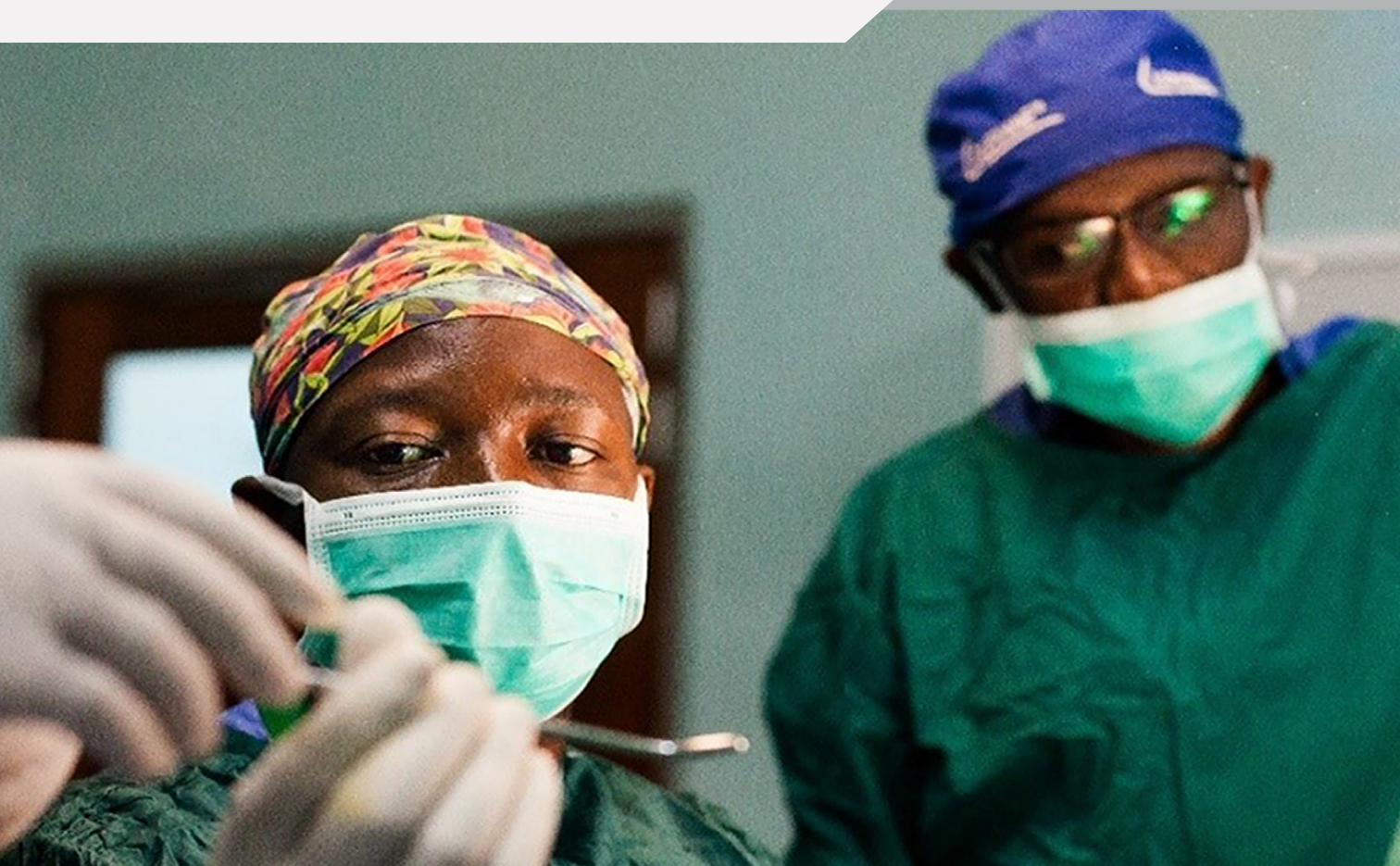


The Republic of Zambia



OBSTETRIC FISTULA STRATEGIC PLAN

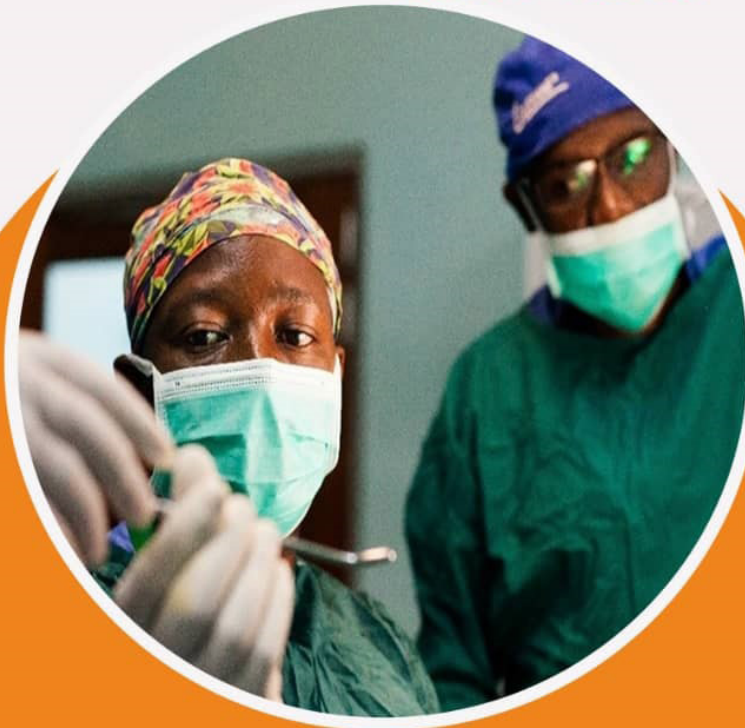
2022–2026



The Republic of Zambia



OBSTETRIC FISTULA **STRATEGIC PLAN** 2022–2026



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Abbreviations

ADH	Adolescent Health
ANC	Antenatal Care
BCC	Behavioral Change Communication
CBO	Community Based Organization
CSO	Central Statistics Office
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CBV	Community Based Volunteer
CHV	Community Health Volunteers
DIM	District Integrated Meeting
DHO	District Health Officer
EmONC	Emergency Obstetric and Newborn Care
FBO	Faith Based Organization
FF	Fistula Foundation
FFZ	Fistula Foundation - Zambia
FIGO	International Federation of Gynecology and Obstetrics
GBV	Gender Based Violence
HIA1	Health Information Aggregation Form 1
HIA2	Health Information Aggregation Form 2
HMIS	Health Management Information System
IDEOF	International Day to End Obstetric Fistula
IEC	Information Education and Communication
IGA	Income Generating Activities
LARC	Long-Acting Reversible Contraceptive
M&E	Monitoring and Evaluation
MNCH	Maternal Newborn Child Health
MPDSR	Maternal and Perinatal Death Surveillance Response
MoH	Ministry of Health
NHSP	National Health Strategic Plan
NGO	Non-Governmental Organization
OBGYN	Obstetrician Gynecologist
OF	Obstetric Fistula
OPD	Out Patient Department
PIM	Provincial Integrated Meeting
PHC	Primary Health Care
PPFP	Postpartum Family Planning
PS	Permanent Secretary
SILC	Savings and Internal Lending Communities
SBA	Skilled Birth Attendants

SRH	Sexual Reproductive Health
SRMNCH	Sexual Reproductive Maternal Newborn and Child Health
SOP	Standard Operating Procedure
SMAGs	Safe Motherhood Action Groups
TWG	Technical Working Group
UNFPA	United Nations Population Fund
ZAGO	Zambia Association of Gynecologists and Obstetricians
ZDHS	Zambia Demographic Health Survey
ZAMMSA	Zambia Medicines and Medical Supplies Agency
ZSA	Zambia Statistics Agency

Preface

Globally, over two million women live with obstetric fistula (OF) with the majority of the cases being from Africa.

In low-resource settings such as ours, OF is a visible indicator of gaps in maternal health care resulting in failure to provide adequate, accessible, quality maternal health care, including family planning, skilled birth attendance, basic and emergency obstetric and neonatal care, and affordable treatment of fistula. OF is preventable and treatable, and no woman in Zambia should continue to endure the condition.

It is obvious that without proper planning and organization for national scale up that promotes equity, training of personnel in required quantity and quality, and resource mobilization/governance, the nation will continue to deal with the backlog of cases as currently is the situation, and delaying management of new OF cases. It is therefore, necessary that we intensify national scale up of OF management centers including community based interventions, train more surgeons and other health workers to handle this backlog and provide quality and affordable care closer to the women who are silently suffering from obstetric fistula.

The aim of the Obstetric Fistula Strategic Plan is to provide a standard reference guide that can be used to train health workers and guide their practice in the provision of integrated, holistic, respectful, affordable, quality and evidence-based care for OF women and, which will guarantee improved quality of life for these women and their families.

It is with great pleasure therefore that, I approve the use of the Obstetric Fistula Strategic Plan which has been professionally developed by the OF Technical Working Group and I am convinced it will facilitate timely, quality and uniform OF care and services in Zambia.



Hon. Sylvia T. Masebo (MP)
Minister of Health

Acknowledgements

On behalf of the Ministry of Health, I wish to thank our collaborative partners, all the health institutions and individuals who contributed to the process and the successful development of the Obstetric Fistula Strategic Plan, which has been professionally developed with support from key partners; UNFPA and the Fistula Foundation through the National OF Technical Working Group. Special thanks go to the OF Technical Working Group with membership drawn from our collaborative partners and health care workers, and which worked tirelessly, providing the necessary technical input resulting in the development and finalization of the Obstetric Fistula Strategic Plan.

In addition, I would like to express our gratitude to our collaborative partners; the United Nations Population Fund (UNFPA), for funding the initial phase of the Obstetric Fistula Strategic Plan development and Fistula Foundation for funding the finalization of the same document. Special thanks go to the consultants who facilitated the development process and put together the document.

I further wish to commend the Directorate of Public Health and staff of my Ministry, and all our partners and technical experts, who contributed to the process of developing this Obstetric Fistula Strategic Plan for use by health care providers at all levels of the health care system and other private/faith-based practitioners.

Thank you,



Professor Lackson Kasonka,
Permanent Secretary – Technical Services
Ministry of Health

Executive Summary

Introduction: Globally, over two million women live with obstetric fistula with the majority of the cases being from Africa¹. In low-resource settings such as Zambia, obstetric fistula (OF) is a visible indicator of gaps in maternal health care resulting in failure to provide adequate, accessible and quality maternal health care, including family planning, skilled birth attendance, basic and emergency obstetric and neonatal care, and affordable treatment of fistula.

OF is preventable and treatable, and no woman in Zambia should continue to endure the condition. It is therefore necessary that Zambia intensifies national scale up of OF management centers including community based interventions, train more surgeons and other health workers to provide quality and affordable care closer to the women who are silently suffering from obstetric fistula.

Background and context: Over the last decade, OF has received increased attention in the national and international agenda. New resources have been invested to improve medical care, train surgeons and health workers including community volunteers, and fund fistula surgery. Education campaigns have alerted more women, families and communities to the importance of obstetric care as well as the specialized surgery available to help them.

In 2003 UNFPA and partners launched the Global Campaign to End Fistula. More partners such as Fistula Foundation have since joined the campaign. This campaign is active in more than 50 countries in Africa, Asia, the Middle East and Latin America². Zambia joined the campaign to end fistula in 2005, which calls for an improvement in Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH-N). The Government of the Republic of Zambia has put high priority on RMNCAH-N as reflected in a range of policies and strategies which are critical in reducing maternal and perinatal morbidity and mortality and hence reduction in the incidence and prevalence of OF.

The efforts invested have resulted in maternal mortality ratio progressively declining from 591/100,000 live births in 2007 to 398/100,000 live births in 2013 and currently stands at 252/100,000 live births³. Despite these efforts, there is great need to scale up the program to more centers, train more surgeons and nurses, and strengthen community mobilization processes for identification of OF cases and reduction of stigma to aid effective rehabilitation/re-integration activities nationally.

Situation Analysis of OF in Zambia: The ZDHS 2018 indicates that childbearing in Zambia begins early, with more than one-third of women giving birth by age 18 and more than half giving birth by age 20. Forty-seven percent (47.2%) develop fistula on first pregnancy. However, it is important to note that multiparous women are equally at risk for OF⁴. Although 80% of deliveries in Zambia are supervised by SBA⁵, only 18% of EmONC facilities in Zambia are fully functional⁶ with various factors contribut-

1. World Health Organization. Obstetric Fistula. World Health Organization. 2018. <https://www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula>

2. UNFPA. UNFPA Campaign to End Fistula. 2018. www.globalfistulamap.org

3. Zambia Statistics Agency. ZDHS 2018. <https://dhsprogram.com/pubs/pdf/FR361/FR361.pdf>

4. MoH. Fistula Tracking Study. 2015.

5. GRZ/UNFPA. Zambia Country Programme Evaluation. 2019. <https://www.unfpa.org/sites/default/files/board-documents/Zambia>

6. MoH. National Health Strategic Plan. 2017-2021

ing to poor quality of safe motherhood services including inadequate infrastructure, insufficient skilled health personnel, an inefficient referral system, inadequate supplies of drugs, inadequate family planning services and information, lack of knowledge of danger signs and complications, young maternal age at first pregnancy and harmful traditional practices during labour and delivery⁷.

Although WHO recommends a caesarean section rate of 5-15%, Zambia stood at 5% in 2015⁸ which is attributed to geographical, socioeconomic and cultural factors that limit equitable access to quality health services. The Fistula Tracking Report showed that the majority of women who sustained fistula delayed at the Health Centre (46.2%) and Community level (42.3%) although they eventually delivered from the hospital. The modern contraceptive prevalence rate in Zambia is 50%. Among the Adolescents, the group that is most vulnerable to obstetric fistula, the rate is 14.2%⁹, and yet reducing frequent and poorly spaced pregnancies through the use of contraception contributes to reduction in the risk of developing obstetric fistula.

According to the 2017-2021 National Health Strategic Plan, close to 2,000 fistula surgical repairs were done in the preceding 10 years with most of the surgical operations being done through ‘fistula repair camps, in designated centers due to limited institutional capacity in all provinces and limited fistula surgeons and support staff. Limited data on the magnitude of obstetric fistula cases in Zambia results in poor decision making in design and management of programme interventions¹⁰. According to the Zambia MoH OF Tracking Study of 2015, 63% of OF patients were abandoned by their partners/spouses.

There are very few research studies on obstetric fistula conducted in Zambia. Those that have been conducted have been at local scale and primarily descriptive in nature¹¹. According to WHO, indicators to measure OF should include indicators in the following areas; epidemiology, service delivery, training and quality of care¹². While partner supported programmes have M&E frameworks/indicators, not all of these indicators are measured in the national HMIS system.

Aim: The aim of the OF Strategic Plan is to provide a standard reference guide that can be used to train health workers and guide their practice in the provision of integrated, holistic, respectful, affordable, quality and evidence-based care for obstetric fistula women and, which will guarantee improved quality of life for these women and their families.

