



REPUBLIC OF SIERRA LEONE

Ministry of Health and Sanitation

THE NATIONAL STRATEGY TO END OBSTETRIC FISTULA IN SIERRA LEONE

2023 - 2027

HELPING WOMEN REGAIN
THEIR HEALTH AND DIGNITY

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FOREWORD

Sierra Leone has made significant progress in addressing maternal morbidity and mortality over the last decade. The United Nations maternal mortality estimates released in February 2023 revealed a 74 per cent reduction in maternal mortality in the country over two decades, from 1,682 deaths per 100,000 live births in 2000 to 443 deaths per 100,000 live births in 2020. The 2019 Demographic and Health Survey also revealed an almost 40 per cent reduction of the maternal mortality ratio in five years, from 1,165 deaths per 100,000 live births in 2013 to 717 deaths per 100,000 live births in 2019. The country has made marked progress in effective coverage of proven reproductive maternal, newborn, child and adolescent health services. Access to skilled birth attendance more than doubled in 10 years, from 42 per cent in 2008 to 87 per cent in 2019. Over the same period, the percentage of institutional deliveries increased from 25 per cent to 85 per cent, while births attended by traditional birth attendants dramatically decreased from 45 per cent in 2008 to 10 per cent in 2019. Antenatal and postnatal coverage have also increased steadily.



The country's high maternal mortality rate despite improved coverage indicators is a sign of challenges with quality of care. Sub-optimal quality services during pregnancy and childbirth may lead to death or severe morbidity. Literature shows that for every woman who dies giving birth, 20 to 30 are left with morbidity, including obstetric fistula. Obstetric fistula is an abnormal hole between the vagina and urinary and/or rectum, mainly caused by prolonged obstructed labour during childbirth. This causes the woman to leak either urine or faeces or both. The lack of access to timely obstetrical intervention is directly related to the occurrence of obstetric fistula and the disability is mainly found among women living in rural and hard-to-reach areas.

In addition to the physical discomfort of wetness, women with obstetric fistula suffer both socio-economic, psychological and mental health consequences. Affected women lose their means of livelihood as they are unable to work outside the home or farm, resulting in the deepening of poverty. The plight of such women is worsened by their isolation from social gatherings, resulting in the loss of self-esteem. In view of the low level of knowledge about the causes of obstetric fistula and the fact that it is curable, several myths have been associated with obstetric fistula, leaving some sufferers totally ostracised as they are believed to be cursed.

As Sierra Leone moves towards universal health coverage, and access to essential care for women in pregnancy and childbirth is placed high on the agenda, obstetric fistula should be reduced to near zero occurrence. Furthermore, every effort should be made to reach and treat affected women still living with the condition regardless of their location. The National Fistula Strategy and Implementation Plan clearly articulates how the country intends to achieve this.

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May 2023

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The National Fistula Task Force was constituted on 13 May 2022 and given the mandate to lead and strengthen coordination of fistula-related activities across the country, including development of the National Fistula Strategy. We express our deep appreciation to the Members of the National Fistula Task Force for their immense contribution to the development of this strategic plan.

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May 2023



CONTENTS

| | |
|--|----|
| FOREWORD | 3 |
| ACKNOWLEDGEMENTS | 4 |
| PREFACE | 7 |
| 1 INTRODUCTION | 9 |
| 1.1 The Strategy Framework | 10 |
| 1.2 Guiding principles of the strategy to end obstetric fistula in Sierra Leone | 12 |
| 2 CONTEXT | 14 |
| 2.1 Global context | 14 |
| 2.2 Regional context | 14 |
| 2.3 National context | 15 |
| 2.4 Declarations, commitments and resolutions on obstetric fistula | 15 |
| 3 BASELINE INFORMATION FOR SIERRA LEONE | 18 |
| 3.1 The reproductive health and rights epidemiology of Sierra Leone | 20 |
| 3.2 SWOT analysis | 22 |
| 3.3 GAP analysis | 23 |
| 3.4 Rationale | 25 |
| 4 STRATEGIC OBJECTIVES | 26 |
| Objective 1 - Prevent obstetric fistula | 26 |
| Objective 2 - Improve care for women with obstetric fistula | 28 |
| Objective 3 - Strengthen governance, leadership, programme management and partnerships .. | 30 |
| Objective 4 - Improve resource mobilisation and financing | 32 |
| Objective 5 - Strengthen research, monitoring and evaluation, and learning | 33 |
| 5 IMPLEMENTATION | 34 |
| ANNEX | 37 |
| I Composition of the National Obstetric Fistula Task Force in Sierra Leone | 37 |
| II Roles and responsibilities of stakeholders | 38 |
| III Care- and referral pathway and stakeholder contributions | 41 |
| VI Monitoring and evaluation framework for the fistula strategy | 45 |

ACRONYMS AND ABBREVIATIONS

| | |
|--------|--|
| AWC | Aberdeen Women's Centre |
| ANC | Antenatal Care |
| CBO | Community-based Organisation |
| CHC | Community Health Centre |
| CHO | Community Health Officer |
| CHP | Community Health Post |
| EmONC | Emergency Obstetric and Newborn Care |
| FP | Family Planning |
| ICPD | International Conference on Population and Development |
| IP | Implementing Partner |
| MCHP | Maternal and Child Health Post |
| M&E | Monitoring and Evaluation |
| MoHS | Ministry of Health and Sanitation |
| MSW | Ministry of Social Welfare |
| NGO | Non-governmental organisation |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| SOP | Standard Operating Procedure |
| SRH | Sexual and Reproductive Health |
| UNFPA | United Nations Population Fund |
| WAFF | West Africa Fistula Foundation |

PREFACE

In response to the global call to eradicate obstetric fistula and recognising the need to address the preventable problem of obstetric fistula more strategically, the Government of Sierra Leone, through the Ministry of Health and Sanitation with technical support from UNFPA and other partners, commissioned the development of a national fistula strategy and implementation plan.

Although obstetric fistula (vesico-vaginal and recto-vaginal fistula) has practically been eliminated in middle- and high-income countries, it remains a serious reproductive health problem in many low-income countries, particularly in Africa and Asia. It occurs mainly due to prolonged obstructed labour, leading to tissue damage and the typical clinical presentation of continuous leakage of urine or faeces or both through the vagina. The constant leakage of urine and/or faeces through the vagina and the unbearable odour it causes very often leads to social isolation of the victims, and severe physical and mental ill-health.

The actual burden of obstetric fistula in Sierra Leone is unknown. Based on maternal mortality estimates and the prevalence of teenage pregnancy, a report in 2019 by the Islamic Development Bank estimated that about 2,400 women live with obstetric fistula in Sierra Leone.

Global best practices for the elimination of obstetric fistula revolves around building awareness (sensitisation); case identification, referral, and treatment of victims; and support in rehabilitation, psychosocial counselling, and empowerment training to facilitate reintegration into their communities. The 2023 commissioning of a national fistula strategy and implementation plan with support from the Republic of Iceland could not have come at a better time. Although in-country fistula surgeons are very few, the diaspora has Sierra Leoneans with expertise that can be brought into the strategy. Equally timely is the establishment of the first national post-graduate training programme in obstetrics and gynaecology which has the potential to incorporate fistula management in the pre-service curriculum.

Making the universal age of consent for marriage 18 years, by reviewing and amending the Child Rights Act 2007, is a commendable step by the Ministry of Social Welfare to prevent childhood marriages which feed the menace of obstetric fistula.

The national fistula strategy recommends the integration of best practices of fistula awareness-building and sensitisation, case identification and recruitment, rehabilitation, and re-integration, into the routine activities of the Ministry of Health, drawing largely on its structures at the community level. The strategy further recommends that community-level partners in the health sector leverage their organisational strengths to build the synergy needed to maximise advocacy for the prevention and management of obstetric fistula. Joining forces with the Ministry of Social Welfare and NGOs established in the fistula space could improve case identification and recruitment to the treatment centres.

The objective in West- and Central Africa is to end the occurrence of obstetric fistula by 2030. The envisioned impacts are as follows:

- No untreated new fistula cases by 2030
- Surgical treatment of 80 per cent of existing cases of fistula by 2030
- Socio-economic reintegration for all women with incurable fistula

For Sierra Leone, all stakeholders that worked on the development of the strategy at the very least aim to reduce the occurrence of obstetric fistula by 50 per cent by 2027, and 9 out of 10 pre-existing fistula cases shall be successfully treated.

To accelerate progress in eliminating obstetric fistula in Sierra Leone, decrease the backlog of cases awaiting repairs and foster national ownership of the fistula elimination programme, this strategy recommends the institutionalising of obstetric fistula activities in Sierra Leone.



1 INTRODUCTION

Obstetric fistula is the presence of an abnormal tract created between the vagina and rectum (recto-vaginal fistula) or vagina and the bladder (vesico-vaginal fistula) mainly as a result of prolonged obstructed labour.¹ This leaves women with chronic urinary or faecal incontinence or both, with a persistent and offensive smell which usually leads to stigmatisation and social ostracisation.² It is estimated that about 80 percent of women who develop fistula suffer a chronic excoriation of the skin around the perineum (caused by direct irritation by urine), amenorrhea, vaginal stenosis, infertility, bladder calculi, infection and foot drop. Sadly, many pregnancies that complicates with fistula often also end up with stillbirths, further compounding the plight of these women. Most of these women are young, poor, illiterate and mostly live in remote areas.³

Ending obstetric fistula is fundamental to reducing maternal morbidity and improving maternal and newborn health. Nearly 30 years after the International Conference on Population and Development (ICPD) in Cairo in 1994, obstetric fistula still affects women and girls living in some of the most under-resourced regions of the world, mainly in sub-Saharan Africa and Asia, although it has been eliminated from the developed world. This represents the global community's failure to protect the reproductive health and rights of women and girls and achieve equitable access to comprehensive sexual and reproductive health (SRH) services.

Today, the success of fistula elimination programmes relies on strong health service delivery systems, an understanding of the reproductive health epidemiology and the state of obstetric fistula in the country.

¹ Wall, L. Lewis. "Obstetric Fistula Is a 'Neglected Tropical Disease.'" 2012, *PLOS Neglected Tropical Diseases*, Public Library of Science, [journals.plos.org/plosntds/article?id=10.1371%2Fjournal.pntd.0001769](https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0001769).

