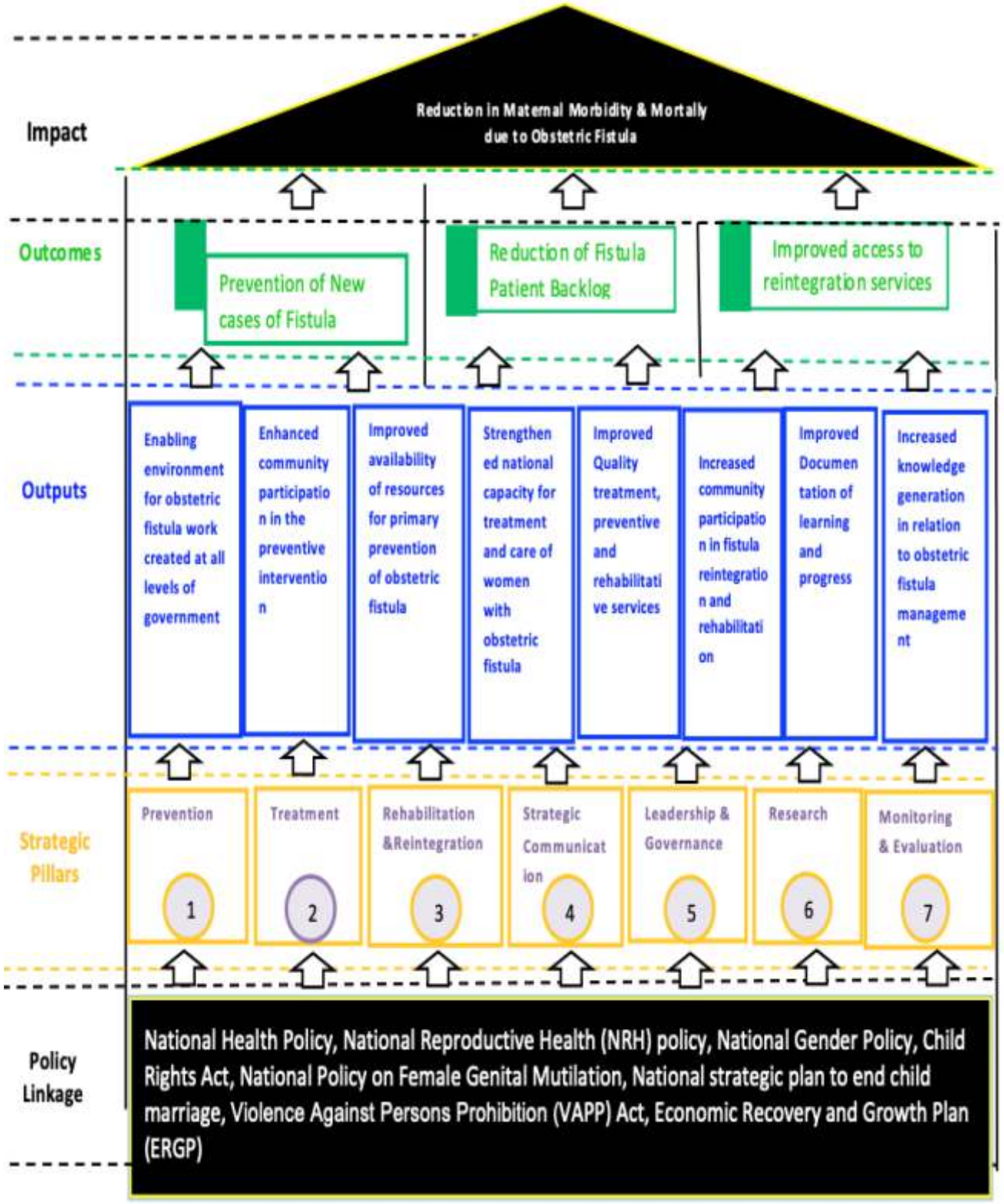
Key Activities:

- Conduct Baseline survey to determine prevalence, distribution and risk factors associated with OF
- Conduct participatory midterm evaluation
- Conduct an external evaluation

4 IMPLEMENTATION MONITORING AND EVALUATION PLAN

The purpose of the M&E Plan for the NSF- OF 2019 – 2023 is to describe how the programme will evaluate the strategies and interventions described in the Plan; and also monitor progress on implementation of the activities described in the Operational Plan. It also briefly describes the recording and reporting as well as data management system.

Figure 3: Conceptual Framework for OF Morbidity and Mortality Reduction in Nigeria.



Source: FMoH and UNFPA

4.1 OBJECTIVES OF M&E PLAN

The objectives of the NSF – OF M&E plan are to:

1. Track progress and monitor the outcomes and outputs of the NSF- OF 2019 - 2023

2. Ensure standardization of OF indicators and harmonize recording and reporting tools for use by all entities within the OF Programme in Nigeria

3. Define clear roles and responsibilities in monitoring and evaluation of OF across different levels of the system

4. Facilitate efficient data transmission and feedback flow

5. Facilitate processes for ensuring good OF data quality and availability across all levels

6. Strengthen mechanisms to ensure dissemination of critical information to stakeholders

7. Promote the use of information and OF M&E results for policy decision-making and improving quality of service

8. Coordinate and strengthen surveys and operations research

9. Mobilize adequate financial and material resources to support full operationalization of the M&E plan.

4.2 DATA COLLECTION AND STORAGE

Currently, there are a number of OF data collection tools being used by different partners. These tools need to be standardized and harmonized for National dissemination and use by public and private health facilities providing fistula services.

4.3 MONITORING PLAN

Organization of the system

The OF Programme, resident in the Department of Family Health has overall responsibility for the coordination of OF programme, and it is responsible for the formulation of policy, programme development, human resource development, supervision, monitoring and evaluation.

At the national level, an officer with overall responsibility for M&E will be deployed/recruited to the VVF section of the department. The officer will be responsible for:

- Collation and analysis of OF data
- Writing and dissemination of reports
- Oversee and coordinate planning and implementation of M&E-related events, including reviews and evaluations

At the state-level, there will be a designated OF desk officer, who shall have responsibility for the collation, analysis and dissemination of state-level OF M&E data; and also, transmission of OF data to the national level.