Purpose: The document rationalizes the provision of obstetric fistula services to girls and women, providing guidance on services that need to be provided for prevention, treatment, and rehabilitation. These services are linked to national goals, priorities and aspirations of equity, quality, timely access to and affordable services.

Target audience: The OF Strategic Plan has been developed for use by professional and volunteer Health Care Workers at all levels of the health care system (Community, Health Post, Health Facilities, 1st Level Hospitals, 2nd Level Hospitals and Tertiary Hospitals) to enable all providers to participate in OF care/management, according to their respective roles and responsibilities in the provision of preventive, treatment and rehabilitation/re-integration services to women and girls.

7. Zambia Statistic Agency. ZDHS. 2018

8 WHO.WHO Statement on Caesarean Section Rates. 2015. http://apps.who.int>WHO_RHR_15.02_eng.pdf

9. Zambia Statistic Agency. ZDHS. 2018

10. Singini MG, 2017, Obstetric Fistula Among women Aged 15-19 years in Zambia

11. Singini MG, 2017, Obstetric Fistula Among women Aged 15-19 years in Zambia

12. <https://www.afro.who.int/sites/default/files/2017-06/mps20Fistula2.pdf>

OF Strategic Plan Direction: The Vision of the OF Strategic Plan is that Zambia becomes a country free of obstetric fistula with a Goal to end obstetric fistula in Zambia by the year 2030. Five (5) strategic objectives are outlined to facilitate effective prevention and management of obstetric fistula. These include: 1) Prevent occurrence of new obstetric fistula cases; 2) Identify and treat all women living with fistula; 3) Rehabilitate and reintegrate women with post-repaired fistula into their communities; 4) Provide effective leadership and an enabling environment that ensures adequate oversight and accountability for delivery of quality OF care; and, 5) Strengthen and facilitate research in OF for evidence-based decision making; and monitoring and evaluation of OF activities.

Priority areas for programme interventions have been identified as follows:

- 1) Obstetric fistula prevention;
- 2) Obstetric fistula treatment;
- 3) Obstetric fistula rehabilitation and re-integration;
- 4) Leadership and governance;
- 5) Research promotion; and
- 6) Monitoring and evaluation.

1.0 BACKGROUND AND CONTEXTUAL ANALYSIS

1.1 Introduction

Obstetric fistula (OF) is an abnormal opening between a woman's genital tract and her urinary tract or linked to obstructed labour when a woman lacks access to emergency obstetric care such as timely caesarean section which is one of the major causes of maternal mortality¹³.

Women who experience obstetric fistula suffer constant incontinence, shame, social segregation and health problems. This condition is a life reality for over two million women and girls globally and an additional 50,000 to 100,000 are affected each year. For the vast majority of these girls and women, services to repair their condition remain unattainable for a number of reasons: their lack of knowledge that such a condition can be repaired; the long distances to health facilities that provide treatment; their inability to pay for the services if they are available; and the resulting backlog of clients faced by facilities that provide repairs¹⁴.

Both the 2006 UNFPA Annual Report and the 2010 Kalilani P. et al Study on Obstetric Fistula Prevention indicate that obstetric fistula is an indicator of deep socio-economic inequalities and inadequate maternal and reproductive health systems. OF is still largely neglected in the developing world. It has remained a "hidden" condition because it affects some of the most marginalized members of the population that are poor, young often illiterate girls and women in remote regions of the world. Therefore, it has limited visibility in decision-making processes at all levels of the health care system.

Over the last decade, OF has received increased attention in the national and international agenda. New resources have been invested to improve medical care, train surgeons and health workers including community volunteers, and fund fistula surgery. Education campaigns have alerted more women, families and communities to the importance of obstetric care as well as the specialized surgery available to help them.

The Southern African Development Community (SADC) Sexual Reproductive Health and Rights Strategy (2019–2030) and SDG 3 regionally and globally respectively aim to reduce maternal mortality ratio to less than 70/100,000 live births by the year 2030 and to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030¹⁵. Countries can significantly reduce OF by addressing the SDG 3 to ensure healthy lives and promote well-being for all and at all ages¹⁶. Zambia is among the countries committed to achieving the SDGs by 2030 on reduction of maternal mortality. Efforts invested have produced significant results as the maternal mortality ratio has progressively declined from 591/100,000 live births in 2007 to 398/100,000 live births in 2013 and currently stands at 252/100,000 live births¹⁷.

13. World Health Organisation. WHO FACT Sheet. 2006.

14. <https://www.who.int> 10 facts on obstetric fistula; WHO. Feb 2018.

15. SADC. SADC Regional Strategy on SRHR. 2019-2030.

16. SADC. SADC Regional Strategy on SRHR. 2019-2030.

17. Zambia Statistics Agency. ZDHS. 2018.

In 2003 UNFPA and partners launched the Global Campaign to End Fistula. More partners such as Fistula Foundation have since joined the campaign. This campaign is active in more than 50 countries in Africa, Asia, the Middle East and Latin America¹⁸. Zambia joined the campaign to end fistula in 2005. The campaign calls for an improvement in Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH-N). The government of the republic of Zambia has put high priority on RMNCAH-N as reflected in a range of policies and strategies which are critical in reducing maternal and perinatal morbidity and mortality and hence reduction in the incidence and prevalence of OF.

In Zambia, service delivery follows the Primary Health Care (PHC) approach. The definition of PHC in Zambia is action-oriented, focused on promotive, preventive, curative, rehabilitative, and palliative care efforts within and outside the health sector. These services are provided by government institutions through MoH and/or defense and security forces, faith based organizations, mining and private institutions.

The NHSP (2017-2021) defines the framework within which both public and private health service delivery is organized, and recognizes 5 levels of health care system. Hospitals are designated in three levels which are level 1 (District Hospital), Level 2 (General/Provincial Hospital) and level 3 (Central/Tertiary/Teaching Hospitals). In addition, there are Health Centres (urban and rural) and health posts (predominantly in rural areas) which are prominent at community level. All these levels of care have a role in the care of women and girls with regards to prevention and treatment of OF. Lower levels refer to higher levels of care. In this organizational structure, current evidence shows that Health Centres contribute a major delay that lead to OF.

There is political commitment at the highest level in Zambia. On 18th May 2019, the country declared maternal and perinatal deaths as a public health emergency. In response, the Zambian Government has created a strong policy framework aimed at guiding implementation of RMNCAH-N programme. Building on the lessons learned in implementing the earlier plans and to be highly responsive to the current socio-economic landscape, the government of Zambia in its NHSP 2017-2021 has a transformative agenda which focuses on building robust and resilient health systems.

The Zambian government is committed to accelerating the elimination of fistula by the year 2030, by implementing the RMNCAH-N programme and adopting the WHO three-pronged approach to obstetric fistula elimination which includes prevention, treatment and rehabilitation/re-integration. A blended model developed by the MOH in partnership with UNFPA and Fistula Foundation will be used for this strategy. Prevention of new cases of OF, identification of cases, referral and treatment of existing cases form the basis of this OF Strategic Plan.

UNFPA and Fistula Foundation in 2005 and 2017 respectively, launched support to the MoH and Faith-based health facilities/centers and camp sites for reduction of OF through prevention, treatment and rehabilitation/re-integration services. At least 4, 150 patients have been reached with OF surgeries in 9 treatment centers (St Francis Hospital- Katete, Monze Mission Hospital- Monze, Chilonga Mission Hospital- Mpika, Mansa General Hospital- Mansa, Kabwe General Hospital- Kabwe, Mbala General Hospital- Mbala, Chilenje Level 1 Hospital, University Teaching Hospital- both in Lusaka and Lewanika General Hospital- Mongu with support from these two partners.

18. UNFPA. UNFPA Campaign to End Fistula; 021. www.globalfistulamap.org

1.2 Process for Development of the Obstetric Fistula Strategic Plan in Zambia

The Obstetric Fistula Strategic Plan 2022-2026 has been developed following an extensive, all-inclusive and consultative process with cooperating partners (UNFPA, Fistula Foundation Zambia (FFZ), WHO), staff from the MoH and NGOs/CSOs including representatives of Zambia Association of Gynecologists (ZAGO).

The OF Strategic Plan development process was in two phases. The first phase included a five-day workshop, with 21 representatives of the different stakeholder organizations. The process comprised section by section group work and discussions resulting in group consensus of what content had to remain in the document. This was then followed by a review process which saw the production of the second draft.

The second phase involved reaching out to all the technical working group members who participated in the first phases through Zoom meetings. Three templates were developed, an information matrix which assisted in collecting information related to the different chapters of the document, an M&E template for collection of M&E indicators and a costing framework. All this information was used to finalise the document resulting in the output of the second phase of document development.

Phase three included a 5 days validation meeting comprising 19 individuals from UNFPA, Fistula Foundation and the MoH respectively. During the meeting the team was divided into 6 groups, covering the 6 document chapters to review and validate the content of the document. A final document was produced which underwent further editing by the Consultants, FFZ and UNFPA. Final cleaning was done by the consultants and the MoH Chief Safe-motherhood Officer and the document was handed over to the MOH for approval.

1.3 Scope, Purpose and Target Audience

Scope: The Obstetric Fistula Strategic Plan is a guide for implementation of Obstetric Fistula programming in Zambia. The document is in six chapters: 1) Background and Contextual Analysis; 2) Situational Analysis of Obstetric Fistula in Zambia; 3) Strategic Direction; 4) Implementation Framework; 5) Monitoring and Evaluation and, 6) Costing of the Obstetric Fistula Strategic Plan.

The strategic plan provides information on the current status of the provision of OF prevention, management/treatment and rehabilitation services in Zambia, the challenges around service provision and evidence based programming that can be replicated and scaled up to other provinces, districts, health facilities/centers and communities. Further, the priority services have been clearly outlined; classified in priority areas, interventions and activities, guiding the service providers on what services need to be provided for each of the identified Priority areas under; prevention, treatment, and rehabilitation/re-integration.

The document also outlines how the services will be monitored and evaluated using appropriate measurable indicators that are linked to the existing Health Information Management System (HMIS). The roles and responsibilities at national, provincial, district, health facility and community health system levels to make service delivery a success are outlined. The understanding of these roles and responsibilities is deemed as a tool for improved governance and accountability as well as ensuring policies and service delivery are in tandem. An understanding of the estimated cost for implementing the program in Zambia is provided to guide budgeting and resource mobilization activities.

Purpose: The document rationalizes the provision of obstetric fistula services to girls and women, providing guidance on services that need to be provided for prevention, treatment, and rehabilitation. These services are linked to national goals, priorities and aspirations of equity, quality, timely access to and affordable services.

Target Audience: The Obstetric Fistula Strategic Plan has been developed for use by professional and volunteer health care workers at all levels of the health care system (Community, Health Post, Health Facilities, 1st Level Hospitals, 2nd Level Hospitals and Tertiary Hospitals) to enable all providers to participate in OF care/management, according to their respective roles and responsibilities in the provision of preventive, treatment and rehabilitation/re-integration services to women and girls. It is designed for use by all stakeholders (Government, Faith-based, International and Local non-governmental organizations, and donors with the mandate to implement obstetric fistula related services in Zambia). The document is also beneficial to policy makers, line ministries and, traditional, religious and civic leaders representing the different levels of the health care system – national, provincial, district, health facility and community respectively who are expected to provide leadership to ensure smooth and successful program implementation.

2.0 SITUATION ANALYSIS OF OBSTETRIC FISTULA IN ZAMBIA

Globally, it is estimated that 2 million women live with obstetric fistula with the majority of the cases coming from Africa and South Asia¹⁹. The 2013/14 Zambia Demographic and Health Survey report included, for the first time, a module to measure the prevalence of symptoms of fistula in Zambia. Slightly more than one in three (36%) of the women aged 15-49 years had heard of fistula. However, only 0.5 per cent of the women reported ever experiencing symptoms consistent with fistula. Similarly, the 2018 ZDHS show a comparable rate of 0.2%²⁰.

The exact fistula burden in the country is not known. The primary data available documents the number of fistula repair surgeries that have been done throughout the country. The UNFPA Fistula Tracking Study of 2014 established that Eastern Province had more fistula survivors (26%) followed by Luapula Province (22%), and Northern Province (14%). This may not show the actual picture of fistula burden on the ground but rather suggest that community mobilization was strongest in these particular regions and therefore helped improve patient identification and referral for treatment. The same study indicates that out of 638 women treated for fistula, 64.9% were completely healed at the time of the study.

Most of the surgical operations are done through ‘fistula repair camps’ because of limited institutional capacity in all provinces and fistula surgeons and support staff. Most fistula repair camps are conducted at provincial level general hospitals. From the time of the launch of the Campaign to End Fistula, MoH with support from partners (Fistula Foundation and UNFPA) have conducted fistula surgeries in 9 treatment centers (St Francis Hospital, Monze Mission Hospital, Chilonga Mission Hospital, Mansa General Hospital, Kabwe General Hospital, Mbala General Hospital, Chilenje Level 1 Hospital, University Teaching Hospital and Lewanika General Hospital); reaching at least 4, 150 patients with OF surgeries.

In addition, there is limited data on the magnitude of obstetric fistula cases in Zambia, making it difficult to design management interventions²¹. According to UNFPA, more women with obstetric fistula in Zambia are accessing treatment and reintegration services, as reflected by an increase in the total number of women living with fistula who receive surgery – from an estimated 160 in 2005 to 1,786 by 2015²².

To effectively address the burden of fistula, it is critical to know how many women are in need of fistula repair and where they live. It is equally important to know the outcome of fistula repair and conditions of survivors. By systematically registering and tracking each woman who has or had an obstetric fistula, whether repaired or not and the outcome of the repair, we can make enormous strides in improving their well-being.