² (Khisa & Nyamongo, Khisa, Anne and Nyamongo, Isaac, Still Living with Fistula: An Exploratory Study of the Experience of Women with Obstetric Fistula Following Corrective Surgery in West Pokot, Kenya (November 1, 2012). *Reproductive Health Matters*, Vol. 20, No. 40, November, 2012, Available at SSRN: <https://ssrn.com/abstract=2319891>

³ Capes T, Ascher-Walsh C, Abdoulaye I, Brodman M. Obstetric fistula in low- and middle-income countries. *Mt Sinai J Med*. 2011 May-Jun;78(3):352-61. doi: 10.1002/msj.20265. PMID: 21598262.

1.1 The Strategy Framework

VISION

A Sierra Leone where obstetric fistula is eliminated and the health, dignity, and quality of life of women and girls has been restored.

MISSION

Promote empowerment of women and girls and equitable access to timely, quality emergency obstetric and newborn care to prevent the occurrence of new cases of fistula and to treat all existing fistula patients.

GOAL

Whilst eliminating obstetric fistula by 2027 is the ultimate goal, at the least, the occurrence of fistula cases shall be reduced by half, and 9 out of 10 pre-existing fistula cases shall be successfully treated.

PRIORITY OBJECTIVES

- Prevent obstetric fistula
- To enhance the capacity of the health facilities to manage (screen and treat) obstetric fistula.
- Improve care for women with obstetric fistula through case identification, treatment (surgery), rehabilitation and empowerment
- Strengthen governance, leadership, programme management and partnerships for the elimination of obstetric fistula
- Improve resource mobilisation and financing
- Strengthen reporting, monitoring and evaluation, learning and research on obstetric fistula

CONTENT

The strategy places Sierra Leone's efforts to eliminate obstetric fistula within a regional and global context, explains the rationale behind the strategy, details the implementation plan and highlights the roles and responsibilities of the various stakeholders.

OPERATIONALISATION

The obstetric fistula strategy will be implemented within the context of the National Reproductive, Maternal, Newborn, Child and Adolescent Health policy and within the health tier system of Sierra Leone i.e., the MCHPs, CHPs, CHCs, district and regional hospitals and tertiary referral centres.

The Strategy to End Obstetric Fistula in Sierra Leone recommends the integration of the creation of awareness and sensitisation around obstetric fistula, case identification and recruitment, and the rehabilitation and reintegration of those cured of fistula, into the routine activities of the Ministry of Health and Sanitation and the Ministry of Social Welfare, making use of its presence at the community level. The strategy further recommends that community level partners in the health sector routinise sensitisation and building awareness of obstetric fistula. Joining forces with the Ministry of Social Welfare and NGOs that are established in the fistula space shall improve case identification and recruitment to the treatment centres.

In response to the global call to eradicate obstetric fistula and recognising the need to address obstetric fistula more strategically, the Government of Sierra Leone, through the Ministry of Health and Sanitation, with technical support from the UNFPA and other partners, commissioned the establishment of a national fistula strategy and implementation plan. To that end, the comprehensive strategic plan to eliminate obstetric fistula in Sierra Leone by 2027 has been developed through deep and broad stakeholder consultation, at all levels.

This strategic plan is grounded in key programmatic strategic interventions and actions under each specific objective, to be carried out within the context of the National Reproductive Health Programme and within the health tier system of Sierra Leone.

Strategies under prevention will include

- improving access to comprehensive SRH services, and basic essential obstetric care, across the life span,
- sensitising all community members on obstetric fistula,
- sensitising and training staff of all health facilities on obstetric fistula,
- expanding capacity of health facilities in obstetric fistula prevention while strengthening the obstetric referral system at all levels.

Strategies under identification and referral of suspected cases will mainly focus on

- strengthening community mobilisation for case identification, notification and referral of women with obstetric fistula,
- training of health cadres on screening and/or diagnosing of obstetric fistula (as per health care level),
- designing, implementing and operating in line with a care- and referral pathway.

In terms of treatment and care for obstetric fistula clients, strategies will include

- increasing the treatment volume for fistula repairs by building up capacity at two regional hospitals,
- increasing the number of fistula repairs at the AWC (the only available treatment centre at time of publishing this strategy),
- increasing the number of national medical professionals qualified to carry out obstetric fistula repair.

Rehabilitation and reintegration of obstetric fistula clients and caregivers

- will be tailored to their individual needs,
- while special support services will be provided for clients deemed incurable or those requiring complicated surgery.

Funding

- will be sourced for the establishment of a sustainable funding mechanism for obstetric fistula,
- guidelines developed for the disbursement of funds for obstetric-fistula-related activities.

Implementation, data collection and monitoring

This fistula strategy specifies the implementation plan as well as various roles and responsibilities that various stakeholders are to play for a successful implementation. The strategy makes provision for strengthening reporting, monitoring and evaluation activities for obstetric fistula programmes. Further, strategies to develop and implement surveys, operational research, surveillance and programme data collection and analysis to guide programme evaluation and decision-making have also been specified.

1.2 Guiding principles of the strategy to end obstetric fistula in Sierra Leone

The UN Resolution 70/1 on Ending Obstetric Fistula, the Sierra Leone Universal Health Coverage Policy and the RMNCAH Strategy policy have inspired the guiding principles for The Strategy to End Obstetric Fistula in Sierra Leone. These are outlined below.

Non-discrimination

All women and girls of Sierra Leone shall have access to obstetric fistula-related health services without distinction of ethnicity, gender, age, disability, sexual orientation, mental and health status, religion, political belief, economic, socio-cultural condition, or geographical location.

Gender-sensitive design and implementation

Gender integration shall be key to the design, implementation and monitoring of all obstetric fistula programmes and or initiatives. All obstetric fistula programmes or initiatives shall seek to challenge social norms and traditional practices which put women and girls at risk of obstetric fistula, thereby seeking to build equitable social norms and structures in addition to individual gender-equitable behaviour to protect women and girls from obstetric fistula. Men's engagement is key in terms of reducing the first delay and addressing deep-rooted social norms in the patriarchal system.

Ethical considerations

The ethical requirement of confidentiality, safety and efficacy in both the provision of health care and health care research shall be adhered to and respected for every Sierra Leonean woman and girl.

Efficiency and effectiveness

All relevant stakeholders shall be expected to use available resources for obstetric fistula efficiently and effectively to maximise health gains and value for money. Opportunities shall be created to facilitate the integration of obstetric fistula delivery services to leverage efficiency and effectiveness in addressing the obstetric fistula needs of women and girls in Sierra Leone.

Transparency and accountability

Stakeholders shall discharge their respective mandates in a manner that is transparent and takes full responsibility for the decision they make.

Coordination and collaboration

All stakeholders will work towards ending obstetric fistula in Sierra Leone and as such this strategy will promote coordination between and among partners operating within the SRHR subsector and across sectors addressing fragmentation and reducing duplication.

Patient or client centredness

Participation of women and girls affected by obstetric fistula shall be central in addressing obstetric fistula health related needs of women and girls.

Evidence-based decision-making

Sexual and Reproductive Health and Rights sub-sector strategies and activities are chosen and pursued to achieve the optimal possible outcome, based on value, effectiveness and quality, as informed by the current available evidence.

Decentralisation

Obstetric fistula services provision and management shall be in line with the Local Government Act, 2004 which entails devolving health service delivery to local government structures.

Appropriate technology

Obstetric fistula service providers shall use health care technologies that are safe, appropriate, relevant, cost-effective and beneficial to women and girls in Sierra Leone.

Sustainability

A wide range of obstetric fistula services are contingent upon the funds available. Realistic planning is essential to ensuring the successful implementation of activities and the achievement of targets. The institutionalisation of obstetric fistula prevention and treatment in government structures and ensuring resources are available to manage the programme will help sustain the services.

2 CONTEXT

2.1 Global context

Over the years, obstetric fistula has been recognised globally as a human rights violation against women,⁴ for which various global, regional, and national commitments, declarations and efforts have been made towards its elimination.

There is little data available on the epidemiology (incidence and prevalence) of obstetric fistula worldwide. However, the World Health Organisation estimates that between 1 and 2 million women are living with the condition worldwide⁵ and mostly in Africa and Asia.⁶ It is estimated that there are between 50,000 and 100,000 new cases every year.⁷

Globally, obstructed labour (also known as labour dystocia when the presenting part of the foetus cannot progress into the birth canal, despite strong contractions) often leads to fistula. This kind of labour occurs in about 5 per cent of live births and accounts for 8 per cent of maternal deaths.⁸ While obstetric fistula has been virtually eliminated in developed countries, women and girls in developing countries still face this preventable and, in most cases, surgically repairable condition, on a daily basis.⁹

2.2 Regional context

As highlighted in the Strategy to End Obstetric Fistula in West and Central Africa¹⁰, the exact prevalence of obstetric fistula in Africa is unknown but we do know it's a massive problem. According to a 2015 study in 19 SSA countries, prolonged labour, another cause of fistulas, is estimated at 6 per 100 live births.¹¹ It is estimated that in Nigeria alone, 400,000 to 800,000 women are awaiting repair surgery for fistulas and 20,000 new cases occur each year.¹² Given the situation there, it seems reasonable to assume that the total number of women affected by fistulas in West and Central Africa is between 600,000 and 1 million, and that there are about 30,000 new cases there per year, according

⁴ Osotimehin B. Obstetric fistula: ending the health and human rights tragedy. *Lancet*. 2013 May 18;381(9879):1702-3. doi: 10.1016/S0140-6736(13)61001-6. PMID: 23683623.

⁵ "Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development." World Health Organisation, World Health Organisation, www.who.int/publications/i/item/9241593679.

⁶ "Twenty Years of Progress Is Not Enough: We Must Act Now to End Obstetric Fistula." *United Nations*, United Nations, www.un.org/en/un-chronicle/twenty-years-progress-not-enough-we-must-act-now-end-obstetric-fistula.

⁷ International Federation of Gynaecology and Obstetrics and United Nations Population Fund (2002). Second Meeting of the Working Group for the Prevention and Treatment of Obstetric Fistula. Sponsored by Columbia University. *Addis Ababa - United Nations Population Fund*, unfpa.org/sites/default/files/pub-pdf/fistula_meeting02_eng.pdf.

⁸ Abou Zahr, Carla. Global burden of maternal death. *British Medical Bulletin*, vol.67, No. 1 (December), pp. 1–11.