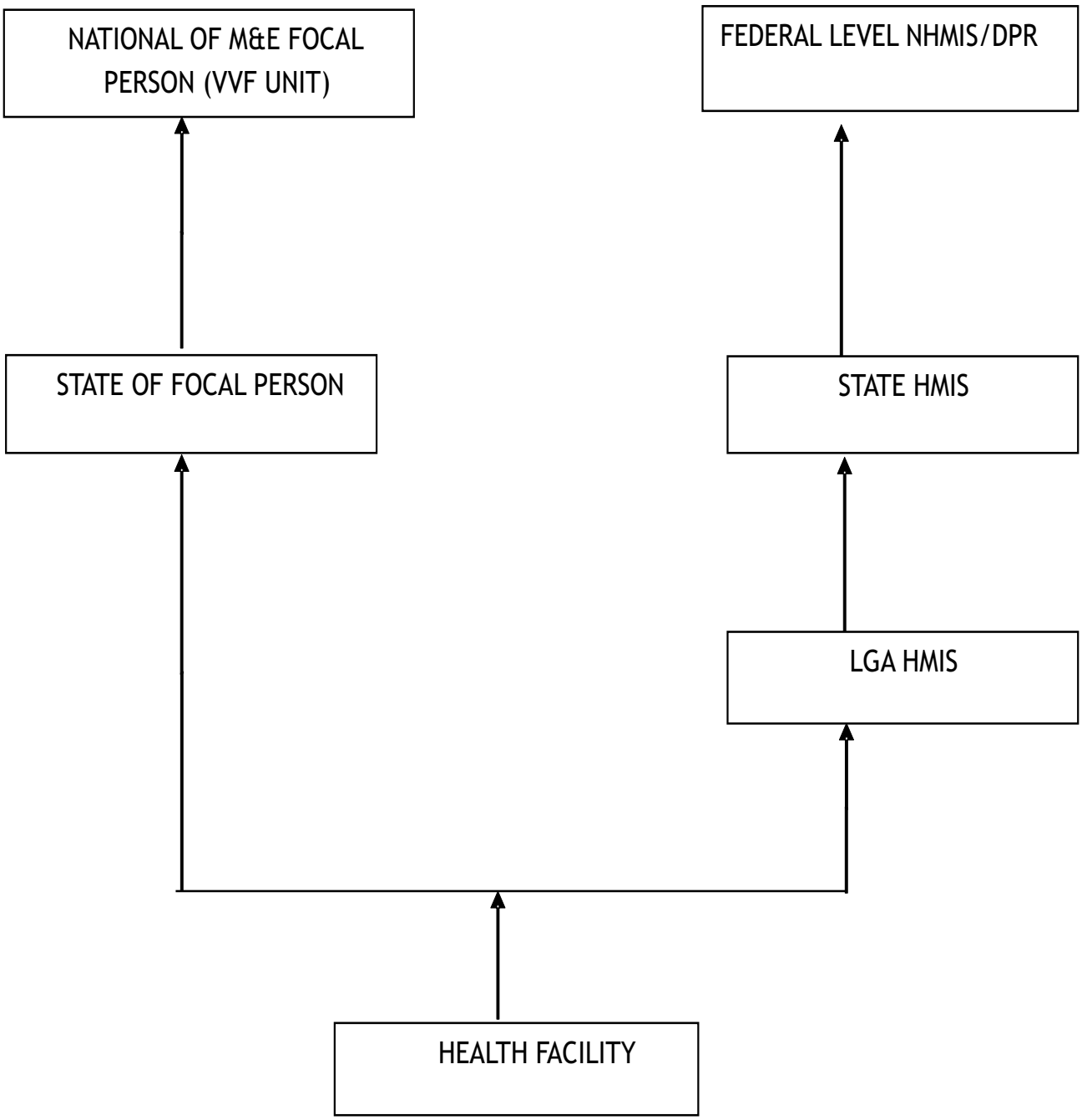
At the facility level, a person shall be designated for the collection and transmission of facility-level OF specific data to the State OF desk officer and to the LGA to feed into the NHMIS.

Both paper-based and electronic data capturing tools will be used for data collection, storage and transmission. For electronic data capture, an OF software will be developed to capture the detailed data needed for monitoring OF work, beyond the needs of the national HMIS. This will be made interoperable with the HMIS platform currently being used in the public sector, which captures some OF data. The HMIS will be expanded to include all stakeholders involved in OF work, especially private sector.

All stakeholders needing data will access the data through the FMoH OF Programme.

4.4 INFORMATION FLOW

OBSTETRIC FISTULA MONITORING AND EVALUATION DATA FLOW



4.5 DATA STORAGE, ANALYSIS, DISSEMINATION AND USE

Data will be stored in a server to be managed by the OF programme, in addition to computer storage, with adequate security. Analysis of the data will be done nationally. A dashboard will be created to monitor and display key performance indicators of OF centres and other stakeholders involved in OF-related work. Additionally, quarterly reports will be produced by the OF M&E officer and disseminated by print and electronic media. Also, the analysed data will be presented at the quarterly meetings of OF stakeholders, National OF Working Group and annual review meetings.

4.6 EVALUATION PLAN

The OF Programme will plan two evaluations during the course of the implementation of this strategy: a midterm evaluation and an end term evaluation

4.6.1 Mid-Term Evaluation

A midterm evaluation will be carried out in 2020. This will be participatory involving consultants and OF stakeholders. The purpose of the midterm evaluation is to determine the level of progress in terms of attainments of output targets and also critically review implementation progress and bottlenecks, which will provide a basis for review of the plan as appropriate.

4.6.2 End Term Evaluation

This evaluation will be carried at the end of the implementation of the programme in 2023. The main objective of the end term evaluation is to determine the level of attainment of the objectives of the strategy and the impact of the strategy on OF morbidity and mortality. This evaluation should be commissioned to external assessors to ensure objectivity.

It is instructive to note that there is no baseline for assessing impact. To this end, one of the first activities to be carried out is to conduct baseline surveys at the population level to determine the prevalence, distribution and risk factors associated with the disease.

4.7 Results Framework

The details are as elaborated in Table 4 below:

Table 4: Results Framework for the Elimination of Obstetric Fistula in Nigeria

RESULT AREA : 1	Prevention
STRATEGIC OBJECTIVE:	To contribute to the reduction of incidence of Obstetric Fistula by 30% by 2023
OUTCOME STATEMENT:	Increase access to quality sexual and reproductive health services and empower girls and women

No	Indicator no	Indicators	Baseline	Target	Frequency	Means of Verification	Assumptions
1	P1	Contraceptive prevalence rate			Annually	NDHS FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	**Assumption-1:** Political will and commitment to OF intervention programmes by all stakeholders sustained. Risk rating: High Indicator: Existence of political stability **Assumption-2:** Stable and committed government - FMOH and government at all levels Risk rating: High Indicator: i) Existence of political stability; ii) Total line budget as a component of total relevant budget for government agencies at all levels **Assumptions-3:** Timely release of OF funds released for planned activities Risk rating: High Indicator: Timing of release of funds
2	P2	Proportion of deliveries supervised by skilled birth attendants			Quarterly		
3	P3	Met need for EmOC			Quarterly		
4	P4	Proportion of deliveries by Caesarean section			Quarterly		
5	P5	Proportion of deliveries managed using partograph			Quarterly		
6	P6	Number of clients with obstructed labour catheterized for 10 days			Quarterly		
7	P7	Proportion of girls who complete secondary education or attend vocational schools			Annually		
8	P8	No of fistula centres and other primary and secondary facilities providing family planning services			Quarterly		
9	P9	No of health facilities with IEC materials and job aids for family planning and safe motherhood					
10	P10	No of health workers trained on use of partograph and catheterization					