19. World Health Organization. Obstetric Fistula; World Health Organization; 2018. <https://www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric>

20. Zambia Statistics Agency (ZSA). 2019.

21. MoH. Zambia National Health Strategic Plan 2017-2021.

22. UNFPA. UNFPA Annual Report. 2015

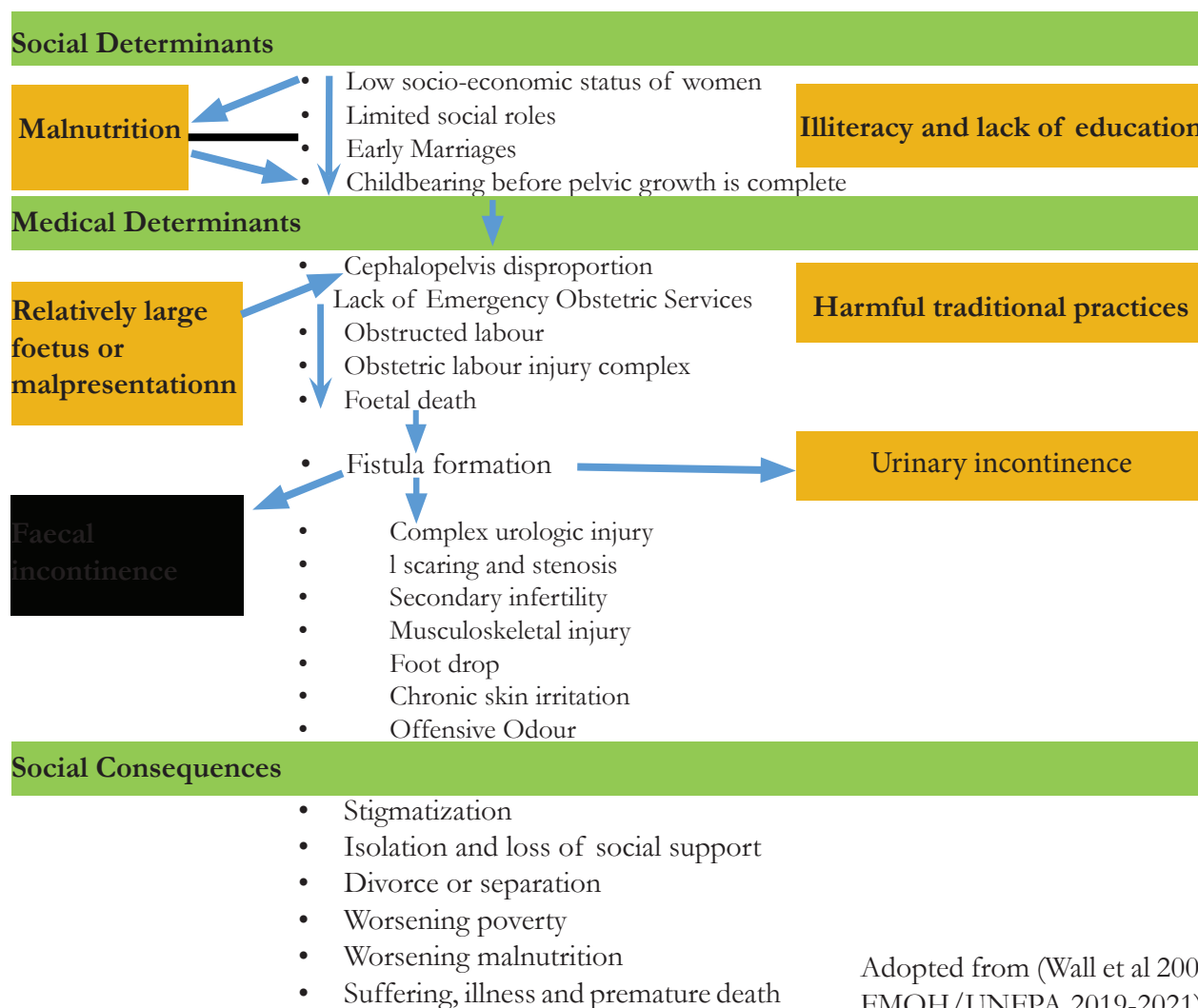
2.1 Socio-medical Determinants of Obstetric Fistula

According to Wall et al 2005, there are several factors that frame the obstetric fistula pathways and most of these factors are preventable. At social level, low socio-economic status of women, the limited social roles, early marriage and child bearing before full development of the pelvis are associated with obstetric fistula. These are further associated with illiteracy, lack of education and malnutrition as a consequence of these factors.

The second level of determinants pertain to medical conditions (obstetric factors) which result in obstetric fistula formation such as Cephalopelvis disproportion, Lack of Emergency Obstetric Services, Obstructed Labour, Obstetric Labour injury complex and Foetal death. Both the medical and social consequences of fistula result in stigma, isolation and loss of social support, divorce or separation, worsening poverty, worsening malnutrition, suffering, illness and premature death. All these factors and resulting consequences, signal the importance of integrated programming and depict the Zambian scenario.

Figure 1 show an illustration of these factors²³

Figure 1: Obstetric Fistula Pathways



Adopted from (Wall et al 2005, FMOH/UNFPA 2019-2021).

2.2 The Strategic Context

Childbearing in Zambia begins early, with more than one-third of women giving birth by age 18 and more than half giving birth by age 20. Twenty-nine percent of adolescent women aged 15-19 are already mothers or pregnant with their first child⁸. The Fistula Tracking Report indicated that 32.2% of the women were aged 15-19 years old for the pregnancy that caused the fistula and that 47.2% develop fistula on first pregnancy however, it is important to note that Multiparous women are equally at risk for OF²⁴. Fistula from prolonged or obstructed labour can strike any pregnant woman, regardless of her age or gravidity.

During the past two decades, Ministry of Health has built an impressive framework for improving access to health services including maternal and neonatal health. This has included a wide range of Policies and Strategies such as the Reproductive Health Policy 2000, the Adolescent Health Strategy 2017-2021, National Strategy on Ending Child Marriage 2016-2021, the Family Planning 2020 Scale Up Plan, RM-NCAH-N Roadmap 2018-2021, the National Health Strategic Plan 2017-2021 and the Seventh National Development Plan 2017-2021. All these strategies are linked to reduction of Obstetric Fistula.

The continued prioritization of maternal health will ensure that strategies important for the prevention of OF including increasing skilled birth attendance and access to EmONC, and improving community awareness through health promotion for better maternal health practices and outcomes are sustained.

2.3 Prevention of Obstetric Fistula

A number of initiatives are ongoing in the country that addresses prevention, at different levels of intensity and coverage. Primary obstetric fistula prevention in Zambia hinges on health systems strengthening for accessible, affordable and quality maternal health care services, including provision of family planning services, skilled birth attendance, basic and comprehensive emergency obstetric care and strengthening of social systems safety nets that empower women. Prevention of new cases is the cornerstone in the elimination of OF. The government has made strides in improving maternal health services as follows:

2.3.1 Health Promotion Services

With support from key partners such as UNFPA and Fistula Foundation, Zambia has been actively participating in the commemoration of key national and international health days linked to the fight against OF such as the Safe Motherhood Week, International Day to End Obstetric Fistula (IDEOF) etc. These are days during which community awareness campaigns to educate women about prevention methods and care during pregnancy and labour are conducted by health care providers, SMAGs and other CHVs. Community Sensitization and Mobilization has been a key health promotion strategy.

Sensitization and mobilization of fistula patients has been through three different ways: Routine PHC IEC activities; Fistula Camp model; and, Self-referral/referral by community based volunteers e.g. SMAGs. Fistula messages are delivered through churches, radio messages and health talks during community outreach. Patients identified are then referred to treatment centers.

To effectively enhance community sensitization and mobilization, there has been a robust implementation of several community-based mobilization strategies aimed at raising community awareness of OF. Ministry of Health with support from partners such as UNFPA and Fistula Foundation have employed

24. MoH. Fistula Tracking Study. 2015

a wide range of innovative community-based mobilization strategies including:

- i. Engagement of community local leaders such as traditional, church and civic leaders who act as gatekeepers in information dissemination.
- ii. Orientation of existing Safe Motherhood Action Groups (SMAGs) members and other Community Based Volunteers (CBVs) in the basic fistula key messages. These individuals in turn act as ambassadors in dissemination of OF messages in the community. The current SMAGs training curriculum has been reviewed and updated to include fistula prevention and management, in particular identification and referral.
- iii. Use of fistula survivors as community ambassadors for fistula identification – to help identify women with fistula and support their referral. Application of community-based screening using a standardized OF Community Based Assessment Tool (See tool in annex 1).
- iv. On-going distribution of I.E.C materials with fistula signs, symptoms, and referral information. IEC materials are currently available in English, Tonga, Bemba, and Chichewa. There is a need for these materials to be translated into all the other five main Zambian Languages (Nyanja, Lozi, Lunda, Kaonde and Luvale) apart from the currently used English and Bemba versions.
- v. Use of live and recorded radio talk shows which often feature the testimony from fistula survivors and expertise of fistula surgeons and other healthcare providers.
- vi. On-site orientation of primary health care providers in the prevention, identification and referral of fistula patients.

Despite all these innovations, there is still great need to intensify identification and referral activities at community level.

2.4 EmONC Services

Only 18% of EmONC facilities in Zambia are fully functional²⁵. Various factors contribute to poor quality of safe motherhood services in Zambia including inadequate infrastructure, insufficient skilled health personnel, an inefficient referral system, inadequate supplies of drugs, inadequate family planning services and information, lack of knowledge of danger signs and complications, young maternal age at first pregnancy and harmful traditional practices during labour and delivery.

Eighty four percent (84%) of deliveries in Zambia occur at health facilities, supervised by SBA²⁶. Births delivered somewhere other than a health facility (20%) are less likely to be attended by a skilled provider²⁷. In addition to access factors, ignorance, socio-cultural practices that impede timely decision-making in an event of prolonged obstructed labour, transportation and communication difficulties and cost may further limit the timely arrival at the health facility.

While timely cesarean section can prevent OF, in most cases fistula patients did not access this form of intervention on time. Although WHO recommends a caesarean section rate of 5-15%, Zambia stood

25. MoH. National Health Strategic Plan. 2017-2021

26. Zambia Statistics Agency. Zambia Demographic Health Survey. 2018. ocumentsZaCountry

27. Zambia Statistics Agency. ZDHS. 2018.

at 5% in 2018²⁸. This could be attributed to geographical, socioeconomic and cultural factors that limit equitable access to quality health services.

The percentage of home deliveries in Zambia have declined over the years from 52% in 2007 to 31% in 2013 and 16% in 2018²⁹. Based on these data, a sizeable percentage of births still take place in circumstances where women and infants are being exposed to conditions in which pregnancy related complications such as OF occur.

The Fistula Tracking Study showed that the majority of women who sustained fistula delayed at the Health Centre (46.2%) and Community level (42.3%) although they eventually delivered from the hospital. Patients perceived the fistula to have been caused by prolonged labour during delivery (42.5%), surgery (17.6%) and witchcraft (9.6%). The study showed that most survivors were in labor for up to 2 days (36.5%). Other studies have also found that on average a woman with OF stays in labour for 2.6 to 3 days³⁰

According to the UNFPA, OF Needs Assessment Study, the cost of transportation, the dearth of skilled health personnel, drugs, equipment and commodities all contribute to poor and delayed care at the health facilities. For example, the issue of transport is critical, given the size of the country, the cost of travelling and the poverty of clients in general—especially fistula clients³¹. All these factors work in tandem to adversely affect maternal outcomes, including formation of fistula.

2.5 Adolescent Health

According to the ZDHS of 2018, 29% of adolescents aged 15-19 had begun child bearing, while 24% had live births, and 5% were pregnant with their first child at the time of interview, 6% started childbearing at age 15. The Zambia Fistula Tracking Study of 2015, indicates that over half of the fistula clients (55 %) were young women, between the ages of 15-24, at the time when they experienced the obstetric fistula. Almost half (47.2 %) of the obstetric fistula resulted from the first pregnancy and these fistulas are related to early marriages owing to the non-fully developed pelvis in young girls, inability to go to a health facility for delivery and late ANC booking. According to the Ministry Of General Education School Re-entry Policy, supporting girls to continue their education and stopping child and early marriages and increasing access to contraception for adolescents are key strategies to preventing OF.

2.6 Family Planning

Reducing frequent and poorly spaced pregnancies through the use of contraception contributes to reduction in the risk of developing obstetric fistula. This is so because each new delivery carries some risks and therefore making sure all pregnancies are planned and spaced is important for reduction of maternal mortality/morbidity e.g. fistula. The modern contraceptive prevalence rate in Zambia is 50%. Among the Adolescents, the group that is most vulnerable to obstetric fistula, the rate is 10.2%³².

28. WHO.WHO Statement on Caesarean Section Rates. 2015. http://apps.who.int>WHO_RHR_15.02_eng.pdf

29. Zambia Statistics Agency. ZDHS. 2018.

30. MoH. National Training Operational Plan 2013-2016 and State of the World's Midwifery (Sowmy report 2014. <https://www.unfpa.org › sowmy-2014>

31. UNFPA/Engender Health. OF Needs Assessment Study. 2003. <https://www.unfpa.org/sites/default/files/pub-pdf/fistula.needs.assessment.pdf>

32. MoH. National Adolescent Health Strategy. 2017- 2021

2.7 Treatment and care

Zambia joined the UNFPA-led Global Campaign to End Fistula in 2005, and since then the capacity to repair fistula has grown. According to the National Health Strategic Plan 2017-2021, close to 2,000 fistula surgical repairs were done in the preceding 10 years.

In partnership with Zambia's Ministry of Health and provincial and district health offices, Fistula Foundation has played a key role in supporting fistula treatment to women across the country. Before the launch of the current Fistula Foundation's Treatment Network in 2017, there were only four committed trained fistula repair surgeons in the entire country, severely constraining women's access to timely fistula care. The Foundation has greatly contributed to the capacity building of fistula surgeons through the sponsorship of three more obstetricians / gynecologists at the FIGO approved training site for obstetric fistula repair in Kenya. Periodic fistula surgical outreach camps have been conducted at designated provincial treatment centers. These surgery outreach camps offer mentorship and skills transfer opportunities from the lead fistula surgeons to Resident Medical Officers and Obstetricians / Gynecologists with a view to achieve sustainable fistula patient care in the selected treatment centers. The Foundation further supports fistula treatment on routine basis in Lusaka at Chilenje Level 1 Hospital, Central Province at Kabwe General Hospital and in Southern province at Monze Mission Hospital.

Unfortunately, this potential OF service provision remains unlocked as many challenges, including the cost of services, competing demand for beds and limited OF surgery provision in health facilities. Currently, no obstetric fistula surgery is provided in private health facilities except in some Hospital facilities owned by the faith-based organizations. There is still a backlog coupled with new cases that surpasses the existing capacity to repair. Additionally, specific medical and surgical supplies and equipment for fistula care are inadequate making treatment a challenge.

2.8 Rehabilitation and Reintegration:

The 2015 Zambia Fistula Tracking Study indicates that a small proportion of fistula survivors are in need of continuous care even after treatment. They require longer term, more intensive clinical follow up, economic and social support. Current data shows that 71.5% survivors still lived with the same partner while 60% remarried after repair, and 73% were able to engage in sex after repair. Only 7.5% felt they were socially discriminated while 94% were still living with family members and 1.4% were isolated from their families. Generally, in Zambia reintegration after OF repair is good. However, there is still a proportion of survivors who may be inoperable and those with incontinence after repair. These women need social support, rehabilitation and reintegration.

It is important to link women returning to their communities with community-based organizations or community development social support structures that can offer health and other support, including income generation, social cash transfers and business development. For example, Fistula Foundation has since 2019 initiated a pilot fistula survivor empowerment model at selected sites in Luapula targeting fistula survivor in need of reintegration services. Plans are underway to roll out to other needy areas in the country. The repaired women themselves can be trained as fistula ambassadors to assist in identification and referral of other survivors and to advocate for improved service delivery.