⁹ "Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development." *World Health Organisation*, World Health Organisation, www.who.int/publications/i/item/9241593679.

¹⁰ *Strategy to End Obstetric Fistula in West and Central Africa 2019–2030*, wcaro.unfpa.org/sites/default/files/pub-pdf/03-en-edited-unfpa-wcaro-obs-fis.pdf. Accessed

¹¹ Maheu-Guiroux, Mathieu, et al (2015). Prevalence of symptoms of fistula in 19 Sub-Saharan Africa countries: a meta-analysis of national household survey data. *The Lancet Global Health*, vol. 3, No. 5 (May), pp. 271–278.

¹² Federal Ministry of Health of Nigeria (2012). National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria (2011-2015), fistulacare.org/archive/files/5/5.4/Nigeria_National_Strategy_2011-2015.pdf.

to estimates by the West and Central Africa Regional Office. However, in 2018, a mere 2,281 women received treatment in the region. If such abysmal repair rates remain unchanged, it will take centuries to end fistula in West and Central Africa. This is unacceptably slow progress, not to mention a tragedy of epic proportions.

2.3 National context

In accordance with the Strategy to End Obstetric Fistula in West and Central Africa,¹³ several continental and regional actions to end obstetric fistula have been implemented over the last two decades.

In 2003, a global campaign to end obstetric fistula was launched with support from UNFPA. The campaign covered 46 countries in sub-Saharan Africa, Asia and the Arab region and was to be undertaken in partnership with governments, NGOs, foundations, corporations and individuals. The campaign aimed at addressing three major areas of intervention:

- Prevention
- Treatment
- Support to clients for rehabilitation

Member countries were encouraged to undertake a needs assessment to determine the extent of the problem, and campaign activities to prevent and treat fistula, as well as reintegrating victims into their communities.

Since around the time of the global campaign launch, Sierra Leone has been providing regular treatment to fistula patients through NGOs and health care activities in collaboration with the respective Ministries and Directorates.

2.4 Declarations, commitments and resolutions on obstetric fistula

There are several commitments towards the elimination of obstetric fistula that support global, regional, and national efforts.

United Nations General Assembly Resolution on Obstetric Fistula

On 9 November 2010, the Social, Humanitarian and Cultural Affairs Committee of the United Nations General Assembly adopted a resolution titled Supporting Efforts to End Obstetric Fistula. In December 2012, 167 countries co-sponsored a biannual resolution of the United Nations General Assembly that called on all Member States to support the activities of its partners in the Campaign to End Fistula. The resolution also called for greater technical and financial support to improve maternal health indicators, in particular for high-burden countries.

In the report to the seventy-third session of the General Assembly in 2018, the United Nations Secretary-General highlighted that obstetric fistula is a stark outcome of gender inequalities, the denial of human rights and poor access to SRH services, including maternal and newborn care, and an indication of high levels of maternal death and disability. He emphasised that ending obstetric fistula is an integral component of achieving the Sustainable Development Goals (SDGs) by 2030, and that improving maternal health, strengthening health systems, reducing health inequities and increasing the level and predictability of funding are crucial to ensure no one is left behind.

¹³ Helping Women Regain Their Dignity: Strategy to End Obstetric Fistula in West and Central Africa 2019–2030, at <wcaro.unfpa.org/sites/default/files/pub-pdf/03-en-edited-unfpa-wcaro-obs-fis.pdf>, accessed on 29 August 2023.

International Conference on Population and Development, 1994 and 2019 (ICPD25)

In the Programme of Action of the ICPD, adopted in Cairo in 1994, and the outcome documents of the review conferences thereon, maternal health was recognised as a key component of SRH and reproductive rights. In his report on the framework of actions for the follow-up to the Programme of Action beyond 2014, the Secretary-General underscored that obstetric fistula “represents the face of failure as a global community to protect the sexual and reproductive health of women and girls” (see A/69/62, para. 384).

In 2019, the international community commemorated 25 years of the ICPD’s Programme of Action. In the Programme of Action, it is stated that “the human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights,” as well as the right to attain the highest standard of SRH, and it calls for the elimination of all practices that discriminate against women, as well as for advancing gender equality and equity and the empowerment of women. In a 2019 report that reviewed and appraised the Programme of Action and its contribution to the 2030 Agenda for Sustainable Development, the Secretary-General indicated there was global progress in key areas, including the reduction of child and maternal mortality, increased standards of living, improved access to education and advances in gender equality and empowerment of women. However, achieving universal access to SRH care, and fulfilling the reproductive rights of individuals remains unmet, with millions left behind.

Sustainable Development Goals

In September 2015, world leaders gathered at the United Nations in New York and unanimously adopted a set of global goals on eliminating poverty, achieving gender equality and securing health and well-being for all people. The bold new universal agenda outlined in the 2030 Agenda for Sustainable Development was adopted by the General Assembly in its resolution 70/1 as the successor to Millennium Development Goals.

Sierra Leone’s national strategy to end obstetric fistula falls within the framework of the SDGs, which have direct or indirect implications on fistula, in particular Goal 1 (ending poverty), Goal 3 (health and well-being for all), Goal 5 (gender equality and empowering all women and girls), Goal 10 (Reducing inequality within and among countries) and Goal 17 (Strengthening the means of implementation and revitalising the Global Partnership for Sustainable Development). The full and effective implementation and achievement of the SDGs will be essential to ending obstetric fistula.

Global Strategy for Women’s and Children’s Health

In 2015, the Global Strategy for Women’s and Children’s Health was revised to take a more comprehensive approach that aims to keep women, children, and adolescents at the heart of the 2030 Agenda for Sustainable Development, in order to unlock their vast potential for transformative change. The Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016–2030) takes a life-course approach to attaining the highest standards of health and well-being, physical, mental and social, at every age. It aims to end preventable maternal and newborn mortality, reduce the rate of global maternal mortality to less than 70 women per 100,000 live births (Goal 3, target 3.1) and support countries in implementing the SDGs. At the sixty-ninth World Health Assembly, Member States were invited to commit to implementing the strategy, along with the accompanying operational plan to take it forward (see World Health Assembly resolution 69.2 of 28 May 2016). The resolution placed strong emphasis on country leadership and highlighted the need to strengthen accountability through monitoring national progress and strengthening capacity to collect, analyse and use data. It underscored the importance of developing a sustainable evidence-informed health financing strategy, strengthening health systems and building partnerships with a wide range of actors across different sectors.

Other conventions, declarations and protocols that support obstetric fistula

- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979 by the United Nations General Assembly
- Safe Motherhood Initiative (SMI)
- Fourth World Conference on Women, 1995 (Beijing Platform for Action)
- Global Women Deliver Conference, Copenhagen
- African Union Protocol on the Rights of Women in Africa, 2003(Supplement to the African Charter on Human and People's Rights, 1981)
- Maputo Plan of Action for Sexual and Reproductive Health and Rights



3 BASELINE INFORMATION FOR SIERRA LEONE

Regular fistula surgeries have been performed by the West African Fistula Foundation (WAFF) at Cottage Hospital (today's Princess Christian Maternity Hospital) and at Choithram Hospital in Freetown since the early 2000s. A few years later, Mercy Ships – a Christian charity that operates hospital ships – docked in Sierra Leone and offered fistula surgeries. When the Aberdeen Community Clinic and Fistula Centre (ACCFC) run by Mercy Ships began operations in 2005, it became the focal point for fistula repairs in the western regions. Since 2008, ACCFC has evolved into the present-day Aberdeen Women's Centre (AWC) and is also registered under the name "Freedom from Fistula Foundation". At the same time, WAFF moved their operations to Bo to get closer to where a great many fistula cases were occurring. During the Ebola epidemic (2014), WAFF had to vacate Bo Government Hospital to make rooms available. WAFF then offered treatment and surgeries at an old HIV facility at Kakua from 2016 to 2017. In 2023, WAFF and the MoHS refurbished this facility to serve as pre-and post-operation centre for obstetric fistula patients in support of surgeries at Bo Government Hospital.

Recognising the importance of case identification and subsequent referrals as major steps in the management of obstetric fistula, Haikal, an NGO situated in Bo, has over the years lead case recruitment and referral to the AWC and subsequently receives the treated patients for rehabilitation at its centre. During the COVID-19 pandemic, there were backlogs of recruited cases at Haikal as the expatriate surgeons could not travel into Freetown. This led Haikal to establish a fistula treatment centre at the Bo Government Hospital, which was operational for a short period. At Haikal, the clients, once cured, are also given livelihood and empowerment training.

To enhance awareness creation and advocacy to end fistula, the Government of Sierra Leone through the Ministry of Health and Sanitation and the UNFPA continues to commemorate the International Day to End Obstetric Fistula, provide free treatment of fistula patients at the AWC and support continuous and sustained training of obstetric fistula advocates (ambassadors) targeting cured patients.

Data

Robust data on the prevalence of fistula is lacking. However, a 2019 report from the Islamic Development Bank estimated that about 2,400 women live with obstetric fistula in Sierra Leone. This was based on the prevailing maternal mortality and teenage pregnancy rates at the time. Currently, expatriate fistula surgeons conduct surgeries at the AWC; about 150-150 per year. However, during the COVID-19 pandemic and the global economic downturn, expatriate visits were curtailed. Although the exact number is unknown, the backlog of cases is thought to be substantial.

Localisation of hot spots

Anecdotal evidence points to Bo and surrounding villages (hard to reach) as an obstetric fistula endemic zone in the southern parts of Sierra Leone, whilst Falaba and Kono in the Northern provinces rank second. This strategy document recommends establishing a treatment centre at Bo to serve the south and eastern provinces and one in Makeni or Masanga to serve the northern provinces

Sensitisation and raising awareness

Community NGOs such as FINE Sierra Leone, Restless Development, West African Fistula Foundation, AWC, Haikal and the Ministry of Social Welfare play active roles in community sensitisation and raising awareness of obstetric fistula.

Prevention and treatment

Health care delivery in Sierra Leone is provided by a mix of government, private and NGO facilities. It is governed by the Ministry of Health and Sanitation with support from health development partners. Six levels of care exist at the community, chiefdom, district, regional and tertiary levels in the country.

An inclusion of prevention, diagnosis and treatment of obstetric fistula into the existing structures will be outlined in this strategic document.