11	P11	Number of RMNCAH +N documents with OF mainstreamed					**Assumptions-4:** Relevant government at all levels support OF elimination by channelling resources (commitment, funds, facility etc.) to health systems strengthening Risk rating: Moderate **Assumption-5:** Adequate and timely funding budgeted and release by government and stakeholders Risk rating: High Communities' willingness to imbibe fistula prevention measures. Indicator: i) Amount budgeted and released for specific OF Interventions ii) Timely release of funds **Assumptions-6**: Women will utilise services Risk rating: High Indicator: i) Harmful socio cultural practices ii) Type of male involvement; iii) Number of women seeking care
12	P12	Number of sensitization/advocacy meetings conducted for other sectors to integrate OF into their plans					

RESULT AREA: 2		Treatment					
STRATEGIC OBJECTIVE:		To reduce the backlog (prevalence) of Obstetric fistula by 30% by 2023					
OUTCOME STATEMENT:		Backlog of Obstetric fistula reduced					
		Indicators	Baseline	Target		Means of Verification	Assumptions
13	T1	Number of Providers trained in fistula management			Annually	FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	**Assumption:** Health workers available for training at facility level. Risk rating: Moderate Indicator: Number trained at facility **Assumption:** Availability of motivated trained personnel Rating: High Indicator: Appropriate enabling environment
14	T2	Number of health facilities equipped to provide quality fistula management			Annually		
15	T3	Number of women with fistula receiving pre and post-operative counselling annually			Quarterly		
16	T4	Number of OF clients who received conservative treatment			Annually		
17	T5	Number OF women with fistula repaired annually			Quarterly		
18	T6	Number of fistula clients who received successful conservative treatment			Quarterly		
19	T7	Number of OF clients that received successful surgical treatment			Quarterly		
20	T8	Number of women diagnosed with fistula			Quarterly		
21	T9	Number of women with fistula receiving pre and post-operative counselling annually			Annually		
22	T10	Number / location of facilities providing simple fistula treatment services			Quarterly		
23	T11	Number/location of centres providing specialist fistula services			Quarterly		
24	T12	Number/location of doctors and nurses able to undertake simple repairs (M: F)			Annually		
25	T13	Number/location of OF surgeons able to undertake complex repairs (M: F)			Annually		
26	T14	Proportion of patients waiting for surgery for more than 2 months			Quarterly		

RESULT AREA : 3		Rehabilitation					
STRATEGIC OBJECTIVE:		To increase the number of women rehabilitated by 30%					
OUTCOME STATEMENT:		Number of rehabilitated OF women increased					
		Indicators	Baseline	Target		Means of Verification	Assumptions
27	R1	Number of fistula treatment services which include social reintegration activities	**5**	**16**	Annually	FMOH OF report FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	**Assumption:** Community Leaders, family heads providing support Risk rating: Moderate Indicator: i) Number of community leaders, family heads providing support; ii) Type of male involvement; iii) Timeliness of support
28	R2	Proportion of women treated for fistula who have access to rehabilitation and reintegration services			Quarterly		
29	R3	Number of partnership established with income generating activities or micro credit institutions			Quarterly		
30	R4	Proportion of community leaders who support community initiatives for social reintegration of women who have experienced OF			Annually		
31	R5	Proportion of community leaders who support reintegration programmes in the communities			Annually		
32	R6	Proportion of former fistula clients who serve as peer educators or advocated in their communities			Annually		
33	R7	Number of media, FBOs, CSOs, CBOs involved in rehabilitation of OF.			Annually		
34	R8	Proportion of women fully reintegrated in the community annually			Annually		

RESULT AREA : 4		Strategic Communication					
STRATEGIC OBJECTIVE:		To improve awareness about OF treatment sites, OF Funding and prevention measures					
OUTCOME STATEMENT:		Enabled environment for OF work and positive OF behaviours adopted					
		Indicators	Baseline	Target		Means of Verification	Assumptions
35	SC1	Number of OF advocacy events undertaken			Quarterly	FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	**Assumptions:** Timely release of OF funds released for planned activities Risk rating: High Indicator: Timing of release of funds **Assumptions:** Relevant government at all levels support OF elimination by channelling resources (commitment, funds, facility etc.) to health systems strengthening Risk rating: Moderate Adequate and timely funding budgeted and release by government and stakeholders Risk rating: High
36	SC2	Number of states with budget lines established for OF			Annually		
37	SC3	Number of states and federal institutions providing free treatment of OF patients			Annually		
38	SC4	No of Ward Development Committees/CBOs/NGO involved in OF-related interventions, including behaviour change communication			Annually		
39	SC5	Number of treated OF patients participating in OF BCC activities at community level			Annually		
40	SC6	Number of media programmes on OF			Annually		
41	SC7	Number of OF IEC materials produced and distributed			Quarterly		
42	SC8	Number of persons reached with BCC interventions			Quarterly		

RESULT AREA : 5		Knowledge Generation (Research)					
STRATEGIC OBJECTIVE:		To strengthen OF -related research for i mproved OF programme performance for reduction of OF -related morbidity and mortality					
OUTCOME STATEMENT:		Enhanced capacity and output of OF-related research					
		Indicators	Baseline	Target		Means of Verification	Assumptions
43	KGR1	Number of researchers trained in OF research			Annually	FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	Availability of resource personnel committed to the work Risk raking: High Indicator: i) Number of personnel who conducted research ii) Types of researches conducted
44	KGR2	Percentage of funding allocated for OF research at federal, state and health facility levels			Annually		
45	KGR3	Number of OF researches funded			Annually		
46	KGR4	Number of collaborative OF researches established			Annually		
47	KGR5	Number of OF researches completed and disseminated through a various outlets (conferences, publications in journals etc.)			Annually		
48	KGR6	Number of policies that are informed by research outcomes			Annually		
49	KGR7	Number of research dissemination workshops conducted			Annually		
50	KGR8	Baseline OF prevalence and incidence study successfully conducted			Annually		

RESULT AREA: 6		Leadership and Governance					
STRATEGIC OBJECTIVE:		To provide e ffective leadership, enabling policy environment, oversight and accountability for OF-related work in Nigeria					
OUTCOME STATEMENT:		Enhanced leadership and governance capacity for OF-related activities					
		Indicators	Baseline	Target	Frequency	Means of Verification	Assumptions
51	LG1	Number of OF-related guidelines reviewed	0	3	Annually	FMOH OF Report Monitoring report Support supervision report Mid-term evaluation report End term evaluation report	Availability of resources for the meetings. Risk rating: Moderate
52	LG2	Number of annual OF planning meetings conducted	0		Annually		
53	LG3	Number of OF coordinating meetings of OF working group held	0		Quarterly		
54	LG4	Number of fistula desks established in states	0	36	Annually		
55	LG5	Number of fistula practitioners meetings conducted	0		Quarterly		