2.9 Research in Obstetric Fistula

There are very few research studies on obstetric fistula conducted in Zambia. Those that have been conducted have been at local scale and primarily descriptive in nature³³. This situation is not unique to Zambia. Billows et al, 2015, state that low resource countries lack rigorous studies of the determinants, prevalence, distribution of fistula and barriers to fistula treatment³⁴.

There is need therefore for more studies that close the knowledge gaps in prevention, treatment, rehabilitation/re-integration including studies that will accurately demonstrate the incidence and prevalence rate. These kinds of studies can provide evidence based information to assist with prevention, treatment, rehabilitation/re-integration programming and policy decision making.

2.10 Monitoring and Evaluation of Obstetric Fistula Programmes

While partner supported programmes have M&E frameworks/indicators, not all of these indicators are measured in the national HMIS system. There is need therefore, for government to standardize the measurement indicators and integrate them in the existing HMIS system in order to have data that will give accurate information on policy and programming decisions.

According to WHO 2017, there are possible specific indicators that can be used for monitoring and evaluating fistula prevention, availability and quality of obstetric care and fistula repair. Any given country should include indicators in the following areas; epidemiology, service delivery, training and quality of care. Other indicators of clinical and social care should be developed in light of local circumstances³⁵.

2.11 Human Resource for Health:

According to the Zambia Demographic Health Survey 2018, 84% of deliveries are conducted by skilled attendants (doctors, midwives, nurses and clinical officers) at health facilities, while 16% are conducted at home.

Government has implemented a policy to train and employ more skilled staff through legacy goal number three. However, the training of surgeons and nursing staff in obstetric fistula management is still lagging behind. Midwives play a key role in prevention of OF.

About 50% of WHO member states report to have less than 3 nursing and midwifery personnel per 1000 population³⁶. There are insufficient numbers of nurses and midwives in Zambia, for example Nurses and midwives (per 1,000 people) in Zambia was reported at 1.0227 in 2018, according to the World Bank collection of development indicators, compiled from officially recognized sources. However, World Health Organization suggests that the standard midwife to patient ratio is 1:4.

33. Singini MG, 2017,'Obstetric Fistula Among women Aged 15-19 years in Zambia

34. Bellows et al. 2015. Barriers to Obstetric Fistula Treatment in Low-income Countries: A Systematic Review. Nairobi: Population Council

35. Ministry of Health, 'Zambia National Maternal and Neonatal Services Referral Guidelines. 2018.

36. <https://www.who.int/activities/strengthening-the-nursing-and-midwifery-agenda-globally>

2.12 Communication and Referral Systems:

Currently there is available at least one ambulance and one utility vehicle in each district. Maintaining an effective transport system is essential for ensuring a functioning and integrated health delivery system. The Ministry continues to experience transport constraints, which adversely impact operations. Basic life support ambulances are unevenly distributed across the provinces. Transport constraints are especially severe for rural-based health facilities; 30% of the health centres use motor bikes for service delivery; and some remote health centres use bicycles³⁷.

Zambia formulated and implemented national maternal and newborn referral guidelines to improve timely referral to higher centers. There has been a move to the use of modern communication technologies to widen access to expert consultations and decision-making processes for challenging cases through local and national WhatsApp groups³⁸. Referral of obstetric fistula patients to and from treatment centers is currently supported by the key cooperating partners such as the Fistula Foundation and UNFPA.

2.13 Health Infrastructure:

According to the MOH, the government has embarked on health infrastructure development; 35 district hospitals have been built and will require medical equipment. The Government is also upgrading health facilities from one level to another, which requires appropriate equipment. The upgrade programme is expected to improve the delivery of specialist tertiary care. By enhancing the functional capacities of hospitals, it is expected that the referral systems will be improved.

All these components of programming are required in order for the OF programme to run smoothly and meet the national goal and objectives.

37. MoH. Zambia National Health Strategic Plan, 2017-2021

38. Ministry of Health, 'Zambia National Maternal and Neonatal Services Referral Guidelines. 2018.

3.0 STRATEGIC DIRECTION

The strategic objective of this Obstetric Fistula Strategic Plan is to have national, institutional and community structures mobilized to deliver a package of fistula prevention, repair and reintegration services to all women and adolescent girls in Zambia. The MoH and partners will implement integrated catalytic interventions to strengthen fistula coordination and management. A model “Zambia End Fistula Model” has been adapted from the UNFPA and Fistula Foundation service delivery models. This blended model aims to prevent new fistula cases, eliminate fistula repair backlog and reintegrate fistula patients into normal life. In addition, research, communication, monitoring and evaluation will be implemented to facilitate improved service delivery.

Zambia’s Obstetric Fistula Strategic Plan 2022-2026 is premised on the need to promote universal access to obstetric fistula prevention, quality treatment and rehabilitative/re-integration services in line with the global campaign to end obstetric fistula by 2030. This Strategic Plan provides direction for service delivery for fistula prevention, treatment, rehabilitation, and reintegration as well as fistula research in Zambia. It will be applied to all levels of the Zambian Health care system – National, Provincial, District, Health Facility and Community Levels.

3.1 Vision

Zambia becomes a country free of obstetric fistula.

3.2 Mission

Strengthen the health care system to enable women and girls access quality, effective and affordable maternal health care services which address human rights issues including poverty, gender inequality, lack of education/illiteracy, early marriages and childbearing, through sustainable collaborative efforts with partners and stakeholders at all levels.

3.3 Goal

To end obstetric fistula in Zambia by the year 2030.

In order to contribute effectively to the attainment of the health sector goals, the main focus of the Obstetric Fistula Strategic Plan will be to:

- Promote good health seeking behaviour for reproductive health services including OF care.
- End the incidence of obstetric fistula by ensuring universal access to and utilization of quality sexual, reproductive and maternal health services for women in the reproductive age group.
- Strengthen and scale up obstetric fistula treatment nationwide to reduce the prevalence of obstetric fistula.
- Foster community participation, inter-sectoral and inter-disciplinary collaboration for the re-integration of obstetric fistula patients.
- Foster community participation, inter-sectoral and inter-disciplinary collaboration for addressing the social determinants of obstetric fistula.

3.5 Guiding Principles

This OF Strategic Plan shall be guided by several principles some of which are enunciated in the National Health Strategic Plan 2017-2021. These include:

- Primary health care
- Equity of access
- Affordability
- Cost-effectiveness
- Accountability
- Inter-sectoral actions and partnerships
- Decentralization, leadership, and governance
- Health systems strengthening
- Health is a basic human right.
- Gender responsiveness and sensitivity and social accountability
- Political commitment
- Community participation
- Integration into sexual and reproductive health programs and services

3.6 Strategic objectives

Six (6) key strategic objectives are outlined in order to facilitate effective prevention and management of obstetric fistula. These are to:

1. Prevent occurrence of new obstetric fistula cases.
2. Identify and treat all women living with fistula.
3. Rehabilitate and reintegrate women with post fistula repair into their community.
4. Provide effective leadership and an enabling environment that ensures adequate oversight and accountability for delivery of quality OF care.
5. Strengthen and facilitate research in OF for evidence-based decision making.
6. Strengthen monitoring and evaluation of OF activities.

3.7 Priority areas and interventions

The Obstetric Fistula Strategic Plan will be implemented over a period of five years from 2022 to 2026. Implementation will involve systematic planning, implementation and coordination of activities at national, provincial, district and community level harnessing the existing Ministry of Health organizational structure and partners with RMNCAH-N initiatives. The Strategy will be operationalized through the

End Fistula Intervention Model depicted in figure 2. Priority areas have been identified as follows:

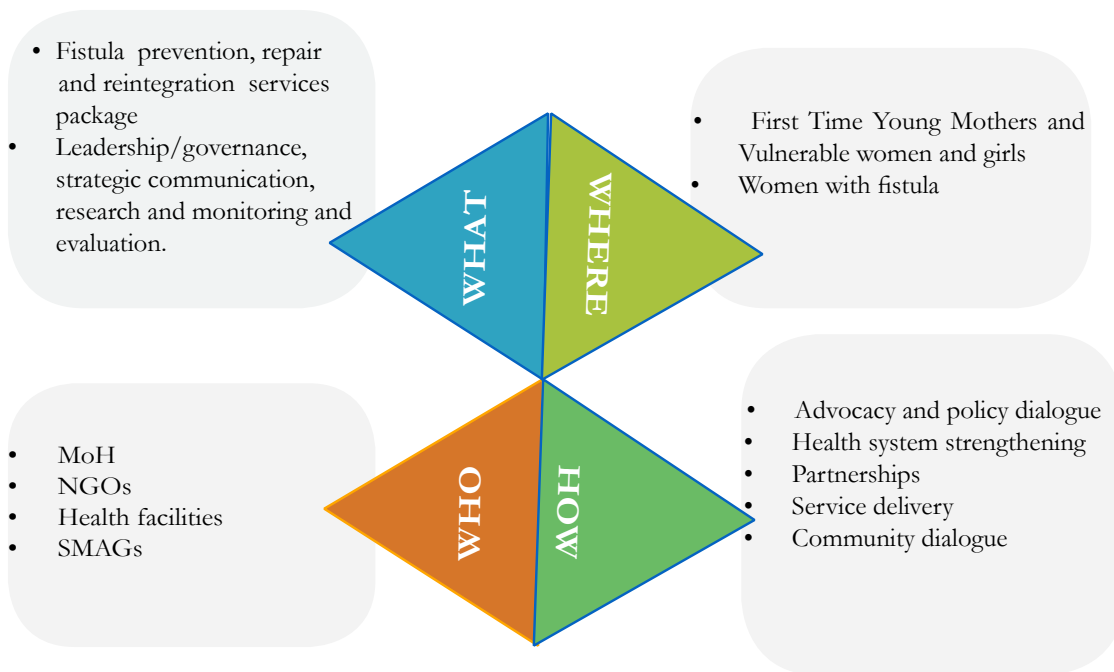
1. Obstetric fistula prevention
2. Obstetric fistula treatment
3. Obstetric fistula rehabilitation and re-integration
4. Leadership and governance
5. Research promotion
6. Monitoring and evaluation

Priority areas 4 through 6 are crosscutting and will be used as supportive pillars for successful implementation of the prevention, treatment and rehabilitation/re-integration priority areas.

Figure 2: The End Fistula Intervention Model

Levels of intervention

There are four levels of intervention. Levels A-D





- Fistula awareness creation and case identification-SMAGs
- Raising community awareness and facilitate reintegration
- Attention to first time young mothers
- Promotion of ANC and postnatal follow-up
- Fistula identification and referral



- Fistula prevention, referral and follow-up - Health centers
- All of Level A +
- ANC and birth planning
- Normal Labor monitoring using partogram and delivery and referral for prolonged labor
- Screening and counseling for fistula and referral and fistula counseling
- Follow up and referral for post operated cases including provision of family planning



- Fistula diagnosis, simple repair and prevention - District/Provincial level and Mission Hospitals
- All of Level B +
- Secondary prevention by catheterization for prolonged labor
- Routine simple repair and outreach camps in some select facilities
- Diagnosis and referral for fistula
- Availability of CEmONC



- Fistula Training and Repair Center- All Provincial Hospitals
- All of Level C+
- Repairs (simple -complex) using routine service delivery and camps
- Training opportunities for fistula repair and EmONC

THE OBSTETRIC FISTULA STRATEGIC PLAN PRIORITY AREAS, KEY INTERVENTIONS AND ACTIONS.

PRIORITY AREA 1: OBSTETRIC FISTULA PREVENTION

Prevention of obstetric fistula includes:

- Primary prevention interventions aimed at reducing the incidence of the condition which includes health promotion (programmes, policies), planned pregnancies, contraception and community awareness.
- Secondary prevention aimed at early diagnosis and effective treatment which includes antenatal care, skilled health personnel at birth, use of partograph, identification of signs and symptoms of obstructed labour, immediate referral and bladder care or catheterization during labour, if needed.

- Tertiary prevention focuses on the limitation of disability such as access to emergency obstetric and neonatal care (EmONC) by providing a timely, safe, quality caesarean section by a competent surgeon and use of an indwelling Foleys catheter to close small fresh fistulae.

The risk of obstetric fistula, 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. In this regard, obstetric fistula prevention should be integrated into on-going primary health care and maternal health interventions.

The social determinants of maternal morbidity and mortality that disempower women and compromise their health should be adequately addressed. These factors include the limited and/or lack of female education, early marriage and childbearing, poor nutrition of girls and women, female suppression etc. These are best addressed by effective collaboration with relevant sectors and stakeholders.

Strategic Objective 1: To increase access to Obstetric Fistula (OF) primary prevention services by 2026.

Intervention 1.1: Strengthen health promotion interventions and policies focused on OF

Service Delivery Location: Health facility – MCH department and community outreach sites

Activities:

- 1.1.1 Conduct feasibility studies in provision of health promotion interventions in selected districts, facility and communities in the 10 provinces by 6 officers for 10 days.
- 1.1.2 Conduct feasibility studies on community awareness on provision of reproductive health services in the health facilities in the 10 provinces by 6 officers for 10 days.

Intervention 1.2: Strengthen community awareness on obstetric fistula

Service Delivery Location: Health facility and community outreach site

Activities:

- 1.2.1 Hold 10 trainings for 250 SMAGs for 5 days in the 10 provinces with knowledge on risk factors of Obstetric Fistula.
- 1.2.2 Conduct quarterly mentorship sessions with SMAGs on OF management.
- 1.2.3 Conduct quarterly service quality assessment for LARC to the 10 provinces for 10 days by 10 supervisors per province.
- 1.2.4 Conduct quarterly service quality assessment for ANC to the 10 provinces for 10 days by 10 supervisors per province.
- 1.2.5 Hold 3 meetings to develop/translate IEC/BCC materials to cover all seven major Zambian languages by 25 participants for 7 days.
- 1.2.6 Train 500 SMAGs and CBVs per year for 25 participants per training for 5 days in OF identification and prevention.
- 1.2.7 Train 500 local leaders per year for 25 participants per training for 5 days to advocate for fistula prevention, support, and treatment.

Strategic objective 2: To increase access to OF secondary prevention services

Intervention 2.1: Strengthen HCW skills to provide quality obstetric care (LARC, ANC and EmONC)

Service Delivery Location: Health facility – MCH department

Activities:

2.1.1 Conduct 2 EmONC training meetings of health care providers 1 per province for 25 participants for 14 days in all the 10 provinces.

Strategic Objective 3: To increase access to OF tertiary prevention services

Intervention 3.1: Capacity building of HCWs in management of obstetric emergencies

Service Delivery Location: Health facilities and communities during outreach activities.

Activities:

3.1.1 Hold 10 trainings of 25 HCWs per province for 14 days in EmONC for all the 10 provinces.

3.1.2 Conduct orientation of 25 Health Care Workers in 10 provinces on the use of Maternal and Newborn Referral Guidelines for 5 days.

Strategic objective 4: To increase access to quality sexual and reproductive health services

Intervention 4.1: Increase access to quality sexual and reproductive health services (SRH)

Service Delivery Location: Health facilities and communities during outreach activities

Activities:

4.1.1 Train 250 health workers (25 per training) per province in Long Acting Reversible Contraception (LARC) and Post-Partum Family Planning (PPFP) for 10 days.