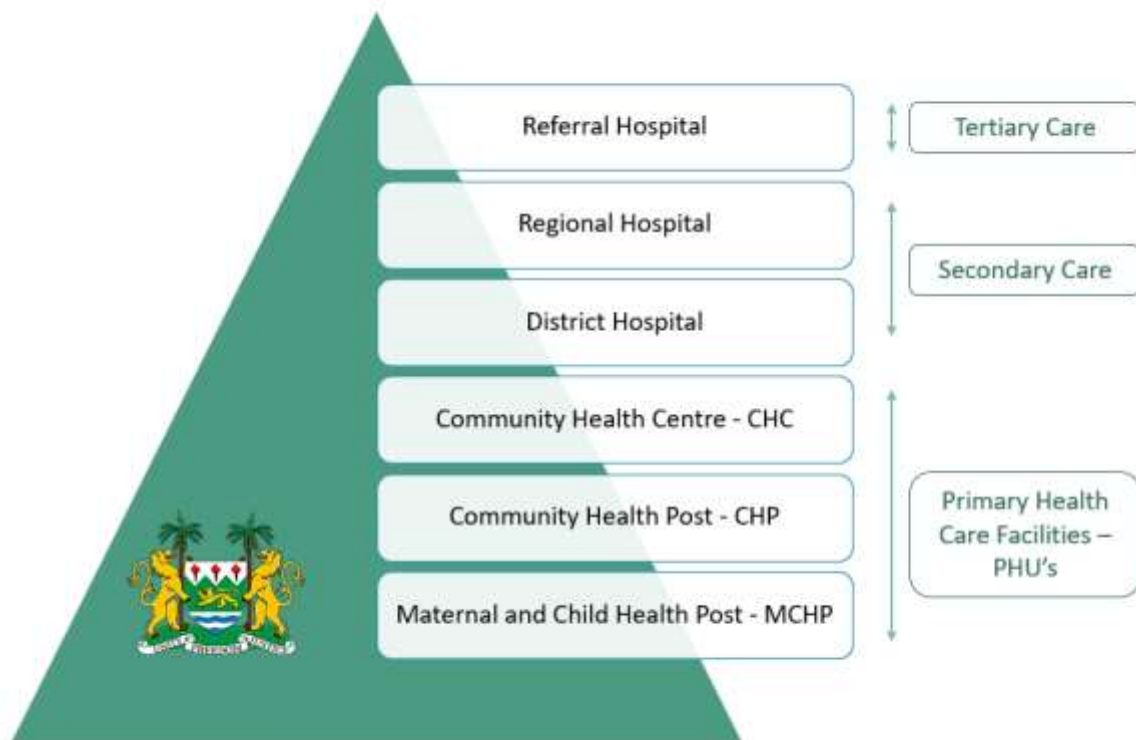


Figure 1 The tertiary health care and referral system in Sierra Leone

Reporting, monitoring and evaluation

There is currently no monitoring nor reporting on activities around obstetric fistula. Missing are also comprehensive patient files and coverage of treatment activities as well as a reporting system to indicate how well cured patients have been rehabilitated and successfully been reintegrated into their communities.

3.1 The reproductive health and rights epidemiology of Sierra Leone

Age at first sexual intercourse and first marriage

The median age at first intercourse for women aged 20 to 49 years is 16 years (DHS 2019¹⁴). By age 15, over a quarter (26 per cent) of women have already had sexual intercourse. This age is slightly lower for rural girls. The younger the age of exposure to sexual intercourse and marriage, the higher the risk of obstructed labour (because of smaller pelvises) and the higher the risk of developing obstetric fistula if obstruction is prolonged. Age at first marriage is often used as a proxy for women's exposure to the risk of pregnancy and subsequent exposure to risk of obstetric fistula. However, since some women become sexually active before marriage, the age at which women initiate sexual intercourse more precisely marks the beginning of the likelihood of pregnancy.

Total Fertility Rate

Every pregnancy carries with it a risk of developing obstetric fistula. The higher the total fertility rate, the higher the risk of exposure to obstetric fistula. The total fertility rate for Sierra Leone is 4.2 children per woman (DHS 2019), with rural women bearing slightly more children than urban women. More than one out of five girls aged 15–19 are pregnant with their first child or have already had a birth, a teenage pregnancy rate of over 20 per cent. Childbearing at a very young age is fraught with delivery complications, the most devastating being obstetric fistula. Starting childbirth early and having many more increases the risk of developing obstetric fistula.

Skilled attendance during pregnancy and childbirth

Adverse outcomes of pregnancy are reduced when mothers avail of ANC early in the first trimester and do not default until delivery. In the new ANC model of the World Health Organisation, the number of minimum contacts a pregnant woman should have with health providers throughout her pregnancy has been increased from four to eight. This is because evidence indicates that a higher frequency of antenatal contacts by women and adolescent girls with the health system is associated with an increased opportunity to detect and manage potential problems. Nearly all mothers in Sierra Leone (97 per cent) receive ANC at least once from a skilled provider and almost none from a traditional birth attendant. A large proportion of pregnant women in Sierra Leone (87 per cent) attend ANC four or more times during pregnancy, 92 per cent in urban areas and 83 per cent in rural areas (DHS 2019). More than eight out of 10 births are attended by a skilled birth attendant (doctor, nurse or midwife). Yet, adverse outcomes are also high (maternal mortality and morbidity) pointing towards a low quality of care.

State of emergency obstetric and neonatal care in Sierra Leone

In 2021, although exceeding UN recommendations for Comprehensive Emergency Obstetric and Newborn Care facilities, Sierra Leone reported a gap of 11 EmONC facilities. Facilities were not fully prepared to provide EmONC signal functions primarily due to lack of the required drugs, equipment, and supplies rather than a lack of health personnel. Hospitals were the least ready to provide caesarean section deliveries and blood transfusions, among all signal functions. The lack of supplies and equipment makes timely access to emergency obstetric care challenging. This care is, however, critical to preventing obstetric fistula. The caesarean section rate is low (at 5 per cent, according to the 2019 DHS).

¹⁴ StatsSL, Statistics Sierra Leone -, and Icf. "Sierra Leone DHS, 2019 - Final Report (English)." *Sierra Leone: DHS, 2019 – Final Report (English)*, 1 Oct. 2020, dhsprogram.com/publications/publication-FR365-DHS-Final-Reports.cfm.

Family planning

Although knowledge of contraceptive methods is nearly universal in Sierra Leone, among currently married women (15–49), the contraceptive prevalence is only 21 per cent. Evidence shows that if all women who want to avoid a pregnancy used modern contraceptives, the burden of disability related to pregnancy and delivery (like obstetric fistula) would reduce by two thirds.¹⁵ Given the relatively early onset of sexual activity (26 per cent by age 15), the lack of adolescent friendly SRH services is a gap that needs to be addressed.

Maternal mortality in Sierra Leone

Sierra Leone achieved the highest reduction in maternal mortality rates in the sub-region with a 74 per cent reduction from 1,682 maternal deaths per 100,000 live births in 2000 to 443 maternal deaths per 100,000 live births in 2020. Maternal mortality, however, remains high, with an estimated 1,200 maternal deaths in 2020 and a lifetime risk of maternal death of 1 in 52. With the high skilled birth attendant rate (87 per cent), increased facility delivery rates (80 per cent) and a slight dip in total fertility rate (4.2 in 2021 as per DHS from 2019, see footnote 15), the forecast suggests a reduction in the incidence of obstetric fistula.

If this assumption is true, then clearing the backlog of fistula cases, the amount of which is unknown, will help end the incidence of fistula in Sierra Leone. Enhancing local capacity in fistula repairs (grossly lacking at present) and increasing fistula repair centres will be a helpful adjunct to clearing the backlog of cases.

This forecast is, however, not matched by evidence on the ground. The situation is not unique to Sierra Leone as fistula eradication programmes globally are plagued with a lack of robust data.

¹⁵ Singh, S., Darroch, J.E. and Ashford, L.S. (2014) Adding It up the Costs and Benefits of Investing in Sexual and Reproductive Health 2014, Guttmacher Institute, New York. - References - Scientific Research Publishing, www.scirp.org/reference/referencespapers?referenceid=2147453.
Alternatively: <https://www.unfpa.org/sites/default/files/pub-pdf/Adding%20It%20Up-Final-11.18.14.pdf>

3.2 SWOT analysis

| | |
|---|--|
| <p>STRENGTHS</p> <ul style="list-style-type: none"> • Government support (political will) • Supportive donor partners, funding is available through Republic of Iceland • Existence of the subregional strategy for the elimination of fistula • An existing fistula surgery centre (AWC) • Two existing rehabilitation and reintegration centres (Haikal and AWC) • One refurbished pre- and post-operation ward (WAFF) • Guidelines (RMNCAH, Emergency Obstetric and Newborn Care [EmONC] and Integrated ANC) available | <p>WEAKNESSES</p> <ul style="list-style-type: none"> • Lack of policy direction • Lack of state ownership • Uncoordinated stakeholder activities • Low morale among physicians due to poor remuneration • Lack of robust data collection system for obstetric fistula • No indication of investment in electronic medical records |
| <p>OPPORTUNITIES</p> <ul style="list-style-type: none"> • First in-country postgraduate training in obstetrics and gynaecology • Presence of a urogynaecologist and FIGO-certified fistula surgeon in-country • Return of Sierra Leonean obstetrician gynaecologists from the diaspora • Implementation of the fistula communications strategy | <p>THREATS</p> <ul style="list-style-type: none"> • Lack of timely access to EmONC services • Out-of-pocket payment for gynaecological services including obstetric fistula • Low empowerment of women • Low school enrolment of girls • Inadequate stakeholder engagement – duplication of roles • Political instability |

Table 1: SWOT analysis for the elimination of obstetric fistula in Sierra Leone by 2027

3.3 GAP analysis

A participatory gap analysis was performed among key stakeholders that are involved in addressing obstetric fistula in the country, in early 2023. By interviewing health cadres, Ministry of Health and Sanitation personnel and funders to obtain their perspectives on what they considered to be missing in the efforts to end obstetric fistula in Sierra Leone, the following recurring gaps were identified:

