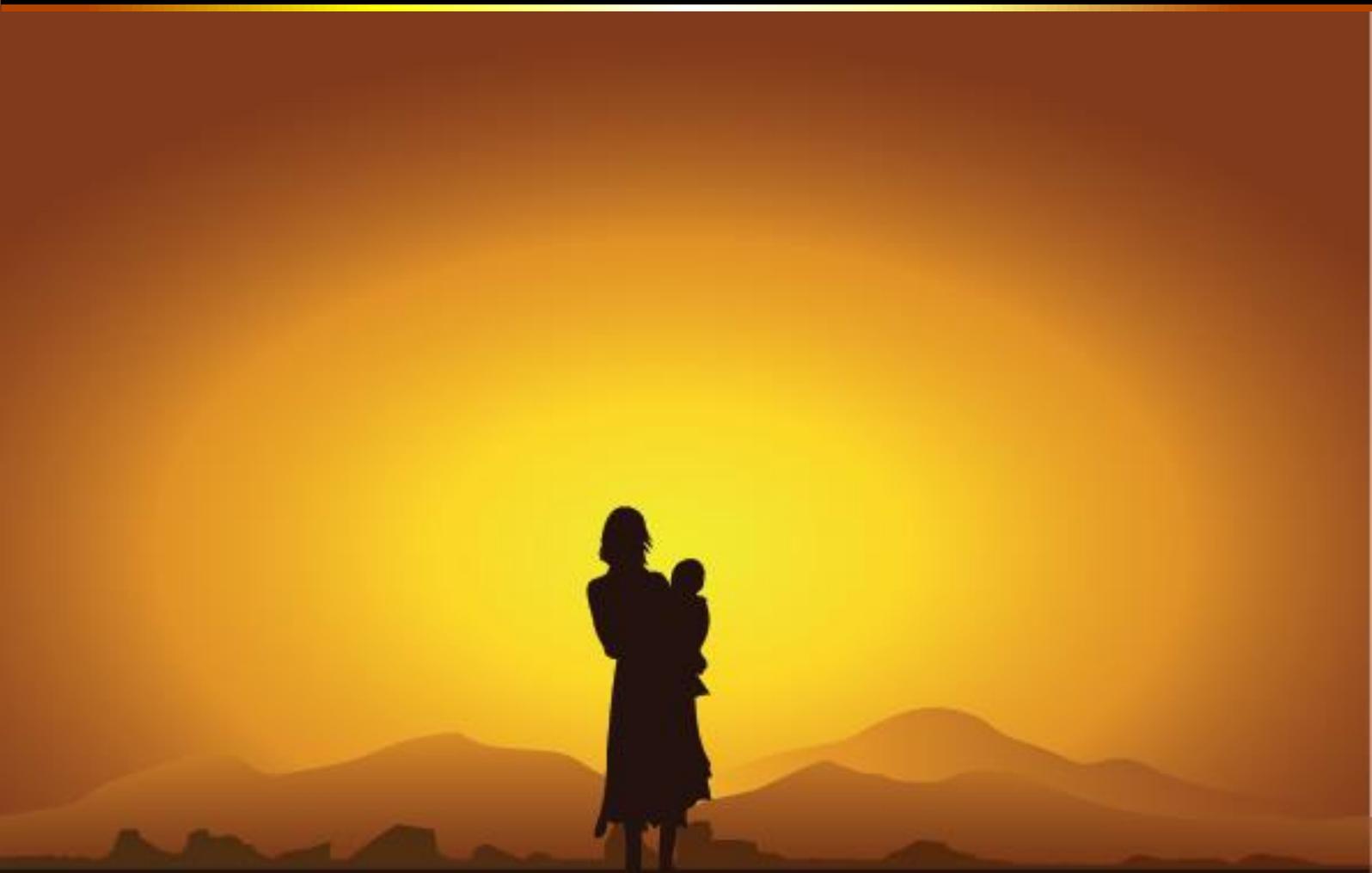


NATIONAL STRATEGIC PLAN FOR ELIMINATION OF OBSTETRIC FISTULA

2021-2025 (2013-2017 EFY)



DECEMBER 2021

The Ministry of Health has instituted measures to accelerate the reduction of morbidity and mortality through the implementation of the first Health Sector Transformation Plan (HSTP-I) from 2016 to 2020 with other strategies that helped to translate the plan into action. As a result, the large-scale efforts to improve the health of the population and increase access to and utilization of health services have succeeded in saving millions of lives and preserving the livelihoods and social fabric of the population. Although enormous progress has been made in Maternal and child health services including improvement of skilled birth attendance, Ethiopian women are still facing complications of pregnancy and childbirth.