4.1.2 Conduct a CBD training of 250 Peer Educators per province for 10 days in the provision of short term family planning services at all levels.

4.1.3 Partner with NGO actors in the quarterly distribution of family planning commodities by 2 officers for 3 days per province in 10 provinces.

Strategic objective 5: To Enhance Social and Behaviour Change Communication (SBCC) on OF prevention.

Intervention 5.1: Obstetric fistula social behaviour change communication

Service Delivery Location: Health facilities, media houses and communities during outreach activities

Activities:

5.1.1 Conduct 10 quarterly local radio/TV programs on obstetric fistula matters across the 10 provinces.

5.1.2 Hold 10 quarterly community meetings to discuss obstetric care across the 10 provinces.

Strategic objective 6: To promote inter-sectoral collaboration

Intervention 6.1: Strengthen inter-sectoral collaboration in the implementation of OF programme

Service Delivery Location: National and subnational levels

Activities:

6.1.1 Conduct quarterly one day OF programme TWG meeting with 20 participants from line ministries, NGOs and UN Agencies.

6.1.2 Conduct training and formation of OF working groups -116 districts targeting 20 participants for 3 days.

PRIORITY AREA 2: OBSTETRIC FISTULA TREATMENT

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 training of personnel – doctors and nurses in obstetric fistula 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.

Strategic Objective 1: To identify and treat all women living with obstetric fistula.

Intervention 1.1: Strengthen health system capacity to provide quality, appropriate and accessible fistula treatment services.

Service Delivery Location: Health facilities

Activities:

1.1.1 Expand the number of obstetric fistula treatment centres from 7 to 12 with coverage of at least one centre per province.

1.1.2 Increase the number of routine and pooled (Camp) fistula repairs to at least one (1) fistula repair camp and 30 routine repairs per province per year.

1.1.3 Identify at least one committed OBGYN specialist doctor that will be responsible for routine fistula surgeries in each provincial hospital.

1.1.4 Conduct 30 workshops to orient 600 Nurses and Clinicians in management of obstructed labour and the use of catheterization for the prevention of obstetric fistula per year.

1.1.5 Strengthen the system for identification and referral of very difficult and complex OF cases to expert surgeons for further management.

1.1.6 Review and adapt protocols and guidelines for identification and tracking of obstetric fistula patients to treatment centres.

- 1.1.7 Launch and disseminate 10000 copies of protocols and guidelines.
- 1.1.8 Review the existing curriculum in obstetric fistula prevention and management for standardized basic and specialist training for clinicians and nurses.
- 1.1.9 Train 200 Nurse Tutors, Clinical Instructors and lecturers in obstetric fistula prevention and management in order to strengthen the mainstreaming of obstetric fistula in the pre-service training curricula of doctors, nurses, community health workers.
- 1.1.10 Sustain the supply of commodities and consumables for obstetric fistula management.
- 1.1.11 Procure at least two obstetric fistula (VVF) surgical sets per treatment centre per year in order to ensure adequate provision of required instruments and equipment for fistula management in treatment centres.
- 1.1.12 Develop and disseminate a list of fistula repair module to treatment centers and other health facilities.
- 1.1.13 Conduct forecasting and quantification of reproductive health commodities that includes supplies for OF repair.
- 1.1.14 Conduct annual needs assessment to inform the supplies and equipment needs.
- 1.1.15 Conduct quarterly provincial and annual national data review meetings of OF management.
- 1.1.16 Develop a service quality assessment tool for obstetric fistula management.
- 1.1.17 Procure necessary furniture and surgical equipment.

Intervention 1.2: Build capacity at community level in identification and referral of fistula patients.

Service Delivery Location: Health Facility

Activities:

- 1.2.1 Procure 5000 working tools (teaching aids, bicycles, gumboots, reflective vests, bags, raincoats and umbrellas) in order to support community based volunteers to identify and support women with OF to access treatment centers.
- 1.2.2 Procure community radios, airtime for monthly TV and radio programs to promote transmission OF messages and participation in obstetric fistula community awareness, sensitization and client mobilization.
- 1.2.3 Conduct 1 TOT of 20 SMAG trainers per province.
- 1.2.4 Conduct refresher training on OF management for 1000 SMAGs.
- 1.2.5 Revise and update the SMAG register, referral and reporting tools to include obstetric fistula.

Intervention 1.3: Build district and health facility capacity to plan and mobilize communities for fistula identification and referral.

Service Delivery Location: District and health facility level

Activities

- 1.3.1 District Health Offices to strengthen the identification of OF patients and plan and budget for patient mobilization to treatment facilities.
- 1.3.2 Review and update the postnatal home visit job aids to include questions about fistula identification at 6 weeks postnatal visit.
- 1.3.3 Review and adapt the OF screening tool for use at the health centres.
- 1.3.4 Build capacity in health care workers on the diagnosis of OF.
- 1.3.5 Orient the District Technical MPDSR committee on near-miss reviews including OF cases.
- 1.3.6 Conduct by-annual partnership meetings to discuss OF management including referrals.

Intervention 1.4: Strengthen the referral system for obstetric fistula clients.

Service Delivery Location: Community and health facility level

Activities

- 1.4.1 DHOs to plan and allocate funds towards transportation of OF clients.
- 1.4.2 Provide funds for referrals of five hundred (500) OF clients per year.
- 1.4.3 Hold quarterly community sensitizations meetings on OF referral support.

Intervention 1.5: Capacity building of obstetric fistula care teams.

Service Delivery Location: Sub-national level

Activities

- 1.5.1 Conduct ten (10) trainings of OF care teams comprising 2 clinicians (OBGYN, MO, ML) and 8 nurses per treatment centre in 10 provinces per year.
- 1.5.2 Conduct one training for 20 OF care support staff comprising physiotherapists and psychosocial counselors/social workers.
- 1.5.3 Conduct mentorship for trained fistula care teams (clinicians, nurses, physiotherapists and psychosocial counselors) during fistula treatment camps for at least 4 times per year per person.
- 1.5.4 Engage an international expert fistula surgeon once a year to provide mentorship during camps in managing complex fistula surgeries and fistula related surgeries.

Intervention 1.6: Strengthen obstetric fistula treatment support systems.

Service Delivery Location: National and sub-national levels

Activities

- 1.6.1 Establish fistula desk/screening in all health facilities to coordinate fistula activities.
- 1.6.2 Establish budget lines for obstetric fistula prevention and treatment at national and sub-national levels.
- 1.6.3 Mobilize additional resources from cooperating/implementing partners for obstetric fistula interventions.

PRIORITY AREA 3: OF REHABILITATION AND RE-INTERGRATION

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 obstetric fistula are still supported by their husbands. There is the need to develop client-centered needs-based rehabilitation and reintegration strategies that meet the needs of individual clients.

Strategic objective 1: To Rehabilitate and reintegrate OF survivors into their community

Intervention 1.1: Provide psychosocial support and physical rehabilitation to all OF survivors

Service Delivery Location: Community and health facility levels

Activities

- 1.1.1 Develop tools for needs assessment for psychosocial and physical rehabilitation needs for OF survivors
 - 1.1.2 Conduct needs assessment for psychosocial and rehabilitation needs for OF survivors
- Provide psychosocial support and rehabilitation services to OF survivors

Intervention 1.2: Identify women with inoperable fistula and support/link them according to their individual needs.

Service Delivery Location: Health facilities

Activities

- 1.2.1 Hold two (2) meetings for 20 participants to develop guidelines for declaring an obstetric fistula patient inoperable for three days.
- 1.2.2 Print 500 copies of the guidelines and disseminate treatment centres.
- 1.2.3 Hold an orientation meeting for 30 participants for one day.

Intervention 1.3: Establish and strengthen community support groups for the reintegration of OF survivors.

Service Delivery Location: Community

Activities

- 1.3.1 Hold a one day meeting for 25 participants in each of the 116 districts to orient provincial and district development coordinating committees (PDCC & DDCC) in OF survivors' support.
- 1.3.2 Conduct biannual technical support and supervisory visits to the existing two (2) community social support groups of OF survivors.
- 1.3.3 Hold a one day meeting with 20 OF survivors from each of the nine (9) provinces to orient and form OF survivors support group.
- 1.3.4 Train and empower eligible OF survivors in Income Generating Activities (IGAs) and link them to existing financial lending/savings institutions or groups.

PRIORITY AREA 4: LEADERSHIP AND GOVERNANCE

Effective leadership and governance are central to the realization of the goals and objectives of this OF Strategic Plan. Providing effective leadership and an enabling policy environment ensures adequate oversight and accountability for the delivery of quality obstetric fistula interventions that result in the elimination of obstetric fistula. This priority area promotes government's sense of ownership, specific intervention to lobby for the inclusion of OF in the reporting system of MoH (HMIS- Health management information system) and inclusion in training curricula at different levels.

The following implementation strategies will be used to achieve these aspirations.

Strategic Objective 1: To provide effective leadership and enabling environment that ensures adequate oversight and accountability for delivery of quality obstetric fistula care.

Intervention 1.1: Provide clear policies and plans and regulatory framework

Service Delivery Location: National and sub-national levels

Activities

- 1.1.1 Print and disseminate 10 000 copies of the OF Strategic Plan to all the 10 provinces.
- 1.1.2 Conduct quarterly advocacy meetings with 30 key OF actors and stakeholders for 3 days.
- 1.1.3 Provide technical support during development of annual plans to include OF activities for 10 participants for 10 days.
- 1.1.4 Conduct 3 meetings to develop protocols on identification and management of obstetric fistula for 30 participants for 6 days.

Intervention 1.2: Strengthen coordination at all levels to improve performance

Service Delivery Location: National and sub-national levels

Activities:

- 1.2.1 Convene quarterly coordination meetings of the National Obstetric Fistula Technical Working Group for 30 participants for day.
- 1.2.2 Conduct biannual technical meetings for 20 fistula management team members for 5 days.
- 1.2.3 Conduct quarterly planning and coordination meetings with 30 fistula practitioners and other stakeholders for 5 days.
- 1.2.4 Integrate OF data review in the provincial integrated meetings with 50 key stakeholders for 2 days.
- 1.2.5 Conduct national annual review meetings for all stakeholders on obstetric fistula for 100 participants for 2 days.

Intervention 1.3: Increase the number of health workers trained in obstetric fistula management

Service Delivery Location: National and sub-national levels

Activities

- 1.3.1 Conduct 3 meetings to develop a training package on identification and management of obstetric fistula for 30 participants for 6 days.
- 1.3.2 Conduct 1 training of trainers of health care providers in identification and management of obstetric fistula for 30 participants for 5 days.
- 1.3.3 Create a data base of all health workers trained in obstetric fistula management.
- 1.3.4 Hold 10 consultative meetings with health training institutions in order to strengthen curricula in obstetric fistula management for 30 participants for 5 days).

PRIORITY AREA 5: RESEARCH PROMOTION

Noting the limited investment in organized focused obstetric fistula 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 obstetric fistula action. Consequently, the following implementation strategies are proposed:

Strategic Objective 1: Strengthen research in OF to facilitate evidence-based decision making

Intervention 1.1: Strengthen National capacity for OF research in Zambia**Service Delivery Location: National level****Activities**

- 1.1.1 Support annual meeting for 30 participants to develop the National Obstetric Fistula research agenda for 5-days.
- 1.1.2 Hold quarterly meetings for 20 participants by the National Obstetric Fistula Research Working Group for 2 days.
- 1.1.3 Conduct annual training in OF research for 30 participants for 5 days.

Intervention 2.1: Increase resource mobilization and allocation for obstetric fistula research**Service Delivery Location: National level****Activities**

- 2.1.1 Hold a meeting to engage 20 parliamentarians and other stake holders in resource mobilization for OF research for 1 day.
- 2.1.2 Fund 1 research proposal on OF in all 10 provinces of Zambia.

Intervention 3.1: Strengthen strategic partnerships for dissemination and utilization of obstetric fistula research findings to inform policy and practice**Service Delivery Location: National level****Activities**

- 3.1.1 Create a repository for obstetric fistula - related research work in Zambia.
- 3.1.2 Support attendance and presentation of OF research papers at local and international conferences annually.

PRIORITY AREA 6: MONITORING AND EVALUATION

While obstetric fistula interventions have been going on for more than a decade and there has been no Strategic Plan developed and implemented, at the national, provincial, district, health facility and community level, data capture has been very weak, resulting in inadequate data to guide prevention, treatment rehabilitation and re-integration interventions. There is still no population-based data on the prevalence and incidence of obstetric fistula, and key determinants of the obstetric fistula problem.

Limited integration of OF with family planning and safe motherhood programs including in adolescent friendly sexual and reproductive health services still exists. Additionally, data from centres supported by partners are not regularly shared with the Ministry of Health and there is variability in the tools used by the different partners. In this regard, the need to capture, analyze and disseminate obstetric fistula data within the national HIMS is necessary.

Strategic Objective 1: To strengthen monitoring and evaluation of obstetric fistula activities

Intervention 1.1: Include fistula data in HMIS.

Service Delivery Location: National and sub-nations level

Activities

- 1.1.1 Formulate/adopt and submit obstetric fistula indicators to the M&E department at MoH.
- 1.1.2 Integrate fistula data review into DIM and PIM.
- 1.1.3 Hold annual national fistula data review meetings.
- 1.1.4 Conduct a mid-term evaluation of the OF Strategic Plan for 2022-2026.
- 1.1.5 Conduct end-term evaluation of the OF Strategic Plan for 2022-2026.

Intervention 2.1: Operationalize electronic database for obstetric fistula.

Service Delivery Location: National and sub-national level

Activities

- 1.1.6 Establish an electronic database for fistula survivors by the M&E department at MoH.
- 1.1.7 Replicate data base at all fistula treatment sites.
- 1.1.8 Adopt the WHO proposal of minimum 85% closure rate of first repairs and 90% should be without post repair incontinence.
- 1.1.9 Develop obstetric fistula indicators.
- 1.1.10 Roll out mobile electronic data capture technology to health facilities.
- 1.1.11 Employ the use of mobile technology for Obstetric Fistula data collection and transmission to improve effective and efficient reporting.

Intervention 3.1: Strengthen routine data generation and flow from Government/private facilities and community-based health Centres for the National Health Management Information System (NHMIS).

Service Delivery Location: National and sub-national.

Activities

- 3.1.1 Identify a core set of indicators for reporting obstetric fistula activities.
- 3.1.2 Harmonize data collection tools for use in government and private obstetric fistula health facilities.

- 3.1.3 Print and distribute the revised tools to promote usage.
- 3.1.4 Train the assigned health service providers on the revised tools.
- 3.1.5 Strengthen mainstreaming of obstetric fistula data needs into the HIMS.
- 3.1.6 Support regular analysis of data and reporting of obstetric fistula activities nation-wide.