- Lack of policy direction
- Lack of national ownership
- Very limited in-country medical expertise
- Knowledge around prevention and diagnosis of obstetric fistula is not included in midwifery training curriculum nor in ante-natal and post-partum care
- Low morale among health cadres and especially physicians due to poor remuneration
- Inadequate resource mobilisation and funding mechanisms
- No suitably equipped operation theatres in government run health facilities and no suitable government run medical rehabilitation wards
- Little availability of medical equipment, specific surgical instruments and medical consumables
- Referral pathway, monitoring and reporting tools are not in place, resulting in uncoordinated stakeholder activities with low accountability and insufficient information sharing about number of fistula cases and about activities around treatment of O.F patients by privately run hospitals.
- Due to lack of robust data collection system for obstetric fistula activities, including treatment and rehabilitation, evidence for success of O.F surgeries or success of rehabilitation and social reintegration of cured patients is not available

| Area | Gap | Recommendation |
|------------|---|--|
| Prevention | <ul style="list-style-type: none"> • Community-level factors: • Persistence of child marriage and teenage pregnancies • Low knowledge of causes of obstetric fistula | <ul style="list-style-type: none"> ➤ Promoting of gender equality, women’s empowerment, and ‘Girl Child Education’ ➤ Strengthen collaboration with community and traditional leaders ➤ Enforcement of the harmonised Child Rights Act of 2007 |
| | <ul style="list-style-type: none"> • Prolonged labour due to delays in decision-making | <ul style="list-style-type: none"> ➤ Awareness creation and advocacy through mass media, community durbars and high-level advocacy events ➤ Education of men, being head of households and often the decision makers in families (Male involvement) ➤ Enhanced cooperation with Civil Society Organisations (CSO) |
| | <ul style="list-style-type: none"> • Poor quality obstetric care, iatrogenic cases | <ul style="list-style-type: none"> ➤ Focus on quality improvement programmes ➤ Enhance in-service training of relevant health cadres ➤ Include education of mothers about prevention of obstetric fistula in antenatal care (ANC) screening ➤ Focus on strengthening midwifery capacity, pre- and post-partum (incl. |

| | | |
|---|--|--|
| | | promoting the use of partograph and focus on bladder care during labour) |
| Identification and Referral | <ul style="list-style-type: none"> • Patients are marginalised due to stigma, which hampers easy case identification • Inadequate funding compromises quality and quantity of advocacy, community sensitisation, recruitment of patients and transportation to diagnosis and treatment sites. • Unclear referral pathway • Missing monitoring and reporting tools • Lacking motivation and training of field workers (Community Health workers) | <ul style="list-style-type: none"> ➤ Collaboration with traditional and religious leaders ➤ Training of community-based functions, e.g. teachers ➤ Engage fistula survivors as O.F Champions and O.F Ambassadors to support advocacy and for identifying obstetric fistula cases. ➤ Build peer-to-peer capacity amongst adolescents ➤ Provide means of mobility for patients to and from treatment centres. ➤ Develop and implement a reliable care- and referral pathway for fistula patients at all health care levels ➤ Develop training curriculum and roll-out the training for respective Health Cadres, to educate and empower staff for decision making ➤ Develop respective Job Aids ➤ Inclusion of screening for obstetric fistula to post-partum and well women care ➤ Develop and implement monitoring and reporting tools |
| Treatment | <ul style="list-style-type: none"> • Inadequate treatment centres • Reliance on foreign expertise • Free health care initiative excludes gynaecological cases like fistula | <ul style="list-style-type: none"> ➤ Establish new treatment centres ➤ Train local surgeons ➤ Cooperate with non-governmental health facilities offering fistula repair in Sierra Leone, if and when indicated. ➤ Inclusion of fistula treatment and repairs in core competencies of pre-service curricula ➤ Source funding for free fistula care |
| Rehabilitation and Reintegration | <ul style="list-style-type: none"> • Clients are unemployable and face a loss of livelihood • Clients lose their social support • Clients face high divorce rates | <ul style="list-style-type: none"> ➤ Offer psychosocial and medical support pre- and post-repair ➤ Offer SRH education post-repair ➤ Enhance training in vocational and income generating skills ➤ Offer employment avenues for post-repair clients ➤ Offer medical and psychosocial care for non-repairable patients |

Table 2: Gap analysis and recommendations

3.4 Rationale

The Government of Sierra Leone, being a signatory to various global commitments to end obstetric fistula by 2030, prioritises the health and well-being of women and girls suffering from obstetric fistula. To this end, the country has made commitments to the SDGs as well as the Global Strategy for Women's, Children's, and Adolescents' Health. Extensive consultations with stakeholders identified the following as the rationale for the development of a fistula strategy:

- Provide guidance to strengthen and define the road map for fistula elimination in Sierra Leone
- Align Sierra Leone's fistula elimination efforts with subregional and global approaches
- Define the referral pathways for fistula care in Sierra Leone
- Prescribe a central coordinating mechanism and encourage state ownership of the fistula elimination programme in Sierra Leone
- Provide guidance on resource mobilisation and implementation of the fistula elimination programme
- Establish the strategic framework that will leverage the strengths of stakeholders for synergy in the efforts to eliminate the incidence of fistula
- Provide direction and support for restoring fistula treatment at Bo, consolidating treatment and care at the AWC and establishing a new treatment centre at Makeni
- Bring fistula care in alignment with the national RMNCAH policy
- Define and provide the foundation for monitoring and evaluation (M&E) of fistula elimination in Sierra Leone
- Provide backing for national adaptation of evidence-based approaches to eliminate fistula
- Provide a basis for the integration of fistula elimination into the activities of relevant Ministries, Departments, and Agencies

The reproductive health and rights epidemiology of Sierra Leone has implications for the development of fistula. These include

- Age at first sexual debut and age at first marriage
- Fertility rate and family planning (FP)
- Skilled attendance at pregnancy and delivery
- EmONC

Evidence shows that women who are in the lowest wealth quintile, have low educational status, are young and live remotely from care are more likely to develop obstetric fistula.

The strategy is also an advocacy tool to mobilise resources to address the problem of fistulas in Sierra Leone. It has a vision and guidelines for a consolidated and integrated approach to increase the impact of actions taken, to increase the proportion of cases treated from 10 per cent to 80 per cent.

4 STRATEGIC OBJECTIVES

Objective 1 - Prevent obstetric fistula

Strategy 1.1 - Improve access to quality, comprehensive sexual and reproductive health services across the life stages, including comprehensive obstetric care

Key interventions

1.1.1 Primary prevention of obstetric fistula

ACTIVITIES

- Increase health promotion and education in SRH services, especially among young people, for prevention of unplanned pregnancies
- Enable demand creation for SRH services for the prevention of unplanned pregnancies
- Increase non-traditional service delivery points (as nationally appropriate) for FP commodities

1.1.2 Secondary prevention of obstetric fistula

ACTIVITIES

- Provide timely access to quality antenatal care (ANC) according to national guidelines
- Include prevention of O.F in ANC
- Improve knowledge of all stakeholders to identify signs and symptoms of obstructed labour in a timely manner and to action upon
- Empowering Community Health Workers for identification and timely referral of women in labour in their communities
- Provide improved, timely referral during pregnancy and childbirth
- Strengthen national ambulance services across all levels of the referral system
- Increase the number and distribution of key skilled birth attendants
- Promote deliveries in health facilities
- Improve quality of care including respectful maternity care, labour monitoring using partograph/labour care guide and bladder care during labour
- Improve quality of and access to post-partum care, including diagnosis of obstetric fistula
- Encourage the setting of birth waiting homes where appropriate

1.1.3 Tertiary prevention of obstetric fistula

ACTIVITIES

- Refer suspected obstructed labour in a timely manner
- Provide timely and safe caesarean sections by competent service providers
- Promote the use of partograph
- Promote the use of indwelling bladder catheter in the management of prolonged obstructed labour

Strategy 1.2 - Sensitise communities including health workers on the prevention of obstetric fistula

Key interventions

1.2.1 Engagement of key community actors on prevention of obstetric fistula

ACTIVITIES

Strategic engagement with the following:

- Religious leaders and groupings
- Traditional leaders such as chiefs and headmen
- Influential adolescents and young people
- Women's groups including 'bondo' society heads and pregnant women associations
- Association of Bike riders, Keke riders and drivers
- Political and civic leaders at all levels of the governance system
- Educational institutions (primary schools, secondary schools, tertiary institutions)
- Professional associations
- Market groups
- Celebrities (athletes, musicians, actors/actresses, and others)
- Men's groups

1.2.1 Use of multimedia for promotional messages for the prevention of obstetric fistula

ACTIVITIES

- Use of social media platforms
- Use of TV jingles, drama, talk shows
- Use of road shows
- Use of town criers
- Use of print media

Strategy 1.3 – Cross-cutting interventions for prevention of obstetric fistula

Key interventions

- Sustainable mentorship approaches for SRH services
- Deployment of health professionals especially to health facilities in rural and hard-to-reach areas
- Provision of adequate infrastructure, equipment and supplies at all levels of care
- Inclusion of management of obstetric fistula in the curriculum of pre-service and in-service training programmes
- Training of health professionals in respectful maternity care

Objective 2 - Improve care for women with obstetric fistula

Strategy 2.1 - Strengthen case identification, notification, mobilisation and referral of women with obstetric fistula

Key interventions

- Creation of an enabling environment to empower fistula patients to seek care
- Educating community members about the signs and symptoms of fistula and case notification protocols
- Identifying, training and incentivising community fistula advocates/ambassadors/volunteers for active case search and case notification protocols
- Use of the snowball approach (using a satisfied client post repair to find another fistula patient) to identify more cases using the satisfied fistula repaired clients
- Establishing a toll-free hotline for fistula notification linked to the national call centre
- Training of Health Workers and Midwives about the signs and symptoms of fistula and case notification protocols
- Developing and adapting screening, monitoring and reporting tools for identification and referral
- Include screening for obstetric fistula in post-partum care
- Providing adequate equipment and logistic supplies for diagnosis of fistula
- Adoption of a task-sharing approach for the assessment of identified fistula clients
- Providing nutritional support to identified cases before and after surgery
- Providing resources (transport, communication, appropriate gears etc.) for the recruitment teams
- Commemoration of the International Day for the Elimination of Obstetric Fistula (IDEOF) at all district and regional levels