Of the maternal health problems, obstetric fistula (OF) is one of the worst complications of childbirth. Most victims of this horrific condition are the young, those who are married at an early age, living in poverty or in rural Ethiopia. In 2016, less than one percent of women experienced obstetric fistula, which is indeed significantly lower than earlier estimates. The observed decline could be due to the improved maternal health services including access to cesarean section delivery. This indicates that Ethiopia is probably at the turning point to eliminate OF. The coming five years are, therefore, the critical time to deepen the intervention and make OF history.

Cognizant of this, the Ministry reiterates its commitment towards eliminating OF by 2025 by putting a national strategy in place to guide the implementation of strategic plans for prevention, treatment, rehabilitation and reintegration of the OF survivors. The strategy puts forth the key priorities which guide government sectors and non-governmental organizations in resource mobilization, community engagement, monitoring and evaluation of OF elimination endeavor.

I, therefore, call upon all stakeholders, including Development Partners, Civil Societies, Private Sectors, and the Community to use this strategy as a guide to plan programs and gear activities towards elimination of OF from Ethiopia.



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Acronyms

ANC	Antenatal Care
AWC	Aberdeen Women's Centre
BEmONC	Basic Emergency Obstetric and Newborn Care
BCC	Behavior Change Communication
CS	Caesarean Section
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CSA	Central Statistics Agency
CBHI	Community Based Health Insurance
CPR	Contraceptive Prevalence Rate
EOF	Elimination of Obstetric Fistula
EmNOC	Emergency Obstetric and Newborn Care
EDHS	Ethiopian Demographic and Health Survey
FGM	Female Genital Mutilation
HFC	Hamlin Fistula Hospital and Centers
HTP	Harmful Traditional Practice
HC	Health Center
HEW	Health Extension Workers
HSDP	Health Sector Development Plan
HSTP	Health Sector Transformation Plan
HP	Hospital
HRH	Human Resource for Health
IEC	Information, Education, and Communication
IESO	Integrated Emergency Obstetric and Surgical Officers
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn, and Child Health
MWH	Maternity Waiting Home
MDG	Millennium Development Goal
MOH	Ministry of Health

OF	Obstetric Fistula
OFSR	Obstetric Fistula Surveillance and Response
OL/PL	Obstructed Labor/Prolonged Labor
OOP	Out of Pocket
POP	Pelvic Organ Prolapse
PNC	Postnatal Care
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management System
RVF	Recto-Vaginal Fistula
RHCS	Reproductive Health Commodity Security
RMNCAYH	Reproductive, Maternal, Newborn, Child, Adolescent, and Youth Health
SARA	Service Availability and Readiness Assessment
SRH	Sexual and Reproductive Health
SRHR	Sexual, Reproductive Health and Rights
SBCC	Social and Behavior Change Communication
SHI	Social Health Insurance
SOP	Standard Operating Procedure
SDG	Sustainable Development Goal
TWG	Technical Working Group
UN	United Nations
UHC	Universal Health Coverage
VVF	Vesico-Vaginal Fistula
WHDT	Women Health Development Team
WHO	World Health Organization

Executive Summary

The overall objective of this strategic plan is elimination of obstetric fistula (OF) by 2025 and visioning OF free Ethiopia, like many developed countries, which were able to eliminate OF 100-150 years ago. The six fistula treatment centers and three hospitals can manage more than five thousand women with OF yearly; however, their four years' performance (2016-2019) was only 6304, which is three fold lower than what they could have done.

To estimate the exact prevalence and incidence of OF is challenging. It is known that obstructed labor precedes OF. Over the last five to seven years the prevalence of obstructed labor is becoming less common in Ethiopia; the overall prevalence of prolonged/obstructed labor was estimated to be 2% in 2016. However, data may not represent the true incidence in a country where half of pregnant mothers deliver at home.