RESULT AREA : 7		Monitoring and Evaluation					
STRATEGIC OBJECTIVE:		To improve OF programme performance through enhance OF programme M&E					
OUTCOME STATEMENT:		OF M&E system strengthened					
		Indicators	Baseline	Target	Frequency	Means of Verification	Assumptions
56	ME1	Number of harmonised data collection tools revised			Annually	FMOH OF Report Monitoring review report Support supervision report Mid-term evaluation report End term evaluation report	Availability of Resources Risk rating: High Indicator: i) Number of monitoring reviews meetings held ii) Types and number of report
57	ME2	Number of M&E officers trained on revised data collection tools and OF_M&E	0	37	Annually		
58	ME3	Number of functional computers with M&E data collection software	0	37	Annually		
59	ME4	Number of Monitoring reviews conducted	0	20	Quarterly		
60	ME5	Number of M&E Officers using mobile technology for data transmission	0	37	Annually		
61	ME6	Number of M&E support supervision conducted	0	10	Quarterly		
62	ME7	Number of OF related data analysis and report activities conducted nationally	0	10	Quarterly		
63	ME8	Number of evaluations conducted	0	2	Quarterly		

5 FUNDING FOR THE STRATEGIC PLAN

5.1 OBSTETRIC FISTULA STRATEGIC PLAN COSTING

The main purpose of this section is to provide a cost estimate for the five-year period of the OF Strategic Plan allowing interested parties to find out the costs required for operationalizing the OF-strategic plan. "Program Experience" methodology is used to calculate cost and cost data generated, covering all aspects of service provision (e.g. equipment cost, transportation, training, monitoring and evaluation, and other general costs, etc.) for each intervention in actual programs operating in Nigeria, considering the context in which they are executed.

The Strategic Plan describes all activities and sub-activities, which have been formulated by the Federal Ministry of Health and its stakeholders to achieve the goal of prevention, treatment and rehabilitation services by the year 2023 towards OF elimination. The efforts required to do so are massive and include a rapid expansion of services to reach far more people who are at risk of obstetric fistula in Nigeria more than are being reached through the current predominantly passive case-finding approach and to address the growing problem of obstetric fistula in Nigeria.

5.1.1 Cost of the Plan

The total operational cost of the strategic plan for the five-year period is estimated to be NGN 18,381,637,000.00. This cost is required for achieving the ambitious goal of elimination of obstetric fistula as shown below:

Table 5: Summary of Cost Estimate of OF Elimination Strategic Plan by Priority Area

Priority Area	Description	Amount
Priority Area1:	Prevention of Obstetric Fistula	9,453,583,000.00
Priority Area 2:	Treatment	3,982,755,000.00
Priority Area 3:	Rehabilitation	2,974,063,000
Priority Area 4 :	Communication	470,860,000.00
Priority Area 5:	Research	1,114,316,000.00
Priority Area 6:	Leadership and governance	128,944,000.00
Priority Area 7:	Monitoring and Evaluation	257,116,000.00
GRAND TOTAL		18,381,637,000.00

Source: FMoH

5.1.2 Budget Estimates for 2019-2023 Strategic Plan

Detailed budgets for OF Strategic Plan are provided in Excel files, which can be found in the annexes to this plan. Budgets are provided for each objective, based on activity and sub-activity and related to OF Strategic Plan description. The first tab for each target contains a summary budget, broken down in two different ways: by category, and by the WHO instrument planning and programming category. The second tab contains the text of the operating plan for which the budget is set. The third tab offers a detailed budget, broken into activity costs per year. The fourth tab contains the unit cost assumptions for each activity, and the next tab forms the basis for the cost of consumables, equipment, and other standard items. This detailed budget is summarized by purpose.

Table 6: Annual Cost Estimates of OF Strategic Plan by Priority Area

ESTIMATED COST OF THE STRATEGIC PLAN IN NAIRA							
PRIORITY AREA	2019 ₦	2020₦	2021₦	2023₦	2023₦	Total ₦	%
Prevention of Obstetric Fistula	2,122,503,000	1,549,635,000	2,120,813,000	1,549,635,000	2,110,997,000	9,453,583,000.00	51%
Treatment	917,580,000	626,181,000	917,580,000	612,434,000	908,980,000	3,982,755,000.00	22%
Rehabilitation and Re-integration	634,401,000	547,750,000	634,401,000	537,630,000	619,881,000	2,974,063,000.00	16%
Strategic Communication	108,360,000	90,625,000	90,625,000	90,625,000	90,625,000	470,860,000.00	3%
Research	168,866,000	107,487,000	168,866,000	107,487,000	561,610,000	1,114,316,000.00	6%
Leadership and governance	26,956,000	24,038,000	26,956,000	24,038,000	26,956,000	128,944,000.00	1%
Monitoring and Evaluation	40,112,000	91,344,000	52,445,000	20,770,000	52,445,000	257,116,000.00	1%
GRAND TOTAL						18,381,637,000.00	100%

Source: FMoH

5.2 SOURCES OF FUNDING

The primary source for funding for the OF Strategic Plan in Nigeria is expected from the Government of Nigeria. Additional funding is also expected to come from international and local donors and the private sector. Nevertheless, substantial funding for the program activities is more reliably dependent on external sources. Currently, UNFPA and Engender Health have been the major contributors of funds for OF programs in Nigeria. Efforts are being intensified on the Government of Nigeria (national and states) to provide additional funding support to fight OF because external funds received so far are a little fraction of the required funds.

5.2.1 Strategies for Funding

In reality, the volume of funds received over time falls extremely below the expected amount to fund the strategic plan. It will be absolutely non-practical to implement the activities in the strategic plan and achieve the set targets without additional funds. The negative attendant effects of the shortfall in funds will result in an inability to complete the necessary treatments causing prolonged suffering and hardships for OF patients.

As part of the plan, OF focal persons and key actors will be trained to enable them to acquire the necessary capacity for resource mobilization. To fund this ambitious plan, aggressive mobilization for the necessary resources will need to be embarked upon throughout the planned period. There will also be intensive advocacy campaigns to the Federal, State and Local Governments to ensure appropriate provision of about 2% of the budget is made in the annual budgets for OF elimination, including and for the actual release of the such funds. Efforts will also be made to identify and collaborate with willing civil society organizations for improved demand and

monitoring of the financial commitments of the government to the health.

There will also be efforts by the OF Branch of the Federal Ministry of Health to engage the private sector business entities with a view to leveraging their corporate social responsibility initiatives to achieve program integration. It will also properly engage the Federal Ministry of Women Affairs and Social Development for collaboration and program integration. The unit will also engage the National Health Insurance Scheme to reduce the level of financial burden for OF patients.

OF Branch will continue to maintain a relationship with the current funders while reaching out to new and potential ones. To further boost funding chances, financial management consultants will be engaged to build the capacity of staff in funds management and accountability including fiscal responsibility thereby building donor trust and ability to attract more funding.