Strategy 2.2 - Provide treatment and care for all women with obstetric fistula

Key interventions

- Increase in the number of fistula repairs at available treatment centres
- Intensified awareness of available treatment and specialised repair services
- Increase in the number and frequency of outreach for outreach-based repairs
- Establishment of multidisciplinary (including social workers, psychologist and nutritionist) care teams in the fistula care- and treatment centres, covering pre- a post repair needs
- Establishment or adaptation of treatment guidelines for obstetric fistula services that include patient education
- Encouraging the establishment of support groups of fistula patients
- Repair of identified fistula clients in a timely manner
- Providing a need-specific support package for clients requiring repeated treatments
- Providing a need-specific support package for clients deemed incurable
- Strengthening EmONC services
- Improving provision of SRH education for fistula patients, including family planning
- Establishment and maintenance of a clear care- and referral pathway for women with fistula

Strategy 2.3 - Increase the number of obstetric fistula repair personnel

Key interventions

- Recruitment, training and retention of more caregivers in fistula surgery in-country
- Providing at least one fistula repair team each for the Northern and Southern provinces
- Inclusion of fistula screening and repair in the curricula for OB/GYN specialists in training
- Inclusion of prevention and diagnosis of obstetric fistula in Midwifery training, including post-partum and well women care

Strategy 2.4 - Strengthen the capacity of all regional hospitals to treat obstetric fistula

Key interventions

- Institutionalising of obstetric fistula treatment in all regional hospitals
- Supporting the establishment and equipping of fistula units in all regional hospitals
- Maintaining Aberdeen Women's Centre, Freetown, as a centre of excellence for fistula repair

Strategy 2.5 - Provide rehabilitation, empowerment, integration and re-integration for each client

Key interventions

- Providing rehabilitation, integration and re-integration packages tailored to individual woman's needs
- Providing psychosocial support to clients and caregivers
- Development and implementation of specific guidelines and standards for the rehabilitation, integration and re-integration of repaired clients
- Providing nutritional support to identified cases before and after surgery
- Providing special support services for clients deemed incurable or requiring complex surgery
- Providing extended guidance and counselling support for clients not cured
- Providing long-term medical care as required, especially for clients with additional complications



Objective 3 - Strengthen governance, leadership, programme management and partnerships

Strategy 3.1 - Strengthen Government's commitment to the elimination of obstetric fistula through the MoHS

Key interventions

- Strengthening of the oversight role of the national fistula task force for fistula governance
- Conducting national and regional launches and dissemination of the Sierra Leone Fistula Area of Intervention and Implementation Plan
- Development, support and implementation by MoHS of policies and laws that promote SRHR and accelerate access to education for the girl child at all levels
- Establishing of fistula elimination as a permanent priority agenda in all ministries and agencies whose missions intersect with the agenda to eliminate fistula
- Promotion of the enforcement of the revised Child Rights Act 2007 and other laws on early marriages and other harmful traditional practices
- Creation of a coordination platform to monitor performance of National Fistula programme
- Establishing an intersectoral coordinating mechanism for the fistula programme
- Development of guidelines, training curricula and SOPs

Strategy 3.2 - Establish formal partnerships with NGOs, CBOs and other community actors and linking them with fistula clients for support

Key interventions

- Mapping of NGOs, CBOs and other community actors to identify their potential to support fistula prevention, identification, referral, treatment and rehabilitation/re-integration
- Identification of partners and definition of roles and responsibilities.
- Establishing mechanisms for accountability
- Establishing and maintaining a care continuum for obstetric fistula clients from identification, surgery, integration and re-integration in line with the MoHS policy on Universal Health Coverage
- Encouraging public-private partnerships in fistula management

Strategy 3.3 - Strengthen management and leadership to institutionalise fistula repair

Key interventions

- Creating platforms and developing curriculum for leadership and programme management
- Creating a platform of prominent Sierra Leoneans and fistula ambassadors for advocacy and lobbying for elimination of obstetric fistula

Strategy 3.4 - Programme sustainability, coordination and communication

Key interventions

- Developing a communication area of intervention that ensures regular or periodic engagement with fistula treatment centres
- Community engagement using stakeholders
- Media engagement

- Support for the setting up of a hotline
- Creating a budget line and allocation of budget line for the elimination of obstetric fistula at the district council level
- Creating advocacy at the highest level of governance including the parliamentary select committee on health
- Fostering cross-border coordination on fistula repair
- Providing the requisite cadres in the appropriate numbers
- Ensuring the availability of adequate tools



Objective 4 - Improve resource mobilisation and financing

Strategy 4.1: Promote financial protection mechanisms for pregnant women and girls and fistula survivors

Key interventions

- Inclusion of fistula patients in SLeSHI under the UHC road map
- Encouraging community-led risk pooling initiatives
- Promotion of cooperatives among community members to facilitate access to quality care for pregnant women
- Promotion of cooperatives among women to encourage income generating activities that empower women
- Improving free health care initiative

Strategy 4.2 - Enhance resource mobilisation for obstetric fistula programme

Key interventions

- Increase in government budgetary allocation to SRH including obstetric fistula
- Encouraging district local councils and regional hospitals to include a budget line for fistula elimination in the annual workplan
- Encouraging income generation among fistula patients' post-rehabilitation
- Development of an area of intervention for resource mobilisation
- Advocacy for sustainable funding from traditional and non-traditional donors
- Resource mobilisation from private sector and individual philanthropists
- Establishing a forum for friends of fistula survivors
- Establishing annual activities for obstetric fistula, for example a 'fun run'
- Integrating fistula intervention in all SRHR programmes

Strategy 4.3 - Develop mechanisms for fistula fund management

Key interventions

- Setting up a fistula fund management system including guidelines for disbursement
- Periodic engagement with the fistula programme leads
- Creation of workplans to include relevant line ministries
- Providing technical support for districts to access funding for the fistula programme
- Enhanced resource tracking for obstetric fistula
- Establishing a financial accountability mechanism for obstetric fistula

Objective 5 - Strengthen research, monitoring and evaluation, and learning

Strategy 5.1 - Strengthen planning, and monitoring and evaluation of fistula programmes

Key interventions

- Setting up and incorporation of fistula indicators within the existing health sector M&E frameworks including the DHIS2
- Development of tools for data management including fistula registers at all levels
- Capacity-building in data management
- Institutionalisation of the inclusion of fistula cases, referrals, treatment, and rehabilitation/re-integration in district/national quarterly and annual reports
- Institutionalisation of the inclusion of fistula data and reporting in annual performance reviews and periodic evaluations
- Ensuring all districts develop strategic plans in line with the national fistula strategy and implementation plan
- Facilitation of learning on obstetric fistula
- Supportive supervision of the fistula programme

Strategy 5.2 - Develop and implement operational research

Key interventions

- Periodic surveys to establish and monitor prevalence and incidence of fistula
- Implementation science research and assessments in line with identified fistula priorities
- Mid-term and end-term evaluation of the implementation of the fistula strategy
- Documenting and sharing good practices
- Developing and implementing a fistula research agenda in line with that of the MoHS
- Dissemination of the findings of the research reports

5 IMPLEMENTATION

The lifetime of the Sierra Leone fistula strategy is five years, from 2023 to 2027. It is expected that within this period all the interventions would be implemented in a coordinated and timely manner at all levels to achieve the goal of the strategy.

Three levels of intervention will provide technical support for creating awareness, community engagement and active case finding at the community level. They will also ensure the coordination of screenings and diagnosis at the appropriate health facility level. The District Health Management Teams will support facilities in ensuring that effective follow-up and community linkage mechanisms are in place. Referral linkages between communities, health centres and hospitals will also be strengthened. The District Health Management Teams will strengthen the process of reintegration of rehabilitated post-repair clients into society.

National level

| Activities | Stakeholder | Timeframe |
|--|------------------|-----------|
| Mapping of stakeholders and Implementing Partners | MoHS, UNFPA | 2023 |
| Establishing a Task Force, Technical Working Groups and subsequently a Steering Committee | All stakeholders | 2023 |
| Preparation of new, and review of existing, guidelines, standard operating procedures (SOPs), training manuals, care- and referral pathway and other protocols | Task Force | 2023 |
| Development (resp. review) of Job Aids | Task Force | 2023 |
| Training on and implementation of guidelines, standard operating procedures (SOPs), referral pathway and other protocols as well as Job Aids | Task Force | 2024 |
| Compile and agree on a Memorandum of Understanding, outlining commitment, of stakeholders | Task Force | 2023 |

Table 3: Implementation on national level

Activities shall focus on preparation of guidelines, SOPs, training manuals, protocols and Job Aids. The National Fistula Task Force will provide technical support to the Reproductive Health Directorate of the Ministry of Health and Sanitation to adapt the strategy to regional and district council contexts. Central coordination of fistula activities will be by the Focal Person.

A Memorandum of Understanding clearly delineating the role and responsibilities of all stakeholders will be drawn, implemented and periodically reviewed.

Regional and District Council level

Regional Public Health Units will be resourced to guide and monitor the implementation of the Regional Plan.

High fistula prevalence areas will be identified, especially in the first year of implementation, and prioritised for technical and logistic support. Makeni (among areas in the north and northeast provinces) and Bo (among areas in the south and eastern provinces) are identified as areas with high prevalence of obstetric fistula.