Using statistical modelling which uses different data sources (2016 EmONC, CS rate, estimated OF among obstructed labor, crude birthrate, and population growth), the number of cases with OF was estimated to be 948. Moreover, 1.6% of the prolonged/obstructed labor cases and 0.03% of the total deliveries were complicated by OF.

All these data indicate that Ethiopia is probably at the turning point to eliminate OF, highly persuasive to escalate the case identification to clear probable cases from the community, conducting national surveillance to identify hard to reach cases, and keeping on progressively improving obstetric care. Innovative approaches are given equal priority to the OF case identification and enhancing obstetric service demand creation. This strategic plan has also given due emphasis for reintegration and income generation for OF survivors. As the last mile is always difficult to reach, the OF risk reduction and case identification need to be intensified in the coming five years.

1.1. Background

Ethiopia has achieved a substantial reduction in maternal mortality over the last two decades. Maternal mortality ratio which was estimated to be 1250 deaths per 100,000 live births in 1990 has declined to 401 in 2017. However, it is still unacceptably high.¹ Moreover, even though the magnitude is not clearly known, many more women suffer from short and long term morbidities due to pregnancy and childbirth complications. Evidence showed for every maternal death, additional 20–30 women develop serious complications globally. Among all maternal morbidities, obstetric fistula is one of the most devastating complications as it is not only limited to physical illness, but also has psychosocial and economic consequences.²⁻⁶

Obstetric fistula is an abnormal opening between vagina and bladder (vesico-vaginal fistula/VVF) or vagina and rectum (recto-vaginal fistula/RVF) leading to continuous urinary or fecal incontinence.^{7,8} Obstetric fistula occurs as a result of childbirth injury due to obstructed labor or management of difficult labor such as following operative deliveries (iatrogenic). Worldwide, between 50,000 to 100,000 women are affected by obstetric fistula each year of which almost all are exclusively in sub-Saharan Africa and southern Asia.⁹ However, this is a rough estimate and few data exist about the epidemiology of obstetric fistula.

In Ethiopia, the point prevalence of OF is 1.4 per 1000 women of childbearing age. Although, there is significant subnational variation in the burden of vaginal fistula, overall, there was substantial reduction in the prevalence of vaginal fistula. Districts with more than 200 cases of untreated obstetric fistula has reduced to 6 in 2016 from the 54 in 2005.^{10,11} According to Ethiopian demographic and health survey, less than one percent of women experienced obstetric fistula.¹ The decline in obstetric fistula could be due to improvement of maternal health service, increased availability and accessibility of emergency obstetric care and successful efforts to end fistula in the country.

Despite the substantial progress, there are still a significant number of untreated OF cases in Ethiopia mainly because of weak identification and referral system. It is estimated that over 142,387 fistula patients exist in Ethiopia. Those women who had female genital mutilation (FGM) had higher odds of reporting the condition and women from rural areas were less likely to report obstetric fistula than their urban counterparts.^{12,13} On the other hand, despite decline in the number of fistula cases that arise following obstructed labor, there is a rise in the incidence of fistula that arise following cesarean section.¹⁴

It is, therefore, critical to increase access to comprehensive quality emergency obstetric services to minimize the time delay contributing to obstetric fistula. In addition, more focused effort that targets high burden districts could be an effective intervention to end obstetric fistula in Ethiopia. A strong surveillance system plays vital role to identify surgical backlogs, to discover new cases and to refer patients to OF treatment centers. Addressing the physical, socioeconomic and psychological needs of OF survivors through appropriate social reintegration modality is also crucial. ^{2,3,15,16}

In general, as the majority of OF cases occur among rural and underserved or poor women, the devastating consequence exacerbates the existing poverty. Hence, this is often extremely stigmatizing and discriminating to the survivor. This is despite the known fact that it is both surgically preventable and treatable.

1.2. Rationale

Obstetric fistula (OF) is still one of the major causes of maternal morbidity in Ethiopia. The previous OF strategic plan was aiming to reduce the number of women with obstetric fistula to less than 1,600 in 2020 which is already off the track to achieve the target. As a result, the revised health sector transformation plan II has again put obstetric fistula as one of a priority areas.