Intervention 4.1: Strengthen human resources for Monitoring and Evaluation for obstetric fistula.

Service Delivery Location: National and sub-national level

Activities

- 4.1.1 Train Monitoring and Evaluation Officers at the national, provincial, district and facility levels.
- 4.1.2 Develop monitoring and evaluation plan and supervise sub-national Monitoring and Evaluation Officers and facility officers in charge of data collection and transmission.

Intervention 5.1: Strengthen national documentation of obstetric fistula programme learning and progress.

Service Delivery Location: National and sub-national level

Activities

- 5.1.1 Conduct baseline survey to determine prevalence, distribution and risk factors associated with obstetric fistula.
- 5.1.2 Conduct participatory midterm evaluation.
- 5.1.3 Conduct an external evaluation.

4.0 IMPLEMENTATION FRAMEWORK

The implementation of the Obstetric Fistula Strategic Plan will correspond with the different levels of the health care system, national, provincial, district, health facility and the community. Implementation will be guided by the existing policy, regulatory, institutional, coordination and monitoring and evaluation frameworks. The MoH Department of Public Health will be responsible for the overall implementation of the Obstetric Fistula Strategic Plan countrywide through the National Safe Motherhood Technical Working Group and the OF Subcommittee.

In addition, the Department of Public Health, will spearhead coordination, monitoring and evaluation and supportive supervision including; service delivery quality assessments, performance assessments, training/mentorship, nationally endorsed research studies, baseline surveys, joint reviews and mid-term and end of the strategic plan evaluation.

4.1. Operationalization of the OF Strategic Plan.

Strengthening the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N) Platform

Operationalization of the OF Strategic Plan will be based on key program strategies and interventions that will strengthen the RMNCAH-N platform. The focus will be on the provision of quality family planning, antenatal, Intrapartum, and postnatal care through linkages with the community level health promotion and prevention activities. Implementation of the plan will be achieved by utilizing the existing health system and service delivery mechanisms. Emphasis will be on prevention of OF by building capacity at community level and district management teams to improve program coordination, supervision, mentorship, and evidence –based planning in line with the NHSP 2022-2026, 8th NDP and Vision 2030. Women with OF will be referred directly to the treatment centers from the community through the health facilities.

4.2: Implementation at national level

At national level, the first-year activities in the 2022-2026 OF strategic plan will primarily focus on baseline research, preparation of training manuals, management guidelines and Standard Operating Procedures (SOPs) for national, provincial, district and community level. The OF Subcommittee will support provincial fistula teams to adapt and implement the OF Strategic Plan by participating in the provincial planning and review meetings. The table below illustrates the key roles and responsibilities of the different stakeholders; the MoH, Parliament and Political Leadership, National Safe-motherhood Technical Working Group and the OF Subcommittee.

Roles and Responsibilities at National Level

1. MoH , Parliament and Political Leadership

- Provide national leadership to position Zambia among countries with strong commitment to elimination of OF.
- Foster effective collaboration and synergy between SRMNCAH-N areas around the goals of decreasing maternal, neonatal, child and adolescent morbidity and mortality.
- Ensure implementation of the strategic plan to eliminate OF.
- Foster and support implementation of the strategic plan to establish efficient institutional management systems at all levels, building on existing structures and mechanisms.
- Provide overall policy and technical leadership, guidance, advice, resource allocation, monitoring and evaluation for the strategic plan.
- Support multi-sectoral collaboration with other concerned line ministries and cooperating partners.
- Ministry of Health and other stakeholders will prepare national OF management guidelines, SOPs and training manuals.

2. National Safe-motherhood Technical Working Group

Spearhead planning and implementation of the national baseline research

Spearhead the development of training manuals, management guidelines and standard operating procedures (SOPs) for national, provincial, district and community level related to obstetric fistula

3. Obstetric Fistula Sub-committee

- Provide technical advice to the National Safe-Motherhood Technical Working Group for the implementation of the plan at national, provincial, district and community level.
- Ensure that national and sub-national plans, guidelines, and protocols are endorsed and implemented by all stakeholders.
- Support the implementation of the plan and mobilization of resources for its implementation.
- Provide technical input in the development of guidelines, protocols, and training manuals.
- Support provincial fistula teams to adapt and implement the OF Strategic Plan by participating in the provincial planning launches and review meetings.

Other Key Actions at National Level

- Review and communicate OF related national protocols, policies, guidelines training manuals (such as the Safe-motherhood and EmONC policies and guidelines, the OF Strategic Plan and systems with provincial managers.
- Strengthen provincial ownership and support of the OF Strategic Plan.
- Develop and/or review standard operating procedures and making them available in the provinces, districts, and health facilities including the SRMNCAH-N communication and advocacy strategy, and WHO communication framework for 2017.

- Strengthen multi-sectoral approach to supporting OF management.
- Integrate OF interventions in adolescent programming.
- Provide supportive supervision to OF teams.
- Increase resource allocation for OF interventions including materials and human resources.

4.3 Implementation at Provincial Level

The Provincial level will be responsible for coordination, monitoring and evaluation and supportive supervision. The provincial management teams and provincial Safe-motherhood Technical Working Group and the OF Sub-committee will provide provincial level coordination and provide technical oversight to district management teams/TWGs.

Roles and Responsibilities at Provincial Level

- The provincial MPDSR Committee will monitor the implementation of MPDSR activities in the OF Strategic Plan.
- Identify and prioritize high OF prevalence areas for technical logistics support.
- Conduct biannual reviews of the OF Strategic Plan through the OF Sub-committee.
- Strengthen OF reporting at provincial level.
- Conduct data reviews at the provincial level to inform programming and decision making.
- Plan and conduct capacity building activities in OF health care.
- Provide OF supportive tools (e.g. Safe-motherhood/EmONC strategies and guidelines and all relevant treatment protocols and SOPs) to districts and health facility staff.
- Ensure availability of medical/surgical supplies and equipment at health facility level

4.4 Implementation at District Level

The District Health Office (DHO) will support health centres to ensure effective identification, mobilization and referral to treatment centers with follow up and community linkages. The district and health centre level will lead demand creation such as community meetings on SRMNCH services and also the integrated SRMNCH outreach services.

Roles and Responsibilities at District Level

- Communicate OF related policies, SOPs and the OF Strategic Plan, to facility managers to encourage facility-level actions.
- Encourage facility managers to take ownership and support the implementation of the key policies/guidelines and the OF Strategic Plan.
- Ensure the availability of information and educational materials at the health facility level for onward distribution to community level.
- Plan and conduct OF capacity building activities for facility level.
- Strengthen resource mobilization for implementation of OF interventions.
- Ensure availability of medical/surgical supplies and equipment for OF management.

- Provide health facility staff with work tools e.g. education materials, OF practice aids and M&E data collection and reporting tools.
- Provide integrated supportive supervision and mentorship to health facilities.

4.5 Implementation at Health Centre Level

The health centre level will support community linkages to ensure identification and referral of all suspected cases of OF to health facilities. In addition, health care providers will collect and report progress data on access and utilization of OF services to the district level.

Roles and Responsibilities at Health Facility Level

- Ensure national policies and guidelines, standard operational procedures and the OF Strategic Plan are utilized at health facility level.
- Ensure mobilization of OF survivors in collaboration with existing community structures.
- Ensure timely referral of survivors for surgery in collaboration with existing community structures.
- Provide regular supportive supervision to volunteers to promote effective implementation of community-based awareness, education, referral and community mobilization activities.
- Identify community resources and build synergetic partnerships for effective implementation of advocacy and OF services.
- Plan and conduct training for community volunteers and health facility staff involved in OF service delivery as well as safe-motherhood care and support.
- Support reintegration of treated patients into the community.

4.6: Implementation at Community Level

Community level actions are key in ensuring sustainable behaviour change. In this strategic plan, community mobilization for identification and referral of OF clients, awareness and education and enhanced behaviour change will be a key element of the programme. Building capacity of community based volunteers such as SMAGs and traditional/religious/civic leadership will be a conduit for increased community participation. Outreach activities will not only bring services closer to community members, but will also promote affordability, increased access to services, improved rehabilitation and re-integration of OF survivors and promotion/improved individual and family-based livelihoods.

Roles and Responsibilities at Community Level

- Use community structures and social mobilization to mobilize communities to support OF activities.
- Promote collaboration with community leadership in implementation of OF activities.
- Promote engagement with relevant stakeholders in decision making on OF targeted programmes.
- Coordinate the reintegration, rehabilitation and economic empowerment activities with civic leaders and other stakeholders.
- Establish OF survivors support groups.

5.0 MONITORING AND EVALUATION

Collecting, analyzing and using information to track programme progress to guide management decisions is key in any given programming work. Monitoring and evaluation is and will be a key component for effective implementation of the OF Strategic Plan. In order to accomplish the objectives of the strategic plan, greater coordination of all players at national, provincial, district, health facility and community level for increased access and utilization of OF services is necessary.

In this strategic plan, monitoring and evaluation shall be the responsibility of the Ministry of Health, exercised through the directorate responsible for monitoring and evaluation in collaboration with the Safe-motherhood Unit under the Directorate of Public Health. The Ministry of Health at national level will develop guidelines and provide oversight for implementation of monitoring and evaluation activities. The National Safe Motherhood Technical Working Group through the monitoring and evaluation team will support technical oversight working closely with the service delivery team.

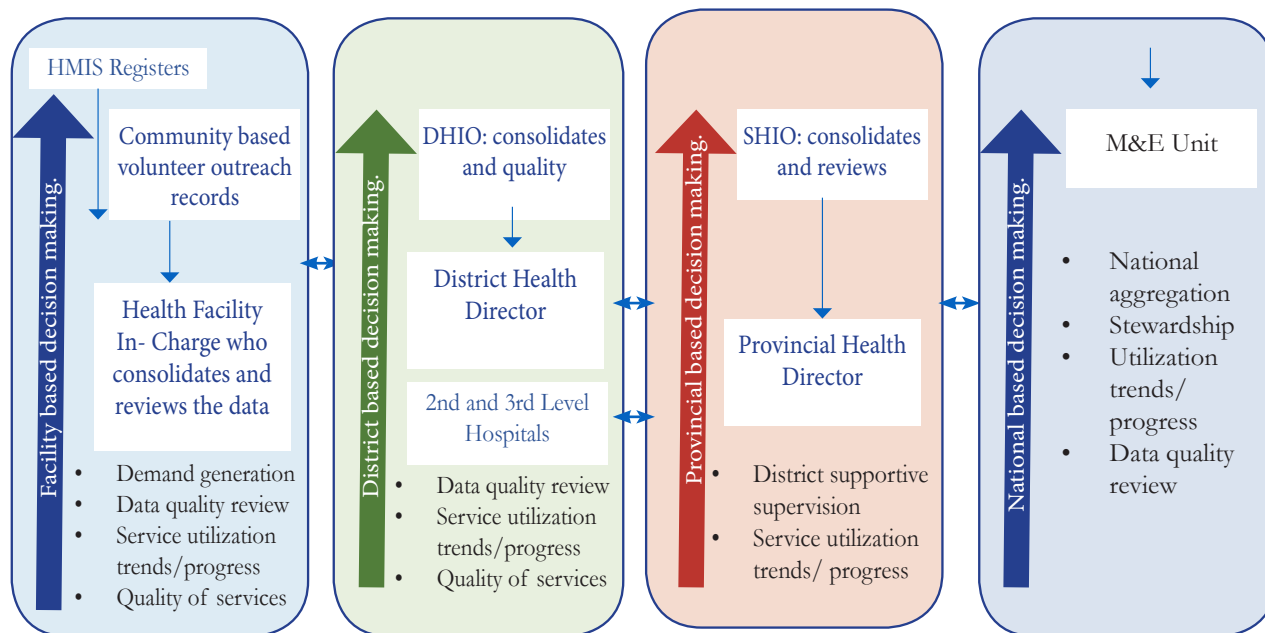
At implementation level, existing monitoring and evaluation systems at provincial and district levels will continue to collect data and report monthly to the national level. Routine monitoring of the implementation of the strategic plan will be a key responsibility for the District Health Office. This will be done through coordination of health facility activities. Service delivery data is expected to be submitted to the District and Provincial Health Offices, depending on the level of care, for consolidation in order to assess the overall implementation of the OF Strategic Plan.

The HMIS has existing registers which facilitate collection of OF related information. These include but not limited to the: Safe-motherhood, Labour, Delivery, GBV, Postnatal Care, Adolescent Health and Family Planning. Currently, there are a number of OF data collection tools being used by different partners which need to be standardized and harmonized for national, provincial, district, health facility and community information dissemination in order to improve OF services at public, private and faith-based health facilities as well as community care. In addition, tools such as the service quality assessment (SQAs) will be used to assess the quality of care provided to clients.

Data flow will be linked to the existing health system data collection, analysis, reporting and information sharing processes. Under the management of designated health systems level specific focal point persons and using existing HMIS system data collection tools, data will be collected from its primary source at primary health care level.

Figure 2 below illustrates how data will flow from the community through health facility, district and province, up to the national level.