Coordination of treatment programmes will be at this level. Quarterly reviews of the fistula work plan will be conducted by the Regional Public Health Units and all stakeholders to ensure adherence to the plan.

| Activities | Stakeholder | Timeframe |
|---|---|---------------|
| Identify high obstetric fistula prevalence areas, discuss and decide on technical and logistical support | MoHS, UNFPA, IP | 2023 |
| Regional Public Health Units will be resourced to guide and monitor the implementation of the Regional Plan | Task Force | 2023 |
| Identify a location outside Freetown area, set up the first treatment unit and begin carrying out surgeries | MoHS, UNFPA, Task Force and Implementing Partners | 2023 |
| Set up the second treatment unit and start carrying out surgeries | MoHS, UNFPA, Task Force and Implementing Partners | 2024 |
| Extend support to existing treatment units in Freetown and in other districts, if available | MoHS, UNFPA, Task Force and Implementing Partners | 2023 and 2024 |
| Coordination of treatment programmes | Task Force | 2023 - 2027 |
| Quarterly reviews of the fistula work plan | Regional Public Health units with all stakeholders | 2023-2027 |
| Develop relevant budgets | MoHS, UNFPA supported by stakeholders with experience in obstetric fistula repair surgery | 2023 and 2023 |

Table 4: Implementation on regional and district council level

District, Community Health Centres and Community Health Posts

The communities, the health workers and the health centres at community level are entry point for referrals of obstetric fistula patients to treatment centres.

| Activities | Stakeholder | Time-frame |
|---|---|---------------|
| Identify implementing partners and develop activities to establish community engagement | MoHS, UNFPA, Task Force and Implementing Partners | 2023 |
| Conduct community engagement activities | MoHS, UNFPA, Task Force and Implementing Partners | 2023 - 2027 |
| Develop awareness and sensitisation programmes | MoHS, UNFPA, Task Force and Implementing Partners | 2023 and 2024 |
| Conduct awareness and sensitisation programmes | MoHS, UNFPA, Task Force and Implementing Partners | 2023 - 2027 |
| Develop screening and diagnosis SOP | MoHS, UNFPA, Task Force and Implementing Partners | 2023 |
| Implement screening and diagnosis SOP | MoHS, UNFPA, Task Force and Implementing Partners | 2024 |
| Train appropriate health facilities and staff and apply SOP | MoHS, UNFPA, Task Force and Implementing Partners | 2023 - 2027 |

Table 5: Implementation on community level



ANNEX

I Composition of the National Obstetric Fistula Task Force in Sierra Leone

Aberdeen Women's Centre (AWC)
Christian Health Association of Sierra Leone (CHASL)
Civil Society Organisations
Chief Medical Officer (CMO)
Fambul Initiative Network for Equality (FINE Sierra Leone)
Haikal
Interreligious Council of Sierra Leone
Ministry of Gender and Children's affairs
Ministry of Social Welfare (MSW)
Ministry of Health and Sanitation (MoHS)

Planned Parenthood Association (PPASL)
RESTLESS Development
Sierra Leone Association of Non-Organisations (SLAGO)
Sierra Leone Maritime Administration (SLMA)
Sierra Leone Nurses Association (SLNA)
University of Sierra Leone Teaching Hospitals (USLTHC) at Princess Christian Maternal Hospital (PCMH)
United Nations Population Fund (UNFPA)
West Africa Fistula Foundation (WAFF)
World Health Organisation (WHO)

II Roles and responsibilities of stakeholders

Ministry of Health and Sanitation

- Provide strong support, political commitment and leadership to the programme.
- Serve as the central coordination unit.
- Create an overall conducive environment for implementation of the strategic plan by establishing efficient institutional and management systems at all levels, building on existing structures and mechanisms.
- Create an enabling environment for effective multisectoral collaboration with relevant ministries (Finance; Social Welfare, Gender and Children's affairs; Education, Justice and Attorney General; Information and Communication; Local Government and Rural development; and Internal affairs).
- Liaise with the Parliamentary select committee on health and the Ministry of Finance to advocate for the inclusion of fistula treatment on the free health care initiative in public facilities.
- Provide overall policy and technical leadership, guidance, advice, resource allocation, and M&E for the implementation of the Plan.
- Collaborate with professional societies (Sierra Leone Association of Non-Organisations, Sierra Leone Maritime Administration, Sierra Leone Nurses Association) to prepare national fistula management guidelines, SOPs and various training manuals.

National Fistula Task Force

- Provide technical support and advice to the MoHS (through the reproductive health directorate) for the implementation of the Plan at the national level and where possible at regional and district levels.
- Provide technical support for development and implementation of subnational plans, guidelines and protocols and assurance of support, effective collaboration and participation by all stakeholders.
- Support resource mobilisation for implementation of the fistula strategy.
- Provide technical support in the preparation of guidelines, protocols, and training manuals in collaboration with Sierra Leone Association of Non-Governmental Organisations, Sierra Leone Medical and Dental Association and Sierra Leone Nurses and Midwives Association.
- Support adoption of national strategic plan into context specific regional plans by the Regional Health Management Teams.
- Coordinate technical support for revision/update of and implementation of district plans in line with the national plan.
- Plan resource allocation, management, supervision and monitoring of all fistula activities and partners in the region.
- Coordinate and ensure quality training and mentoring of health care providers on fistula at the regional and district levels.
- Compile, analyse and disseminate data and reports on fistula from the districts and to the national level and to stakeholders.
- Coordinate and conduct supportive supervision and clinical mentoring visits to hospitals and health centres.

District Health Management Teams

- Develop and implement context-specific district plans to eliminate fistula (including monitoring/supervision and evaluation) by updating existing plans.
- Provide technical support for quality fistula services and referral. This includes establishing effective follow-up mechanisms at the community level for fistula, through the involvement of Community Health Officers, community volunteers, health extension officers, fistula advocates and women's associations.

- Organise advocates, women’s associations, religious and community leaders to promote RMNCAH services, including fistula, for active case finding and referral (Community Health Officers/Community Based Volunteers).
- Identify local barriers to accessing services and act on them (Community Health Officers/CBVs).
- Support the rehabilitation and reintegration of fistula clients at the community level (Community Health Officers/CBVs).
- Support advocates in actively participating in active case searches of women with fistula.
- Support education and raising awareness among the public health facilities.
- Ensure free RMNCAH services, including those for fistula, through consultations with the Free Health Initiative, Sierra Leone Health Insurance Scheme, service providers, partners, civil society, and communities.
- Ensure provision of respectful maternity care services.
- Ensure availability of supplies and motivated staff to undertake quality diagnosis of fistula at the health facility level.
- Participate in community-based case finding and diagnosis of fistula cases in close collaboration with Community Health Posts.
- Institute active referral and tracking mechanisms to ensure that fistula cases are referred and receive all the necessary services when moving from one level of care to the next.

Implementing Partners

- Support funding, coordination, and provision of technical support for the implementation of the national and subnational fistula elimination plans.
- Incorporate the strengthening of community and health systems including human resources into areas receiving donor support.
- Provide technical and financial support for expansion of services at the regional and district levels.
- Provide technical and financial support to regions and districts to identify needs/gaps and translate the strategic plan to eliminate fistula into comprehensive regional and district-specific, actionable and effective plans. The goal is to avoid parallel structures and mechanisms that could undermine national ownership and sustainability.
- Strengthen the coordination of partners at national, regional and district levels to optimise investment, accelerate expansion, improve performance assessment, and facilitate experience sharing and documentation of best practices that can be shared with other stakeholders to improve implementation and outcomes of the programme.
- Support capacity-building activities to enable Regional Health Management Teams and DHMTs to effectively plan, manage, implement and monitor the programme.
- Provide funding through a variety of modalities, including direct budget or pooled support and through support to projects that focus on fistula research and studies as part of comprehensive RMNCAH services.

Communities, Civil Society Organisations, traditional Authorities

- Mobilise community support for the programme.
- Mobilise local resources to support the programme.
- Eliminate harmful traditional practices within the community.
- Support female education and support the drive to eliminate child marriage and early marriage and other harmful traditional practices.

Media, information and communication networks

- Support the development and implementation of a communication strategy for social mobilisation, demand creation and stigma reduction.

- Use standard messages and effective communication channels for different audiences such as youth, women and men.
- Identify fistula elimination champions to support resource and social mobilisation and Behaviour Change Communication activities.

Ministries of Education, Finance, Gender, Children, Social Welfare, Justice, Communication and local Government/Interior

- Ministry of Education to promote improved access to quality education for girls, support implementation of the National Nutrition Strategy focusing on improving girls' nutrition throughout their life cycle and delaying the age of marriage.
- Ministry of Finance to support resource mobilisation for the programme and ensure financial sustainability by instituting budget lines for RMNCAH within the national budget.
- Ministry of Gender and Children's affairs to support women's and children's rights and protections and also support the building of awareness of fistula, case identification, treatment, rehabilitation and social reintegration efforts.
- Ministry of Justice to support child rights and protections and enforce laws on child marriage, and work with the police (Domestic Violence and Victim Support Unit).
- Ministry of Social Welfare to make use of its presence at the community level. Joining forces with the Ministry of Social Welfare and NGOs that are established in the fistula space could improve case identification and recruitment to the treatment centres. Also, it is suggested that the Ministry of Social Welfare support the reintegration process for long-term follow up. The department has offices countrywide and has greater potential for follow up after reintegration.
- Further: Involve the relevant parliamentary subcommittees related to health on obstetric fistula activities.

Academic institutions

- Support pre-and in-service training in RMNCAH, including fistula, and ensure inclusion of fistula in training curricula.
- Include training of fistula prevention and diagnosis into the midwifery training curricula.
- Ensure trainers have adequate knowledge and skills in RMNCAH and fistula and conduct research and studies to inform programme design and implementation.
- Support operational/implementation science research and innovation to accelerate scale-up, identify bottlenecks and solutions with special attention to improve service delivery.
- Enable Obstetrics and Gynaecology registrars to rotate through fistula care centres as part of mandatory rotations.

III Care- and referral pathway and stakeholder contributions

The national strategy proposes screening based on history only at the community level by Community Health Workers. Community health workers with midwifery skills shall then perform a second level of screening at the Maternal and Child Health Post (MCHP) or at the Community Health Centre’s (CHC). This will include a physical examination and a dye test¹⁶. The confirmatory diagnosis and drafting of a treatment plan would happen at pre-operative wards and referral hospitals.

That would mean fewer patients transported from their homes to district level facilities only to be found not to have fistula and help save resources. Thus, the health tier system will form the basis for defining the referral pathway for obstetric fistula from the community to regional level facilities for treatment.

With the setting up of dedicated treatment centres, it is expected that surgeries will occur in the regional hospitals.

The medical part of the care- and referral pathway, is expected to take 6 weeks to 2 months.

The social rehabilitation and re-integration add several months, usually 3.

Care- and referral pathway



Figure 2: Care- and referral pathway for obstetric fistula patients in Sierra Leone

¹⁶ <https://www.ics.org/glossary/investigation/simpledye-test-for-urinary-tract-fistula>

Recommendations on care- and referral pathway

This strategy recommends capturing activities (advocacy, sensitisation, screening, confirmatory diagnosis, treatment, rehabilitation, and reintegration) in a care- and referral pathway, developing respective SOP's, registration and reporting tools and train concerned stakeholders and Health Cadres, including midwives.