6 COSTED STRATEGIC PLAN MATRIX

Priority Areas or Sub Domain						
Goals / Strategic Objectives / Interventions / Activities			BASELINE YEAR 2018 / Output Indicators	Level of Implementation	Stakeholder/ Key Responsible Entity	Grand Total (₦)
						18,381,637,000.00
Goal: To prevent women from developing fistula						18,381,637,000
Priority Area1: Prevention of Obstetric Fistula						
1.1	*To facilitate the reduction of the incidence of Obstetric Fistula by 30% by 2023*					*9,453,583,000.00*
1.1.1	Promote uptake of Contraceptives		• Number of facilities with no stock out of modern contraceptives • Increase Contraceptive Prevalence Rate (CPR)			2,125,107,000.00
	1.1.1.a	Provide family planning services in fistula treatment centres and referral centres.		Secondary Health Facilities	SMOH, SPHCDA, HMB	**676,530,000.00**
	i.	Conduct 6 days annual training for 10 doctors per state in each geo-political zone on LARC			**194,850,000**	
	ii.	Conduct 6 days annual training for 20 nurses per state on LARC.			**481,680,000**	
	1.1.1.b	Provide Information, Education and Communication (IEC) materials and Job aids to health care workers on family planning in fistula centres/states		Health Training Institutions	FMOH, SMOH, PHCDAs	**780,975,000.00**
	i.	Conduct a 5 day technical review meeting for 20 persons on existing print and electronic IEC materials to include Fistula			**15,975,000**	
	ii.	Print and distribute 2000 copies of IEC materials per fistula centre/state per year			**40,000,000**	
	iii.	Produce and broadcast 6 jingles per quarter on radio and 6 scrolling slots on television per quarter per fistula centre/state			**725,000,000**	
	1.1.1.c	Procure family planning Start-up and training kits and strengthen the logistic supply chain management		National Level	FMOH, UNFPA, OSAID-FC+, FF, MSF	**583,100,000.00**
	i.	Provide LARC start up kit for 5 doctors and 15 nurses per fistula			**287,000,000**	

		center/state annually				
	ii.	Provide FP training kits per Zone biennially			**296,100,000**	
	1.1.1.d	Advocate for integration of OF into family planning programmes, biennially		National Level	FMOH, UNFPA, USAID-FC+, FF, MSF	**19,632,000.00**
	1.1.1.e	Conduct supportive supervision on provision of family planning services in fistula centres, annually		National Level	FMOH, SMOH	**64,870,000.00**
1.1.2	Promote uptake of Focused Antenatal Care (FANC)	• Number of women accessing quality FANC services				761,490,000.00
	1.1.2.a	Advocate for free ANC and maternal health care service policy and implementation in the States		National Level	FMOH, NPHCDA	**-**
	1.1.2.b	Training of health care workers on provision of quality maternal health care services at all levels including private health sector (Nurses and CHEWS)		National Level	FMOH, NPHCDA	**761,490,000.00**
	i.	Conduct 7-day annual training for 25 nurses/midwives on Respectful Maternity Care and Focused Antenatal Care (FANC) per state.			**382,050,000**	
	ii.	Conduct 7-day annual training for 25 CHEWs on Respectful Maternity Care and Focused Antenatal Care (FANC) in each State.			**379,440,000**	
	1.1.2.c	Strengthen referral system for OF clients to access free maternal health care services		National Level		**-**
1.1.3	Promote access to skilled attendance at delivery and emergency obstetric care (EmOC)	• Number of OF clients who received Caesarean Section (CS) • Proportion of women cared for during delivery using the partograph				5,827,094,000.00
	1.1.3.a	Provide free delivery services, including caesarean sections for repaired Obstetric fistula clients at fistula centres		State level	SMOH, UNFPA, Fistula foundation, MSF, USAID- FC+	**2,181,040,000.00**
	i.	Conduct one-day advocacy visit to State Commissioners of Health and Guild of Medical Directors to promote free delivery services including CS for OF clients, biennially			**13,540,000**	
	ii.	Provide 200 units of delivery kits per state, to support free delivery services.			**127,500,000**	
	iii.	Provide 100 units of Caesarian Section packs to facilities including private hospitals per state for OF patients.			**2,040,000,000**	
	1.1.3.b	Ensure use of partograph for monitoring progress of labour for all deliveries		National Level	SMOH, UNFPA, Fistula	**303,400,000.00**

				foundation, MSF, USAID- FC+	
	i.	Print and distribute 100 rims of Partograph per state per annum (PHCs, General Hospitals)		**185,000,000**	
	ii.	Supervisory visits to monitor utilization of Partographs		**118,400,000**	
	1.1.3.c	Conduct 2 weeks training of nurses and community health workers on Life Saving Skills including use of partograph and catheterization for prolonged labour, biennially	National Level	FMOH, UNFPA, USAID-FC+, FF, MSF	**1,248,048,000.00**
	1.1.3.d	Train doctors on clinical management of obstetric emergencies	State level	SMOH, UNFPA, Fistula foundation, MSF, USAID- FC+	**2,094,570,000.00**
	i.	Train at least 8 doctors per state annually on EmOC over 4 months		**2,017,610,000**	
	ii.	Supportive supervision of trainees by Senior Doctors		**76,960,000**	
1.1.4	Promote inter-sectoral collaboration for OF prevention	• Number of advocacy/ planning meetings conducted, with well documented briefs and so disseminated			303,890,000.00
	1.1.4.a	Conduct sensitization meetings targeting Ministries of Education, Women Affairs, Youth and Development, Information and the media	State level	FMOH, FMWASD, Relevant Ministries from the STATA, Devt. Partners	**301,500,000.00**
	1.1.4.b	Organize planning meetings to support the mainstreaming of OF interventions into their plans	National Level	SMOH, UNFPA, Fistula foundation, MSF, USAID- FC+	**700,000.00**
	1.1.4.c	Develop technical briefs on OF Integration to other line Ministries programme and disseminate to the key sectors	National Level	FMOH, UNFPA, OSAID-FC+, FF, MSF	**1,690,000.00**
	1.1.4.d	Conduct joint OF-related activities to create synergy	National Level	FMOH, UNFPA, OSAID-FC+, FF, MSF	**-**
1.1.5	Promote integration of OF into MNCH and PHC	• New MNCH and PHC protocol emphasizing OF preventive measures			436,002,000.00
	1.1.5.a	Mainstream OF into MNCH and PHC protocols and guidelines	National Level	FMOH, FMWASD, PARTNERS	**98,940,000.00**
	1.1.5.b	Collaborate with Federal/State Ministry of Education to promote safe motherhood	National and State level	FMOH, SMOH	**337,062,000.00**