Ending preventable maternal mortality and morbidity is of critical importance as such; eliminating OF which is one of the most devastating childbirth complications is essential. To guide the implementation and to accelerate elimination of OF in Ethiopia, the MOH revised the obstetric fistula elimination strategy for the 2021 to 2025. Every effort in pregnancy and child birth should keep on prioritizing prevention of OF as it is 100% preventable, which has been witnessed in many countries.

The rationale for the revision of the obstetric fistula elimination strategy is threefold. Firstly, it will draw attention to the devastating injuries and mobilize resources for a comprehensive and holistic approach to end OF. The second rationale is to offer health professionals, program managers and key stakeholders to guide their OF prevention and treatment effort. The third rationale is to identify the achievements and existing gaps of OF prevention, treatment and rehabilitation as well as key innovative approaches to implement.

1.3. The global effort for OF elimination

Obstetric fistula is a historical issue in the developed world. It was eliminated in USA and Europe between 1935 and 1950, and the best strategy for its elimination was universal access to safe delivery care¹. In these regions, antenatal care and emergency obstetric and newborn care (EmNOC) are comprehensively and equitably available. In addition, the prevalence of child marriage and FGM is very low. Furthermore, other risk factors such as teenage pregnancy, unmet need for contraception, poor nutritional status, and gender inequality are not major problems.

To give more emphasis, OFUNFPA and its partners launched the global Campaign to End Obstetric Fistula in 2003. To promote the individual country's actions towards preventing and treating OF, May 23 was marked by the UN as an International Day to End Obstetric Fistula in 2012. Several topic specific authors showed OF to be highly stigmatizing for those who must live with it and one of the “neglected tropical diseases”, for which elimination is impossible without government's and other stakeholder's commitment.

Therefore, there is no magic bullet to eliminate obstetric fistula better than strengthening the overall health system of the country to provide preventive health services (avoiding harmful traditional practices, improving child and maternal nutrition, providing family planning, antenatal care) and improving access to quality emergency maternal and newborn care (EmONC). In addition, improving the general socioeconomic environment, that predisposes for obstetric fistula, requires a multisectoral and gender transformative

¹ <https://www.thelancet.com/action/showPdf?pii=S2214-109X%2815%2970105-1>

approach to ultimately ensure inclusive universal access to health and socioeconomic development.

1.4. Ethiopian health policy for prevention and elimination of OF

Within the framework of the 1993 national health policy, MOH has formulated and implemented several policies and strategies, which were supportive of the prevention and elimination of OF. Since the launching of the health sector development plan (HSDP-I) in 1997/1998, maternal health was among the top health priorities for the Government. In addition to the commonly used national indicators for maternal health service utilization (antenatal care and skilled person attended delivery) and maternal mortality (MMR), outcome indicators for maternal morbidities (including OF) have also been given due consideration in the series of health policy documents.

During the era of HSDP I-IV (before 2015), a wide range of policy frameworks were developed and implemented to improve maternal health. Moreover, other strategies such as Making Pregnancy Safer in 2000, Reproductive Health Strategy, Adolescent and Youth Reproductive Health Strategy in 2006 and the Revised Abortion Law in 2005 had primarily targeted at reducing maternal morbidity and mortality. Although universal health coverage (UHC) was not clearly stipulated in the early phases of HSDP, the Health Care Financing Strategy was intended to provide financial protection for key maternal health services.

MOH had also established the Millennium Development Goals' (MDG) Performance Package Fund which had given top priority to achieve MDG 5. This was intended to facilitate mobilization of funding opportunities to improve maternal health. In addition, training and deployment of Health Extension Workers (HEWs) as well as Integrated Emergency Obstetric and Surgical Officers (IESO) aimed at reduction of maternal and perinatal morbidity and mortality. In order to reinforce the Health Extension Program, to increase the engagement of the community and create a bridge between the health facilities and the community; Women Health Development army/WHDA has been also introduced.