Figure 2: Health System Data Flow



Adapted from the ADH Operational Plan

5.1: Results Framework

PRIORITY AREA 1: PREVENTION							
Strategic Objective 1: Prevent occurrence of new obstetric fistula cases							
Outcome: Increase access to quality sexual reproductive health services and empowering girls and women							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Contraceptive prevalence rate.	The percentage of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used	Every 4 years	50%		ZDHS 2018	Assumption-1: Political will and commitment to OF intervention programmes by all stakeholders sustained.
2	Proportion of OF Survivors that accessed family planning services.	Number of OF survivors provided with family planning services.	Quarterly		80%	HMIS	

3	Proportion of deliveries supervised by skilled birth attendant.	The proportion of births supervised by skilled health personnel.	Quarterly	68%	80%	HMIS/HIA2	Assumption-2: Stable and committed government – through MoH HQ and Sub-National Levels. Assumption-3: Timely release of OF funds for planned activities
4	Proportion of health facilities providing EmOC functions.	Number of health facilities providing EmOC functions	Every 5years	68%	100	Programme reports	
5	Proportion of deliveries by Caesarean section.	Percentage of births by caesarean section among all live births in a given time period.	Quarterly	8.7%	≤10	HMIS HIA2	
6	Proportion of deliveries managed using partograph.	Number of deliveries monitored using a partograph.	Biannual			Programme reports Performance assessment tool	
7	Number of health workers trained in EmOC.	Number of health workers trained in EmOC.	Annually			Programme reports	
8	Proportional of eligible facilities with protocols and guidelines for management of OF.	Number of facilities with protocols and guidelines for management of fistula.	Annually	7	12	Programme reports	
9	Number of CHVs and SMAGs trained in basic obstetric fistula.	Number of CHVs and SMAG trained in basic OF	Biannual	1464	2500	Programme reports	
10	Number of community engagement and sensitization activities conducted.	Community sensitisation activities conducted on obstetric fistula	Biannual	2081	300,000	Programme reports	

PRIORITY AREA 2: TREATMENT							
Strategic Objective 2: Identify and treat all women living with fistula							
Outcome: Prevalence of obstetric fistula reduced.							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Number of fistula surgeries and related procedures performed.	Eligible fistula and related surgeries performed	Quarterly	284	2500	Programme reports	Assumption: Health workers available for training at facility level Assumption: Availability of motivated trained personnel
2	Number of supportive supervision visits conducted for managers and health care providers.	Conducting technical supportive and supervisory visits	Quarterly	0	240	Programme reports	
3	Number of health facilities equipped to provide quality obstetric fistula management	Facilities that have been accredited to provide obstetric fistula management	Biannual	7	12	Performance assessment tool	
4	Proportion of obstetric fistula clients that received successful surgical treatment.	Number of women declared dry at discharge	Quarterly	85%	100%	Programme reports	

PRIORITY AREA 3: REHABILITATION AND RE-INTEGRATION							
Strategic Objective 3: Rehabilitate and reintegrate women affected by fistula into their community.							
Outcome: Number of rehabilitated obstetric fistula women increased.							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Proportion of eligible fistula survivors that receive rehabilitation and reintegration services.	Eligible women receiving rehabilitation and reintegration services.	Quarterly	50%	100%	Programme reports	Assumption: Community leaders and family heads providing support. There will be male involvement. Timely support.
2	Proportional of OF survivors visited.	Number of visits made to fistula survivors	Quarterly	52%	100%	Programme report	
3	Number of people reached through outreach activities.	Individuals reached during an outreach activity		6550	7,500,000	Programme report	

PRIORITY AREA 4: LEADERSHIP AND GOVERNANCE							
Strategic Objective 4: Provide effective leadership and enabling environment that ensures adequate oversight and accountability for delivery of quality obstetric fistula care.							
Outcome: Enhanced leadership and governance capacity for obstetric fistula related activities.							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Obstetric fistula - protocols and guidelines developed and adopted,	Obstetric fistula protocols and guidelines developed and adopted in line with emerging trends	Once	0	1	Programme report	Availability of resources for the meetings.
2	Proportion of facilities with obstetric fistula IEC materials.	Number of facilities with IEC materials on OF.	Quarterly	0	12	Programme report	
3	Number of Obstetric Fistula Technical Working group meetings held.	National TWG meeting held.	Biannual	0	20	Programme reports	
4	Number of fistula Sub-National Technical Working Groups established in provinces.	Sub National TWG established.	Annually	0	10	Programme reports	
5	Number of scientific seminars and conferences attended at local and international levels.	Scientific seminars and conferences attended.	Annually	0	5	Programme reports	

PRIORITY AREA 5: RESEARCH PROMOTION							
Strategic Objective 5: Strengthen and facilitate research in OF for evidence based decision making.							
Outcome: Enhanced capacity and output of obstetric fistula related research.							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Number of operational research undertaken in obstetric fistula	Operational research conducted	Annually	0	5	Programme reports	Availability of personnel committed to the work
2	Percentage of funding allocated for Obstetric Fistula research at national and sub-national levels.	Amount of funds allocated for OF research.	Annually	0	20%	Budget briefs	

PRIORITY AREA 6: MONITORING AND EVALUATION							
Strategic Objective 6: Strengthen monitoring and evaluation of fistula activities							
Outcome: Obstetric fistula monitoring and evaluation system strengthened							
No.	Indicator	Indicator Definition	Frequency	Baseline	Target	Means of Verification	Assumptions
1	Data collection tools revised.	Data collection tools revised to include obstetric fistula indicators.	Annually	0	1	Programme report	Availability of Resources Indicator: Number of monitoring reviews meetings held
2	Number of Monitoring and Evaluation Officers trained in obstetric fistula data management.	Monitoring and Evaluation Officers trained in obstetric fistula data management using revised tools.	Annually	0	24	Programme reports	
3	Number of data review meetings held.	Obstetric fistula data review meetings.	Quarterly	0	20	Programme reports	
4	Number of treatment centres provided with TSS	Treatment facilities provided with TSS		0	240	Programme reports	

6.0

COSTING OF THE OBSTETRIC FISTULA STRATEGIC PLAN 2022 – 2026

6.1 Overview

The cost estimates of the Obstetric Fistula Strategic Plan 2022 – 2026 purposes at supporting strategic planning, evidence-based decision making as well as domestic and donor resource mobilization. The estimation of the resource needs will also support the operationalization of the OF Strategic Plan in a transparent and accountable manner.

The costing methodology that was used in estimating the resource needs of the plan was activity-based budgeting. This entails the identification of the activities, the inputs required to carry out these activities, the unit costs of the inputs and the associated quantities. The cost is simply the summing up of product of quantity and price of each input used in undertaking the activity. The ingredient approach was used to identify the specific inputs needed to carry out each intervention and the targets set in consultation with the programme focal point persons.

The costing framework used is a model used by the Ministry for detailed inputs and costing of plans under the Medium-Term Expenditure Framework (MTEF) and Annual Action Planning (AAP) and budgeting processes. This alignment to the existing planning and budgeting approaches was considered necessary, in order to avoid multiplicity of methods/approaches, for ease of implementation.

The unit costs baselines were for the year 2021 and these were the prevailing market prices of goods and services and other costs were based on the standard prices set by the Government of the Republic of Zambia (e.g., allowances). The baseline unit prices were then compounded to reflect future values at the rate of 8.5%³⁹ as the cost of capital. The prices were converted into US Dollars at the exchange rate of ZMW19.7 per US\$1.00.⁴⁰

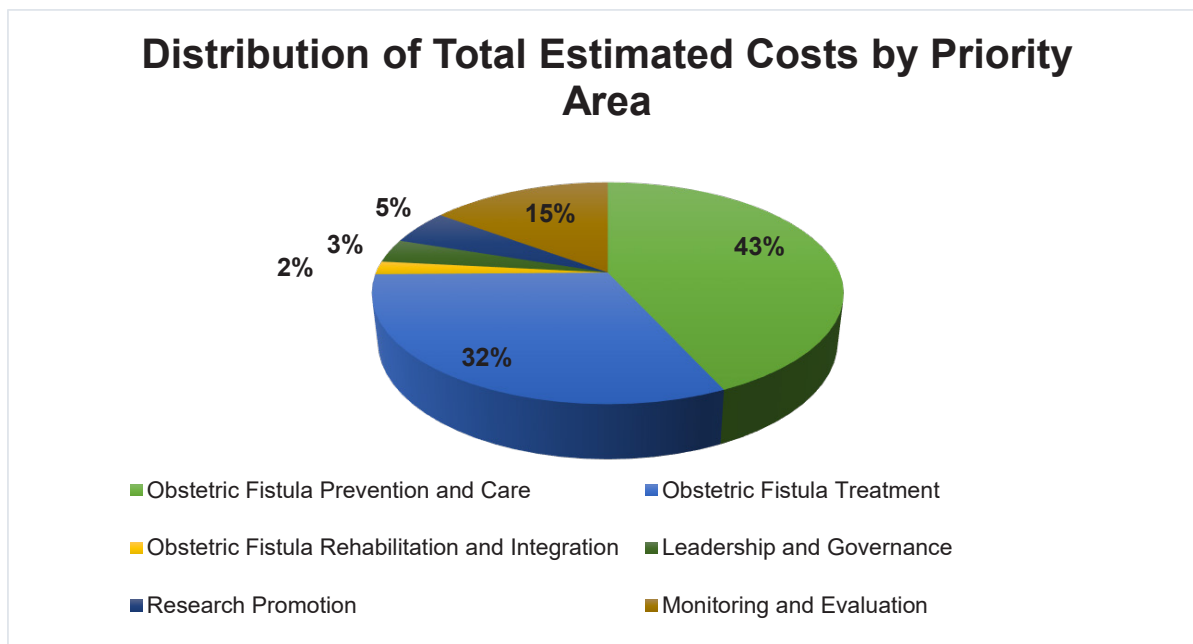
The costings were based on the following key assumptions:

- i. **Costing method:** Activity-based Budgeting (ABB) approach was used, in line with the established costing practices within the Ministry of Health.
- ii. **Duration:** The costing covers a duration of five (5) years, from 2022 to 2026. This is intended to realign the current National Health Strategic Plan 2022-2026 (NHSP).
- iii. **Currency used:** US Dollars (US\$). During the costing exercise, the Zambian Kwacha was used but converted into US Dollars at an exchange rate of ZMW 19.7.00
- iv. **Cost of Capital:** The cost of capital (interest rate) used in this plan is 8.5% as a compounding factor to reflect future values for the 2021 baseline prices.
- v. **Staff Travel Allowances:** Staff travel allowances are determined by the Government from time to time.
- vi. **Sources of Funding:** It is assumed that the budget will be funded from a combination of sources, including: the national budget, through annual budgetary allocations; from established/active cooperating partners, who are currently supporting the OF programmes; and from new partners and funding initiatives, through advocacy of the programme activities and solicitation for support.

39. Bank of Zambia, 2020

40. Budget Call Circular, 2021

The total cost of the OF Strategic Plan 2022-2026 is estimated at **US\$ 76.8 Million**. Figure 1 below shows the distribution of the total estimated costs by priority area namely OF Prevention, OF Treatment, OF Rehabilitation and Re-integration, Leadership and Governance, Research Promotion and Monitoring and Evaluation. The OF Prevention priority area accounts for the highest share amounting to 43% (US\$ 33.2 Million) followed by OF Treatment amounting to 32% (US\$ 24.3 Million). The OF Rehabilitation and Re-integration priority area accounts for the lowest share amounting to 2% (US\$ 1.5 Million).



The cost estimations were also done per year by priority area. Table 1 below shows the distribution of the estimated costs by priority area of the OF Strategic Plan 2022 - 2026.

PRIORITY AREA	COST (US \$)					TOTAL
	YR 2022	YR 2023	YR 2024	YR 2025	YR 2026	
Obstetric Fistula Prevention	6,587,695.31	5,822,203.71	6,381,169.77	6,854,043.77	7,512,072.59	33,157,185.15
Obstetric Fistula Treatment	6,102,438.37	4,441,224.63	4,612,132.07	4,366,808.99	4,737,987.75	24,260,591.81
Obstetric Fistula Rehabilitation and Re-integration	496,006.54	216,014.81	234,376.07	254,298.04	275,913.37	1,476,608.83
Leadership and Governance	579,366.32	452,138.06	490,569.80	532,268.23	577,511.03	2,631,853.43
Research Promotion	776,004.94	687,706.81	746,161.70	809,586.01	878,400.91	3,897,860.37
Monitoring and Evaluation	2,525,572.95	1,874,920.65	2,002,453.17	2,317,642.56	2,668,392.60	11,388,981.92
TOTAL	17,067,084.43	13,494,208.67	14,466,862.58	15,134,647.58	16,650,278.25	76,813,081.50

Table 1: Distribution of the estimated costs by Priority Area per year.

The OF Strategic Plan and budget will be implemented through the established MTEF and Annual Action Planning (AAP) and budgeting frameworks. These frameworks also involve the participation of the health sector partners, who take part in the planning, budgeting, prioritization and identification of areas to support. During these planning cycles, each thematic programme will determine the financing gaps, based on the government planning figures and the available funding and pledges received from the cooperating partners.

6.2 Total OF Strategic Plan Costs by Strategy

Each of the priority areas has the objectives that have been further broken down into strategies. The tables below are for each priority area and they show the total costs for each strategy per year for the period 2022-2026.

1. Obstetric Fistula Prevention

#	OBJECTIVE	#	STRATEGY	COST (US \$)					TOTAL
				2022	2023	2024	2025	2026	
1.1	To increase access to Obstetric Fistula (OF) primary prevention services by 2026	1.1.1	Strengthen health promotion interventions and policies focused on OF	392,421	-	-	-	-	392,421
		1.1.2	Strengthen Community awareness on Obstetric fistula	2,785,581	2,638,418	2,926,762	3,106,012	3,445,458	14,902,231
Sub-Total				3,178,002	2,638,418	2,926,762	3,106,012	3,445,458	15,294,652
1.2	To increase access to OF secondary prevention services	1.2.1	Strengthen HCW skills to provide quality Obstetric care (LARC, ANC, EmONC)	491,968	533,785	579,157	628,385	681,798	2,915,092
Sub-Total				491,968	533,785	579,157	628,385	681,798	2,915,092
1.3	To increase access to OF Tertiary Prevention Services	1.3.1	Capacity building of HCWs in management of obstetric emergencies	854,135	926,737	1,005,509	1,090,978	1,183,711	5,061,070
Sub-Total				854,135	926,737	1,005,509	1,090,978	1,183,711	5,061,070
1.4	To increase access to quality sexual and reproductive health services	1.4.1	Increase access to quality sexual and reproductive health services (SRH)	719,572	780,736	847,098	919,101	997,225	4,263,732
Sub-Total				719,572	780,736	847,098	919,101	997,225	4,263,732

1.5	To enhance Social and Behaviour Change Communication (SBCC) on OF prevention.	1.5.1	Obstetric fistula social behaviour change communication	188,008	203,989	221,328	240,140	260,552	1,114,017
Sub-Total				188,008	203,989	221,328	240,140	260,552	1,114,017
1.6	To promote inter-sectoral collaboration	1.6.1	Strengthen inter-sectoral collaboration in the implementation of OF programme	1,156,011	738,540	801,315	869,427	943,329	4,508,622
Sub-Total				1,156,011	738,540	801,315	869,427	943,329	4,508,622
			TOTAL - FISTULA PRE-VENTION	6,587,695	5,822,204	6,381,170	6,854,044	7,512,073	33,157,185

2. Obstetric Fistula Treatment

#	OBJECTIVE #	STRATEGY	COST (US \$)					TOTAL	
			2022	2023	2024	2025	2026		
2.1	To identify and treat all women living with obstetric fistula.	2.1.1	Strengthen health system capacity to provide quality, appropriate and accessible fistula treatment services.	2,112,585	2,501,405	3,301,447	2,944,716	3,195,017	14,055,170
		2.1.2	Build capacity at community level in identification and referral of fistula patients	2,926,551	819,564	95,207	103,299	112,080	4,056,700
		2.1.3	Build district and health facility capacity to plan and mobilize communities for fistula identification and referral.	903,061	979,822	1,063,107	1,153,471	1,251,516	5,350,976
		2.1.4	Establish an effective fistula client identification and referral system.	30,807	-	-	-	-	30,807
		2.1.5	Provide standardized training for obstetric fistula care teams.	129,433	140,435	152,372	165,323	179,376	766,938
		2.1.6	Establish sustainable obstetric fistula treatment support systems.	-	-	-	-	-	-
Sub-Total			6,102,438	4,441,225	4,612,132	4,366,809	4,737,988	24,260,592	
TOTAL - OBSTETRIC FISTULA TREATMENT			6,102,438	4,441,225	4,612,132	4,366,809	4,737,988	24,260,592	