	i.	Advocate for adoption of reading materials (novels) with Maternal Mortality and Morbidity themes as part of Literature collection for Secondary Schools in Nigeria.	National and State level	**21,120,000**	
	ii.	Organize biennial maternal morbidity and mortality orientation workshops for Secondary School Teachers across all States	State Level	**315,942,000.00**	
Priority Area 2: Treatment					
2.1	***Reduce the prevalence of untreated obstetric fistula by 30% by 2023:***			***3,982,755,000.00***	
	2.1.1	Scale up OF treatment services	• No of designated fistula treatment centres functional • No of fistula repair surgeries	3,997,085,000.00	
	2.1.1.a	Increase National Obstetric Fistula (OF) Centres from 3 to 6 (one per geo-political zone)	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**636,930,000.00**
	i.	Conduct a Scoping Mission to target hospitals, Pre-Verification exercise, orientation of newly absorbed Staff, and Post-verification exercise for newly absorbed staff		**36,930,000**	
	ii.	Procure hospital equipment including fistula kits, supplies and Consumables.		**600,000,000**	
	2.1.1.b	Conduct periodic OF pool effort repairs to underserved areas (at least 2 zones per quarter) targeting 800 repairs annually, LGA level	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**886,600,000.00**
	2.1.1.c	Expand free OF treatment services to all Federal Teaching Hospitals and FMCs, targeting 3000 repairs annually (reduce cost as number to be repaired has been reduced)	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**1,011,100,000.00**
	i.	Conduct zonal 5-day update course for 2 O&G doctors, 2 Theatre nurses, 2 Post-Op nurses, 2 Peri-Op nurses in NOFIC, (41) FTH's and FMC's annually		**376,100,000**	
	ii.	Supply consumables (surgical, laboratory, cleaning agents) biannually to (41) FTH's and FMC's for 3000 repairs		**225,000,000**	
	iii.	Biennial Supply of 5 Fistula kits and equipment to each NOFIC, (41) FTH's and FMC's		**410,000,000**	
	2.1.1d	Facilitate the dissemination and implementation of the Urethral catheterization guidelines in obstetric service delivery at primary & secondary level facilities, including orientation of health workers	State level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**252,708,000.00**
	2.1.1.e	Review and update existing SOPs relating to OF treatment, rehabilitation and re-integration.	National Level	FMOH	**13,747,000.00**
	2.1.1 f	Support routine fistula Repairs in all State designated fistula centres, targeting 4000 repairs annually	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+, Fistula Foundation	**786,000,000.00**

	i.	Support for client mobilization at the facility level, including quarterly radio and television messages and jingles in 17 States			**85,000,000**	
	ii.	Supply surgical consumables and drugs to 17 state-owned treatment centres on quarterly basis			**399,500,000**	
	iii.	Supply of appropriate equipment (Fistula operating table, Operating lights, steam sterilizer, anaesthetic machine) and others for fistula treatment			**301,500,000**	
2.1.2	Build capacity of health workers in OF management	• Number of health workers trained on standard fistula repairs • number of doctors trained at advanced and expert levels of repair			395,670,000.00	
	2.1.2.a	Train doctors in OF repair (standard, advanced and expert trainings as appropriate)	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**290,470,000.00**	
	i.	Conduct 30-day first Level (standard) annual training of 2 doctors from each of the zonal and state-owned fistula centres. (12 doctors+24 nurses)			**182,490,000**	
	ii.	Conduct 14-day second Level (advanced) training of 1 doctor from each of the zonal and state-owned fistula centres annually.(6 doctors)			**38,570,000**	
	iii.	Conduct 7-day third Level (expert) annual training of 5 doctors across the country on Obstetric Fistula. (4 person)			**69,410,000**	
	2.1.2.b	Train nurses in pre and post-operative OF nursing care	National Level	FMOH, SMOH, UNFPA, USAID-EH/FC+ etc.	**88,000,000.00**	
	2.1.2.c	Advocate for the compulsory rotation of OBGYN and Urology residents in OF centres as part of the residency training	National Level	FMOH	**-**	
	2.1.2.d	Conduct Mapping of OF services in all Federal Teaching Hospitals, Federal Medical Centres, National Obstetric Fistula Centres and State Own Fistula Centres (two times in five years)	National Level	FMOH	**17,200,000.00**	
Priority Area 3: Rehabilitation						
3.1	***Facilitate the rehabilitation and re-integration of 75% of mobilized Obstetric Fistula patients:***				***2,974,063,000***	
3.1.1	Strengthen capacity for OF rehabilitation and reintegration	• Number of functional rehabilitation centres • Number of OF clients rehabilitated and reintegrated, target 9,750 annually			2,567,623,000.00	
	3.1.1.a	Mapping of Rehabilitation Centres, Tutors and potential Stakeholders for OF rehabilitation and re-integration	National Level	FMOH, FMWASD, PARTNERS	**- Same as 2.1.2.d -**	

	3.1.1.b	Develop training modules for OF rehabilitation and re-integration including printing of 1500 copies		National Level	FMOH, FMWASD, RELEVANT MINISTRIES FROM TH STATA, DEVT PARTNERS	**10,120,000.00**
	3.1.1.c	Support vocational skills and entrepreneurship training for 75% (5,850) of mobilized OF survivors annually		National Level	FMOH, FMWASD, RELEVANT MINISTRIES FROM TH STATA, DEVT PARTNERS	**2,310,750,000.00**
	i.	3-months training of 5,850 OF survivors on various vocational/entrepreneurship skill acquisition			**1,140,750,000**	
	ii.	Procurement of business start up kits/equipment for 5,850 beneficiaries (Sewing machine, Knitting machine, equipment for hair dressing saloon and others)			**1,170,000,000**	
	3.1.1.d	Capacity building for social workers on OF and provision of psychosocial counselling for OF survivors, targeting 20 per state biennially		National Level	FMOH, FMWASD	**246,753,000.00**
3.1.2	Promote inter-sectoral collaboration for OF rehabilitation and re-integration					29,040,000.00
	3.1.2.a	Conduct advocacy to relevant sectors, programmes, institutions, philanthropists to invest in OF rehabilitation and re-integration (twice in 5 years)		National Level	FMOH, FMWASD, PARTNERS	**29,040,000.00**
3.1.3	Promote community participation in re-integration of fistula survivors					377,400,000.00
	3.1.3.a	Engagement of social workers to follow up and support re-integration/rehabilitation processes for fistula survivors		State level	SMOH, SMOWSD, UNFPA, Fistula foundation, MSF, USAID- FC+	**377,400,000.00**
Priority Area 4: Communication						
4.1	***Create an enabling environment and promote behaviour change for OF prevention and control:***					***470,860,000.00***
4.1.1	Create an enabling environment for OF-related work in Nigeria	• National Communication plan for OF in Nigeria implemented				40,860,000.00

	4.1.1.a	Collaborate with key stakeholders to develop a comprehensive OF communication plan including printing and dissmeniation		National Level		**17,735,000.00**
	4.1.1.b	Develop briefs, playlets and IEC materials (banners, flyers, handbills, posters, etc.) including printing of 5000 IEC materials		National Level		**23,125,000.00**
	4.1.1.c	Collaborate with Ministries of Information, Television/Radio Stations (Government and Private) in implementation of relevant SBCC interventions		State level		**-**
4.1.2	Promote behaviour change		• Percentage of Nigerians who understands the risk factors for obstetric fistula.			430,000,000.00
	4.1.2.a	Partner with media organizations to air TV and radio programs and jingles on OF at states and national level		State level		**430,000,000.00**
Priority Area 5: Research						
5.1	***To strengthen OF research and development, significantly contribute to the national OF response:***					***1,114,316,000.00***
5.1.1	Strengthen the development of a national OF research agenda		• Obstetric Fistula research agenda established			547,274,000.00
	5.1.1.a	Develop a national OF research agenda		National and State	TWG	**154,530,000.00**
	i.	Develop and review research agenda			**24,840,000**	
	ii.	Training workshops on Grantsmanship for teams from national and state fistula centers			**129,690,000**	
	5.1.1.b	Conduct a nationwide survey to determine the burden and progress towards ending fistula.		National Level	FMOH, SMOH, Facilities and Partners	**392,744,000.00**
5.1.2	Mobilize resources and strengthen strategic partnerships for OF research		• Proportion of research activities funded • Proportion of collaborative studies conducted			370,096,000.00
	5.1.2.a	Support Mobilization of Resources for research activities at State and National levels, trainings on per region in proposal writing		National and State	FMOH, SMOH, Facilities	**44,136,000.00**
	5.1.2.b	Advocate for the allocation of 2% of OF funds for research by Federal and States		National Level	FMOH, SMOH	**21,960,000.00**
	5.1.2.c	Promote multidisciplinary, multicentre national and international OF research including supporting at least two research studies				**304,000,000**