The MoHS and the respective directorates aim to develop and deploy job aids and conduct training of Peripheral Health Unit level staff in prevention of O.F, for example during ANC visits, and historical screening after delivery, using standardised adapted tools. Only those who screen positive shall be mobilised to an identified pre-operation care centre. Here, a methylene blue dye test should be performed to confirm the diagnosis. Alternately, the patient can receive a pelvic examination and methylene blue dye test at the nearest district hospital.

A register should be kept at the CHUs. By this approach, the entry point for the care pathway will be the CHU. All the patients so identified should be sent to the pre- and post-operation centre in Bo or other identified sites. Harmonising case identification and recruitment using the pre-existing health structures will be more effective as this can be routinised and eliminate the need to dispatch field officers into the communities.

Any community organisation can refer patients to the PHUs to enter the care pathway.

Basic screening of suspected O.F patients at PHU level will reduce resources for transporting patients experiencing leakage from causes other than fistula from the villages to the diagnosis and treatment centres. The cost of feeding and providing dignity kits will also be reduced.

The district medical officer could recommend a communication mechanism between the community level and the pre-operation centre in Bo, or the nearest district hospital. A means of transportation is needed from the communities to the pre- and post-operation centre in Bo.

Community level and PHU

Interviews of key informants (AWC, Haikal, WAFF, District Medical Officer) have identified the following practices that are used for current case identification and recruitment.

Field officers of the various stakeholders (AWC, Haikal) are dispatched to rural communities' weeks ahead of fistula outreach camps. In the communities, they engage in sensitisation through durbars, radio jingles and at places of worship. During the sensitisation programmes, signs and symptoms of obstetric fistula are elaborated upon. Persons with symptoms or knowledge of people with symptoms are encouraged to come forward or to contact the field officers later via phone. Contact numbers are announced. At time of compiling this strategy, Haikal is the predominant organisation involved in recruitment, followed by AWC.

Each organisation transports the patients to their own bases for further evaluation. Haikal normally sends the patients to AWC or Bo government hospital for surgery. Delays in announcing outreach dates result in a significant burden of care for the patients borne by Haikal at their centre. The resources provided often do not match the demands for boarding and lodging. Occasionally patients are confirmed not to have fistula after travelling from the rural areas to Haikal, which is a great inconvenience for everyone involved.

Pre- and post-operation centres

At the time of launching this strategy, a pre- and post-operation care centre in Kakua, Bo, set-up by the West African Fistula Foundation in cooperation with the Ministry of Health, is equipped to care for 40 patients at a time. The centre is aimed to be the first point of arrival for fistula patients from the communities. Here, detailed medical history, examination and methylene blue dye testing shall

be performed by a resident medical officer with the aim to confirm or exclude obstetric fistula. Once confirmed, the patient will stay at the WAFF centre for pre-operative optimisation. Nutrition care, patient education, surgical counselling, sharing of experiences living with fistula etc. will be the focus. The prognosis will be discussed with the patients.

Patients considered fit for surgery will then undergo pre-operative evaluation including anaesthesia review while at Kakua. They will be transferred to the Bo Government hospital one or two days before surgery. The number of patients that can stay at the hospital is defined by the bed capacity of the fistula ward at the Bo government hospital. At time of printing of this strategy this is 7 beds.

Surgery will be performed at the Bo government hospital during fistula camps. From 48 to 72 hours after surgery, and when stable, the patients will be returned to the WAFF centre to continue recuperating until discharged from care – usually between day 14 and 21. Once discharged from WAFF, the patient will be offered to participate in an extended rehabilitation and reintegration support programme that includes training in vocational and income generating skills at the Haikal Training Centre in Bo. Once the patient graduates from Haikal, she will be ready to return to the community.

Surgeries

Bo Government Hospital

At Bo government hospital, a dedicated operation theatre for obstetric fistula surgeries was refurbished by WAFF and UNFPA in cooperation with MoHS and respective directorates. At the time of publishing this strategy, equipment and instruments are awaited. A supply chain management must be set up for consumables. Haikal supported the refurbishment of a dedicated seven-bed fistula ward in the maternity ward.

At this facility, training for local physicians interested in fistula surgery can be conducted. The hospital shall maintain records of all patients and reconcile records and case numbers with similar records at the pre- and post-operation centre in Kakua and the Haikal training centre.

It is aimed to offer quarterly fistula surgery camps, this to clear the backlog in Sierra Leone and to address newly occurring obstetric fistula patients. The quantity of patients per camp will be restricted by the pre- and post-operation bed capacity.

The Aberdeen Women's Centre

With a mission to provide high quality, holistic care and treatment, free of charge, a clinic on the site of Aberdeen Women's Centre was set up in 2005 by Mercy Ships. It was called the Mercy Ships Aberdeen West Africa Fistula Centre and focused on providing fistula surgeries and running a small outpatient children's clinic. In 2008, Freedom for Fistula (FFF) took over the site, and started the AWC, which has expanded its services considerably over the last 14 years, including the opening of the maternity unit in 2010.

Located in Freetown, AWC is an all-in-one location for fistula care. It is the most experienced facility for fistula care in Sierra Leone given its long-standing history of expertise support from abroad. Cases that cannot be operated upon at Bo due to their complexity can be referred to AWC. Since Freetown has the best opportunities for multidisciplinary care, special cases will be referred to AWC for treatment. AWC will continue to treat fistula patients using their pre-set mechanisms. When necessary, confirmed fistulas from the WAFF centre can be transferred to AWC for treatment.

Rehabilitation and social reintegration services

Currently the most ideal centre in Sierra Leone for rehabilitation and social reintegration of cured fistula patients is the Training Centre in Bo, run by the Haikal foundation.

Haikals' mission is to provide quality education and healthcare services and to improve the capacity of women and young people to acquire livelihood skills, which will engage them in income-generating activities to proactively contribute to their own development. The organization was established in 2001 to respond to the needs of Communities and their environs in Health and Education after the 11-year civil conflict that caused massive devastation and destruction of lives and properties. Haikal is registered as National Non-Governmental Organization (NGO) in Sierra Leone and operating in Bo.

Since 2008. Haikal Organization works with Obstetric Fistula clients. Whilst at the initial stage Haikal engaged in Training and Advocacy (awareness-raising campaigns) in communities around Bo town and its environs on health-related issues, today, Haikal concentrates on support to repaired fistula patients. Since 2010, Haikal successfully rehabilitated and re-integrated over 750 Obstetric Fistula patients in their communities.

In the past, there has been skills training offered for cohorts of cured patients. Haikal offers follow up medical care and counselling services. The vocational training on offer includes literacy and numeracy classes, IT courses, tailoring, catering, and soap making. The facility also has a clinic on site manned by a midwife. The skills training at Haikal is designed to cover three months per patient, tailoring classes can take longer.

This strategy recommends the involvement of the social welfare department in the reintegration process for long-term follow up. The department has offices countrywide and has greater potential for follow up after reintegration.



VI Monitoring and evaluation framework for the fistula strategy

The goal of the strategy is to have 9 out of 10 pre-existing fistula cases treated while new occurrences are reduced by half.

Indicators

Prevalence of obstetric fistula in Sierra Leone.

Baseline: 2,400 (Islamic Development Bank, 2019)

Target for clearing the backlog: 240 (by 2027)

| Indicators | BASELINE | TARGET |
|--|----------|---------|
| 1. Prevent obstetric fistula | | |
| a. Incidence of obstetric fistulas | N.A. | |
| b. Institutional deliveries | 83% | 90% |
| c. Skilled birth attendant | 87% | 93% |
| d. Contraceptive prevalence | 24% | 32% |
| e. Adolescent birth rate (per 1,000 adolescents) | 102/1000 | 74/1000 |
| f. Functional EmONC facilities | 13% | 100% |
| g. Percentage of direct obstetric complications managed at the EmONC facility | N.A. | TBD |
| h. Caesarean section rate | 4% | 5% |
| i. Percentage of functional ambulances in the district | N.A. | TBD |
| j. ANC coverage | 79% | 91% |
| k. Postnatal coverage (48 hours post-delivery) | 86% | 97% |
| 2. Improve care for women with obstetric fistula | | |
| a. Number of fistula patients identified | N.A. | 100 |
| i. Percentage of identified patients who accessed surgery | | |
| ii. Percentage of identified patients who had successful surgery immediate post-op (up to two weeks) | N.A. | 85% |
| iii. Percentage of women who have had two or more unsuccessful repairs | N.A. | 10% |
| b. Percentage of fistula survivors who have benefitted from the reintegration programme | 30% | 90% |
| c. Proportion of post-repair clients receiving counselling | N.A. | 100% |
| d. Development of SOPs for reintegration and rehabilitation | No | Yes |
| e. Number of Sierra Leonean fistula surgeons providing fistula surgery | 0 | 3 |
| f. Number of nurses trained in management of fistula | N.A. | 80 |
| g. Number of centres providing fistula surgery | 1 | 3 |
| h. Number of training programmes for health workers that have integrated fistula management in their curriculum (midwifery, community health | 2 | 5 |

| | | |
|---|------|-----|
| assistants/Community Health Officers, SACHOs, general nursing, physicians) | | |
| 3. Strengthen governance, leadership, programme management and partnerships for elimination of obstetric fistula | | |
| a. Existence of a functional fistula task force | Yes | Yes |
| b. Number of districts with fistula focal points | 2 | 16 |
| c. Number of active Government ministries in the fistula task force | 3 | 5 |
| d. Establishment of a functional referral pathway | No | Yes |
| e. Number of health sector policies, strategies and guidelines that have integrated fistula elimination | 0 | 5 |
| f. Fistula indicators integrated into the DHIS2 | No | Yes |
| g. Existence of a functional fistula register at all levels | No | Yes |
| h. Number of districts with active fistula ambassadors | 5 | 16 |
| 4. Improve resource mobilisation and financing | | |
| a. Number of partners providing funds for fistula | 5 | 7 |
| b. Number of districts with a budget line for fistula in their annual work plan | 0 | 16 |
| c. Percentage of allocated budget used for fistula activities | N.A. | 100 |
| 5. Strengthen M&E, learning and research on obstetric fistula elimination. | | |
| a. Number of research studies conducted on fistula | 0 | 3 |
| b. Number of programme review meetings conducted | 0 | 5 |
| c. Number of knowledge management products developed | 0 | 10 |

Table 6: Indicators for specific objectives and targets



REPUBLIC OF SIERRA LEONE
Ministry of Health and Sanitation



United Nations Population Fund