3. Obstetric Fistula Rehabilitation and Re-integration

#	OBJECTIVE #	STRATEGY	COST (US \$)					TOTAL	
			2022	2023	2024	2025	2026		
3.1	To rehabilitate and reintegrate women affected by fistula into their community	3.1.1	Provide psychosocial support to all fistula survivors	146,907	52,264	56,706	61,526	66,756	384,160
		3.1.2	Identify women with inoperable fistula and support/link them according to their individual needs.	19,178	-	-	-	-	19,178
		3.1.3	Establish community support groups for fistula survivors.	174,922	105,433	114,395	124,119	134,669	
		3.1.4	Establish linkages for physical rehabilitation and integration services.	155,000	58,317	63,274	68,653	74,488	419,733
Sub-Total			496,007	216,015	234,376	254,298	275,913	1,476,609	
TOTAL - OBSTETRIC FISTULA REHABILITATION AND INTEGRATION			496,007	216,015	234,376	254,298	275,913	1,476,609	

4. Leadership and Governance

#	OBJECTIVE #	STRATEGY	COST (US \$)					TOTAL	
			2022	2023	2024	2025	2026		
4.1	To provide effective leadership and enabling environment that ensures adequate oversight and accountability for delivery of quality obstetric fistula care	4.1.1	Provide clear policies and plans and regulatory framework	216,588	234,998	254,973	276,646	300,160	1,283,365
		4.1.2	Strengthen coordination at all levels to improve performance	151,677	164,570	178,559	193,736	210,204	898,746
		4.1.3	Increase the number of health workers trained in obstetric fistula management	211,101	52,570	57,038	61,887	67,147	
		3.1.4	Establish linkages for physical rehabilitation and integration services.	155,000	58,317	63,274	68,653	74,488	419,733
Sub-Total			579,366	452,138	490,570	532,268	577,511	2,631,853	
TOTAL - LEADERSHIP AND GOVERNANCE			579,366	452,138	490,570	532,268	577,511	2,631,853	

5. Research Promotion

#	OBJECTIVE #	#	STRATEGY	COST (US \$)					TOTAL
				2022	2023	2024	2025	2026	
5.1	To strengthen research in obstetric fistula to facilitate evidence-based decision making	5.1.1	Strengthen national capacity for obstetric fistula research in Zambia	231,865	251,574	272,957	296,159	321,332	1,373,887
		5.1.2	Increase resource mobilization and allocation for obstetric fistula research	224,366	268,787	291,634	316,422	343,318	1,444,528
		5.1.3	Enhance strategic partnerships for dissemination and utilization of obstetric fistula research findings to inform policy and practice	319,773	167,346	181,571	197,005	213,750	1,079,446
Sub-Total				776,005	687,707	746,162	809,586	878,401	3,897,860
TOTAL - RESEARCH PROMOTION				776,005	687,707	746,162	809,586	878,401	3,897,860

6. Monitoring and Evaluation

#	OBJECTIVE	#	STRATEGY	COST (US \$)					TOTAL
				2022	2023	2024	2025	2026	
6.1	To strengthen monitoring and evaluation of obstetric fistula activities	6.1.1	Integrate and harmonize fistula data in HMIS.	1,507,627	1,595,358	1,730,963	2,086,713	2,348,788	9,269,449
		6.1.2	Operationalize electronic database for obstetric fistula	603,997	132,375	143,627	155,835	169,081	1,204,915
		6.1.3	Strengthen routine data generation and flow from government/private facilities and community-based health centres for the National Health Management Information System (NHMIS)	123,446	40,417	102,504	47,580	120,670	434,617
		6.1.4	Strengthen human resources for monitoring and evaluation for obstetric fistula	83,626	106,771	25,359	27,515	29,853	273,123
		6.1.5	Strengthen national documentation of obstetric fistula programme learning and progress	206,877	-	-	-	-	206,877
Sub-Total				2,525,573	1,874,921	2,002,453	2,317,643	2,668,393	11,388,982
TOTAL - MONITORING AND EVALUATION				2,525,573	1,874,921	2,002,453	2,317,643	2,668,393	11,388,982

Annexes

Annex 1: OF Community Based Assessment Tool



Obstetric Fistula Community Based Assessment Tool (OF-COMBAT)

Overview

OF-COMBAT is an enhanced verbal screening tool, made up of 27 questions, grouped into four categories with six sections, based on the screening framework. Part IA/B: focus on the Clinical presentation of Vesico-vaginal Fistula (VVF), whereas Part IIA/B focuses on Clinical presentation of Recto-vaginal Fistula (RVF) and fourth degree tears. Part III, on the other hand deals with Causes of obstetric fistula while part IV addresses the interval between the cause and the effect.

The tool is to be administered by a community outreach worker with basic training on verbal screening.

The outreach worker is expected to listen to the client's story prior to administering the test. He or she should be in position to gauge whether to focus on VVF, RVF or Both depending on the client's story. The screening for VVF and RVF is done and scored separately. Part I, III and IV will be administered to potential VVF clients whereas part II III and IV to those suspected to have RVF. Clients who are suspected to have both VVF and RVF will be screened for both conditions administering the VVF test followed by the RVF test, scoring each test separately.

The screening process entails asking the client specific questions from their stories and giving them an option of agreeing or disagreeing with it. The OF-COMBAT is unique in that it utilizes a set of confirmatory questions in order to improve the rates of correctly diagnosing a fistula case. A set of questions in Part IB and IIB have been included to validate the presenting signs and symptoms as explained by the client in part IA and II A. Any yes response in part B counters the yes in Part A making it invalid. All the invalid responses should be rephrased for the client or subtracted from the final score that will be used to give the tentative diagnosis. Further instructions for administering the screening and the scoring of the responses is provided in detail on the tool itself.

It's important to note that the diagnosis obtained from the screening tool is tentative and can only be confirmed through a dye test or any other facility-based diagnosis. It's important to let the client know that a positive verbal screening does not always guarantee the presence of Obstetric Fistula and in turn treatment. There is a red flag for more than four invalid responses hence the process should be repeated.

The purpose of OF-COMBAT

The Obstetric Fistula Community Based Assessment Tool is aimed at identifying potential fistula clients at the community level. This will help increase access to care and treatment for the fistula clients, enhance program effectiveness through reduced physical screening resources and client's transport costs, as well as managing client's expectations. Clinical utility

The primary role for OF-COMBAT is to tentatively diagnose obstetric fistula at the community level. The tool is however able to give an indication of the presence of other forms of incontinence that require further investigation and appropriate referrals.

The Framework of Obstetric Fistula Verbal Screening

The framework of obstetric fistula verbal screening is founded on the signs and symptoms of the condition that causes these symptoms and the interval between the cause and effect.

- i. Part IA/B: Clinical presentation of Vesical-vaginal Fistula (VVF) Continuous leakage of urine via the birth canal
- ii. Part IIA/B Clinical presentation of Recto-vaginal Fistula (RVF) and fourth degree tears. Passage of stool via the birth canal and passage of gas via the birth canal accompanied by particles of stool.
- iii. Part III: Causes of obstetric fistula: Though obstetric fistula can be caused by other factors; It is primarily caused by prolonged obstructed labour. There are however other programs that support traumatic or other forms of fistula. Such programs need to have causes of fistula of their interest at the back of their mind. It is however important to note that the primary role for this tool is obstetric fistula which is a childbirth injury. Shifting this goal can easily lead to misdiagnosis.
- iv. Part IV: The interval between the cause and the effect. Obstetric fistula most often occurs within six weeks of delivery with most signs and symptoms happening within the first three days and very few after two months.

OF-COMBAT Questionnaire and Scoring

Reliability

Split half reliability: .72 to .86

Test-retest reliability: .79 to .93

Client Code/Name: _____

Age: _____

Home Location: _____

Fill in this section after completing the questionnaire:

OF Combat Score: _____ **OF Combat Diagnosis:** _____

IMPORATANT!READ BEFORE STARTING QUESTIONNAIRE

Ask the client to give the history of her condition: how it started and the symptoms she is experiencing. Based on this history you will know whether to complete Part I if she describes symptoms of leaking urine or Part II if she describes leaking of stool. If the client describes both leaking of urine and stool, Part I and Part II should be completed. Part III and Part IV should be completed for all clients.

If the client answers any of the questions below while giving her history, you do not need to ask the question again while giving Part A of the questionnaire. Simply fill in Part A with the information provided by the client. After going through all sections (Part I-IV) you will complete the scoring on the final page and will then determine the OF-Combat diagnosis and plan of action.

Part I: For Suspected VVF Cases
→ SKIP THIS SECTION if client does not describe leakage of urine and proceed to PART II.

Part IA: Signs and symptoms (VVF)

Directions: For each question answered “Yes” score one (1) point.

For each question answered “No” score zero (0) points.

	Yes (1)	No (0)
1. Do you continuously leak urine via your birth canal?		
2. Does the urine leak without you feeling it?		
3. Do you often find yourself wet with urine most if not all the time?		
4. Does the urine pass /leak on your bed while you are asleep most of the night?		
5. Does the urine pass even when it’s not provoked by anything?		
6. Do you need to use diapers and/or protective clothes to prevent the leakage?		
Total Points Section IA:		

Part IB: Validation Questions: (VVF). Instruction: For each question answered “Yes” score zero (0) points.

For each question answered “No” score one (1) point. *

	Yes (0)	No (1)
1. Do you find yourself wet with urine sometimes and dry at other times?		
2. Do you ever have the urge to pass urine?		
3. Do you ever go to the bathroom/ washroom to pass urine?		
4. Do you wake up to pass urine at night?		
5. Does urine leak when you cough or lift something?		
6. Can you go on with your work or leave the house without any diapers and/or protective clothing but still don’t wet yourself?		
Total Points Section IB:		

***Scoring note:** *When the respondent answers the same numeric question in Part A and B with identical response, the question becomes void and should be eliminated from the scoring. E.g., if the respondent answers ‘yes’ to question 1 in Part IA and ‘yes’ to question 1 in Part IB you should eliminate this question from the scoring for Section 1A.*

PART II: Use this section for Suspected RVF or perineal tear

→ SKIP THIS SECTION if client does not report leakage of stool and proceed to SECTION III.

Part IIA: Signs and Symptoms (RVF or perineal tear)

Instructions: For each question answered “Yes” score one (1) point.

For each question answered “No” score zero (0) points.

	Yes (1)	No (0)
1. Do you pass stool via your birth canal?		
2. Do you pass gas with particles of stool via your birth canal?		
3. Do you have a visible tear between your vagina and your anal opening or connecting the two openings?		
4. Do you have stool incontinence that more often soils your birth canal?		
Total Points Section IIA:		

Part IIB: Validation Questions: (RVF or perineal tear)

Instructions: For each question answered “Yes” score zero (0) points.

For each question answered “No” score one (1) points.

	Yes (0)	No (1)
1. Do you pass stool in the normal way without any problems?		
2. Do you pass gas well via your anal opening with no problems?		
3. Is your vagina completely tight and has no tears or injuries from delivery?		
Are you able get to the toilet anytime you need to defecate, and the stool comes out of your anal opening?		
Total Points Section IIB:		

*Scoring note: When the respondent answers the same numeric question in Part A and B with identical response, the question becomes void and should be eliminated from the scoring. E.g. if the respondent answers ‘yes’ to question 1 in Part IIA and ‘yes’ to question 1 in Part IIB you should subtract this question from the scoring for Section IIA.

PART III and PART IV: Use for BOTH Suspected VVF and RVF Cases

Part III: Causes of the obstetric fistula.

Instructions: For each question answered “Yes” score one (1) point.

For each question answered “No” score zero (0) points.

	Yes (1)	No (0)
1. Did you start leaking urine after delivery or Caesarean Section?		
2. Were you in labour for more than 48 hours?		
3. Did you deliver at home?		
4. Did you go to the health facility after more than 24 hours in labour?		
Total Points Section III:		

Part IV: The interval between the cause and effect

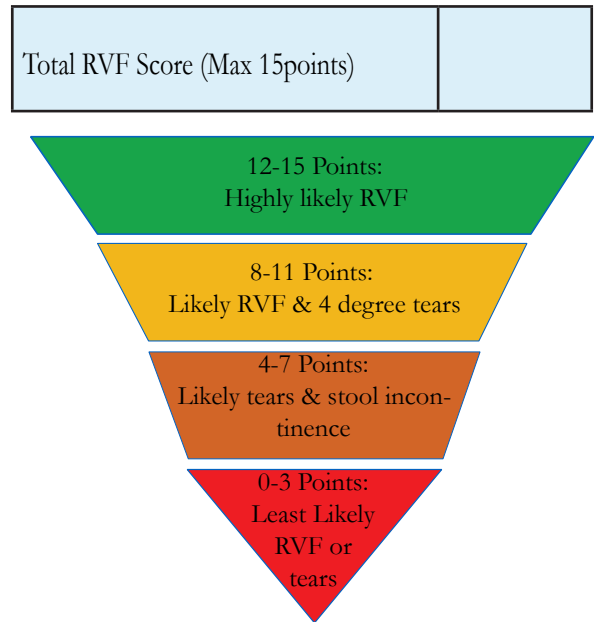
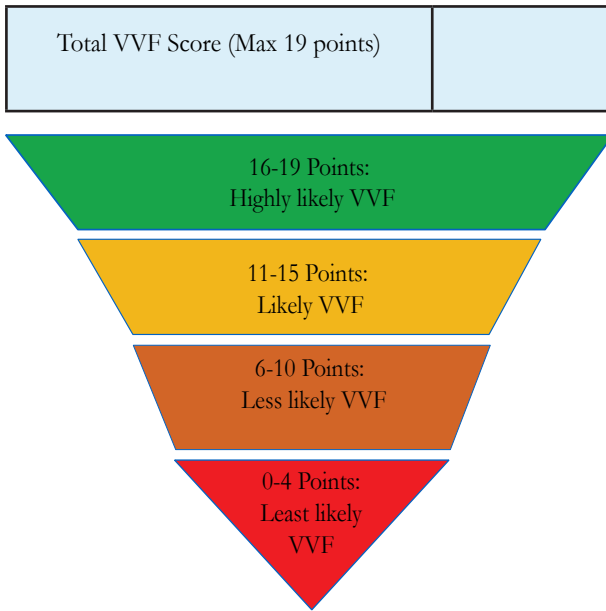
	Yes (1)	No (0)
1. Did the leaking start immediately after delivery?		
2. Did the leaking start within six weeks of delivery?		
3. Did the leaking start immediately after the catheter removal?		
Total Points Section IV:		

Scoring Section

Tally the points from the sections above and place them in the following scoring table.

Scoring VVF (Part I, III, IV)	
Section IA + IB (Max 12 points)	
Section III (Max 4 points)	
Section IV (Max 3 points)	

Scoring RVF (Part II, III, IV)	
Section IIA + IIB (Max 8points)	
Section III (Max 4 points)	
Section IV (Max 3 points)	



General remarks

Plan of Action (POA)

Screening Person Details:

Name: _____ Sign: _____ Designation: _____