		(policy and implementation) annually.			
5.1.3	Promote dissemination of research findings	• Number of research findings published • Number of repository of OF research work available			172,620,000.00
	5.1.3.a	Convene annual meetings for fistula work and research dissemination	National Level	FMOH, Partners	**39,200,000.00**
	5.1.3.b	Support conference attendance for presentation of research findings	National and State	FMOH, SMOH	**24,720,000.00**
	i.	6 persons for 5 days International conferences to present research findings on fistula (Cost of abstract paper presentation, travel expenses, hotel accommodation and stipends)		**16,110,000**	
	ii.	6 persons for 5 days national conferences to present research findings on fistula (Cost of abstract paper presentation, travel expenses, hotel accommodation and stipends)		**8,610,000**	
	5.1.3.c	Conduct workshops to disseminate research works to stakeholders	National and State	FMOH, SMOH	**96,200,000.00**
	5.1.3.d	Support the publication of research findings	National and State	FMOH, SMOH, Partners	**10,000,000.00**
	5.1.3.e	Create repository of OF research work in Nigeria	National and State	FMOH and SMOH	**2,500,000.00**
5.1.4	Promote use of evidence to inform policy and action	• Number of Policy Briefs prepared and disseminated			24,326,000.00
	5.1.4.a	Prepare policy brief and disseminate to stakeholders on OF research findings (twice in 5years)	National and State	FMOH and SMOH	**24,326,000.00**
	5.1.4.b	Monitor use of research findings into practice	National and State	FMOH and SMOH	**-**
Priority Area 6: Leadership and governance					
6.1	***To provide effective policy leadership and an enabling environment that ensures adequate oversight and accountability for the delivery of quality OF care:***				***128,944,000.00***
6.1.1	Promote development of OF policy and mobilize resources	High level political and financial commitment obtained			49,998,000.00
	6.1.1.a	Mainstream OF into National Health Policy, and National Strategic Health Plan	National and State	FMOH	**-**
	6.1.1.b	Develop annual operational plans at federal and state levels from the strategic plan	National and State	SMOH	**-**
	6.1.1.c	Identify champions for OF at National, State and LGA levels, including high Level unveiling of Fistula Champions at National Level	National and State	FMOH	**29,010,000.00**

	6.1.1.d	Conduct biennial advocacy for resource mobilization for OF work and establishment of budget lines for OF at National and states	State level		**20,988,000.00**
	i.	High level Bi-annual advocacy visit to National assembly/representatives committees for health, Committee for Women Affairs, National and International philanthropist, embassies, agencies and private organisations		**1,620,000**	
	ii.	High level annual advocacy visit to Policy makers in State Houses of assembly committees for health, Committee for Women Affairs, National and International philanthropist to 3 states per quarter (In support of state VVF activities).		**19,368,000**	
	6.1.1.e	Support advocacy for policies on free ANC, skilled attendance at delivery, free fistula treatment services, girl-child education and challenges of early marriages.	State level		**- Same as 1.1.1d, 1.1.2a, 1.1.3d and 1.1.5a -**
6.1.2	Strengthen coordination at all levels and improve performance				78,946,000.00
	6.1.2.a	Build capacity of VVF desk officers on programme management and Result Based Management	National and State	FMOH and Partners	**27,496,000.00**
	i.	25 Persons (including partners and resource person) for a 5 day biennial training on project management including proposal writing.		**13,948,000**	
	ii.	25 Persons (including partners and resource person) for a 5 day biennial training on result based management		**13,548,000**	
	6.1.2.b	Convene biannual coordination meeting of the National OF Technical Working Group	National Level	FMOH	**51,450,000.00**
Priority Area 7: Monitoring and Evaluation					
7.1	***To improve OF programme performance through enhanced OF programme M&E:***				***257,116,000.00***
7.1.1	Strengthen OF monitoring at all levels				120,270,000.00
	7.1.1.a	Develop an M & E Plan and review core set of indicators for reporting of OF activities	National Level		**9,960,000.00**
	7.1.1.b	-deleted-deleted-deleted-			
	7.1.1.c	Review NHMIS data tools to mainstream OF	National Level		**61,190,000.00**
	i.	Purchase of ICT equipment to set up OF data bank at Federal and State level (2 complete set of desk top cumputer and a laptop, wireless network, office equipment (printer, photocopier, scanner)	National/State Level	**54,720,000**	

		and stationeries			
	ii.	3 Days Training with the NHMIS desk and VVF ICT desk officers on data handling, security and management.	National Level	**6,470,000**	
	7.1.1.d	Develop standardized tools for data capture	National Level		**8,170,000.00**
	7.1.1.e	Conduct regular analysis of data and report of activities nationally	National Level		**40,950,000.00**
7.1.2		Establish computerized national database			80,136,000.00
	7.1.2.a	Provide computer for all state VVF desk officers for data compilation and reporting	National Level		**11,100,000.00**
	7.1.2.b	Adapt/develop a software for real time data capture	National Level		**1,214,000.00**
	7.1.2.c	Set up an OF information repository	National Level		**4,922,000.00**
	7.1.2.d	Provide regular maintenance for ICT in all sites	National Level		**62,900,000.00**
7.1.3		Strengthen Evaluation of OF interventions			56,710,000.00
	7.1.3.a	Conduct midterm evaluation and report dissemination	National Level		**28,355,000.00**
	7.1.3.b	Conduct end line evaluation and report dissemination	National Level		**28,355,000.00**

7 IMPLEMENTATION ARRANGEMENT

1. The national strategic framework for the elimination of Obstetric Fistula 2019-2023 has been simplified to encourage use by all stakeholders. There is, however, the need to stimulate interest in the document and ensure its availability in order to make stakeholders aware of the existence of the document and its contents. This appears to be a prerequisite for implementation. Consequently, an emphasis is laid on the dissemination of the document at national, state and local government levels.

2. A National Launch and Dissemination of the document should be done as soon as possible in the year 2019. This should be marked by widespread media coverage: social media, radio, television and print media. At the national dissemination, at least one representative of each State Ministries of Health, Local Government Affairs should be invited. All fistula centres should be represented. This activity should be hosted by FMoH including NPHCDA, National Orientation Agency and Development partners. Representatives of Federal Ministries of Education, Information and Culture, Women Affairs and Social Development should also be in attendance.

3. The Fistula centres should coordinate local dissemination at the state-level in partnership with the State Ministries of Health, and Women Affairs. This should also involve all stakeholders at the state level. Copies of the strategic plan should be disseminated to each local government health department, as well as education department.

4. It should be emphasized that electronic copies of this document should be made available online, so as to make it visible and simple to access as much as possible.

5. At every National Obstetric Fistula Technical Working Group Meeting, the National Strategic Framework should form the basis of monitoring. Reference must be made to this document at every meeting, except emergency meetings called for an extraordinary purpose.

6. It should be used for evaluation of the programme.

REFERENCES

Ezegwi, H U, and EE Nwogu*kojo*. 2015. "Vesico-vaginal fistula in Eastern Nigeria." *Journal of Obstetrics and Gynecology* 25 (6): 589 -591. doi: http://dx.doi.org/10.1080/01443610500239479.

Federal Ministry of Health. 2016. National Health Policy 2016: Promoting Health of Nigerians to Achieve Socioeconomic Development. edited by Health Planning. Abuja: Federal Ministry of Health.

Ijaiya, M A, A G Rahman, A P A boyeji, A W O Olatinwo Salam, F A Esuga, O K Ogah, H O Raji, I O Adebara, A O Akintobi, A S Adeniran, and A AAAdewole. 2010. "Vesicovaginal Fistula: A Review of Nigerian Experience." *West African Journal of Medicine* 29 (5):293–298.

National Population Commission, and ICF Macro. 2014. Nigeria National Demographic and Health Survey 2013. edited by National Population Commission (NPC). Calverton MD: National Population CommissionICF Macro.

National Guidelines on Catheterization for Prevention and Management of Obstetric Fistula 2016

National Strategic Health Plan 2010

EngenderHealth. 2010. Strengthening Fistula Prevention and Treatment Services in Nigeria: An Environmental Scan. New York: EngenderHealth.

10 facts on obstetric fistula [Internet]. Geneva: World Health Organization; 2014. Available from: http://www.who.int/features/factfiles/obstetric_fistula/en/ [cited 2014 Nov 28].

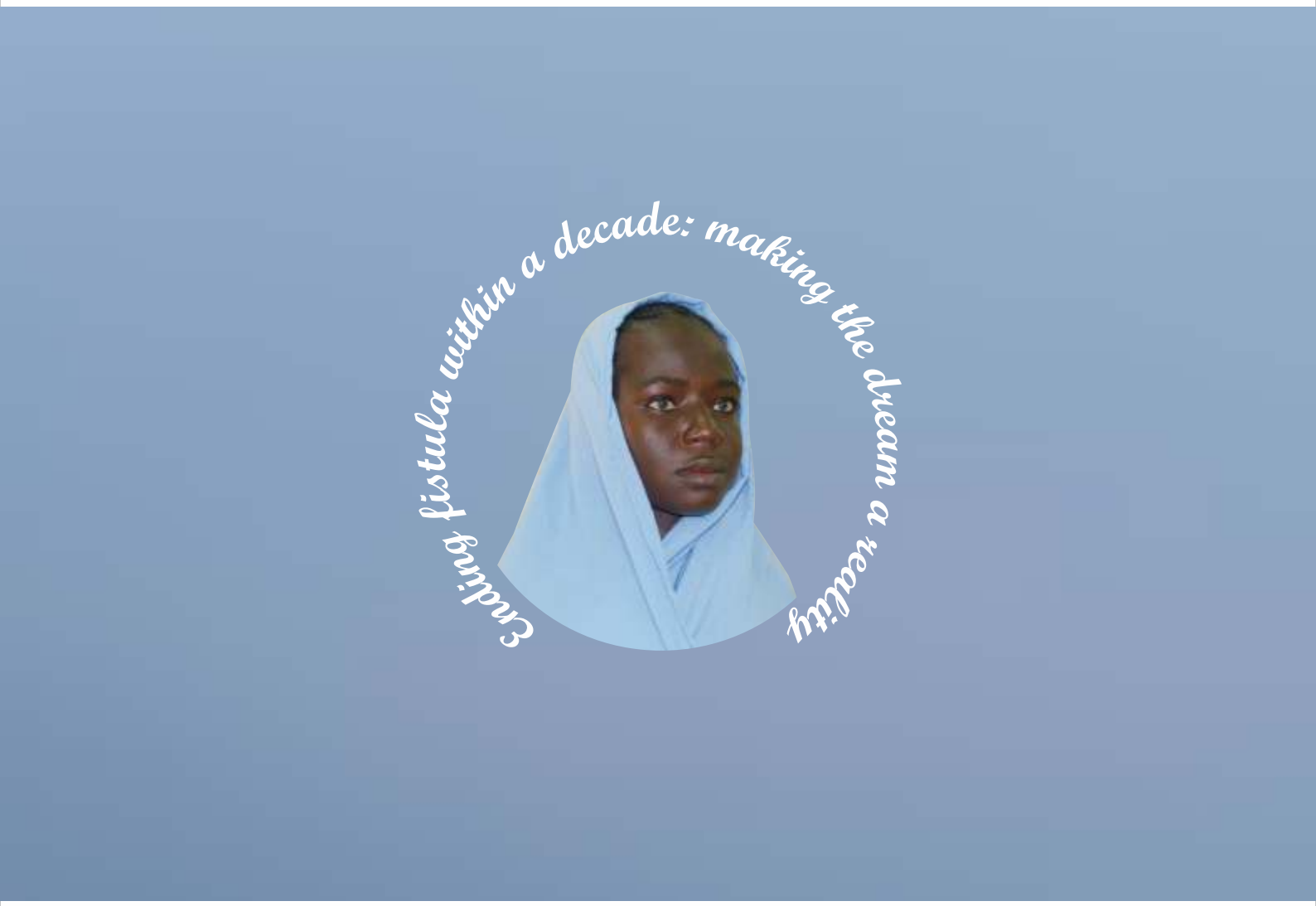
Hancock, B, and A Browning. 2009. " Management of Post Repair Incontinence ". The Royal Society of Medicine Press Ltd. London. https://www.glowm.com/resources/glowm/pdf/POFS/POFS_full.pdf, accessed December 18, 2016.

Hancock, B, and A Browning. 2009b. " Management of Post Repair incontinence, In: Practical Obstetric Fistula Surgery. "The Royal Society of Medicine Press https://www.glowm.com/resources/glowm/pdf/POFS/POFS_full.pdf.

Dolea and AbouZahr. 2003. "Global burden of obstructed labour in the year 2000, "GBD 2000 Working Paper, World Health Organization, Geneva. http://www.who.int/evidence/bod.

Tunçalp 2015. "Tuncalp, O, Tripathi, V, Landry, E, Stanton, CK, and Ahmed, S. "Measuring the incidence and prevalence of obstetric fistula: approaches, needs and recommendations. Bull World Health Organ. 2015

Maheu-Giroux et al. May 2015 "Prevalence of symptoms of vaginal fistula in 19 sub-Saharan Africa countries: a meta-analysis of national household survey data https://www.ncbi.nlm.nih.gov/pubmed/25889469



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