In the last five years, in particular, eliminating OF was one of the strategic objectives in both the health sector transformation plan (HSTP I) and the national reproductive health

strategic plan (2016-2020); and a separate strategic plan (2015-2020) for elimination of OF by 2020 was implemented with the motto of “Eliminating fistula and transforming lives”. There has been a continuous push either to include OF related issues in the Public Health Emergency Management (PHEM) system or to establish Obstetric Fistula Surveillance and Response (OFSR) system, merely to improve the national OF surveillance and case identification. This initiative is inline with UN 2018 resolution that has emphasized: “OF as a nationally notifiable condition, triggering immediate reporting, tracking and follow-up for the purpose of guiding the development and implementation of maternal health programs and ending fistula within a decade”.¹⁸

Although the progress is still far from the target, the Ethiopian Government has expressed its commitment to end FGM and child marriage (which are among major contributors to obstructed labor and development of OF) as noted in the *National Harmful Traditional Practices Strategy* (launched in 2013 by the Ministry of Women, Children and Youth Affairs), the *National Costed Roadmap to end child marriage and FGC in Ethiopia (2020–2024)*.^{19,20}

In addition, criminal code of Ethiopia put in place legal provisions for HTPs, including FGM. The revised Penal Code (EFDRE, 2005) protects young girls from FGM, domestic violence, abduction and early marriage and this creates an enabling policy environment to end fistula in Ethiopia.

In general, the national and international momentum to end OF is lively, and the progressive reduction in maternal mortality and obstructed labor in Ethiopia may indirectly indicate the reduction of OF in Ethiopia in the last five to ten years. For this progress; the health policy, government’s and development partners’ commitment have played a great role to the national endeavors of eliminating OF.

As commonly said, in developing countries, obstetric fistula results from “obstructed labor”, which in turn is consequence of “obstructed transportation”, leading to less motivation to go to a health facility (Delay 1), and lengthy transportation to arrive at health facility (Delay 2). In Ethiopia, transportation access to maternal health services has improved by increasing the number of functional public ambulances. In less than five-years period, the number of public ambulances have increased from a few hundred to more than 3000 and this might have contributed to the observed reduction in obstructed labor and OF.

Nevertheless, the observation needs to be verified by conducting a national representative community based survey for OF. Furthermore, 50% (approximately 1.4 million births) of annual deliveries take place at home²¹ which signifies that the proportion of births which are not attended by skilled health personnel is enormous and a huge potential risk for development of OF. Therefore, implementing a health policy and strengthening the obstetric service in the 'continuum of care' should be recognized as rate limiting intervention in the process of eliminating OF.

1.5. Ethiopian health system for the prevention and treatment of OF

Literature review has shown that the majority of adolescents and women who suffer from OF tend to be poor, uneducated, and from rural part of the country.²² As noted below, the cause of OF is multifactorial and its prevention needs multisectoral participation and community engagement. In the "3-delay" model, laboring adolescent girls and women are vulnerable for the development of obstructed labor and OF as a result of lack of awareness about the danger symptoms of pregnancy, inequality in decision making, lack of access to health facilities and inability to afford transportation costs.

The geographical barriers to access health facilities (for people living in scattered fashion, along the valleys and mountain), the social impact of gender inequality, and the sociocultural factors that restrict opportunities to modern education need a multi-sectoral involvement.

The health sector is responsible for prevention of OF among vulnerable groups by improving the quality of obstetric care, particularly the intrapartum care. Nevertheless, as noted below, the accessible health facilities may not have adequate caliber to provide emergency obstetric care.

Antenatal care service utilization helps to identify women at risk of developing OF, to prepare women for birth and pregnancy complications, and to provide timely intervention for those who are vulnerable to develop obstructed labor and OF. Providing a quality antenatal care is the responsibility of all health facilities, however, provision of intrapartum care depends on the health care delivery level of the specific health facility.

The health sector has introduced a three tier health care delivery system (primary, secondary, and tertiary level health care system). Primary Level Health Care is a Woreda health system or PHCU and comprises of a primary hospital (to cover 60,000-100,000 people), health centers (1/15,000-25,000 population) and their satellite Health Posts (1/3,000-5,000 population) which are interconnected to one another by a referral system.

One HC is staffed with an average of 20 health care professionals and provides both preventive and curative services. The health centers are expected to give the 7 BEmONC signal functions. Services that are given in Primary Hospital are emergency surgery (including caesarean section), blood transfusion, the 9 CEmONC signal functions and inpatient service (with capacity of 25-50 beds). Secondary Level Health Care consists of General Hospital that serves 1-1.5 million people while Tertiary Level Health Care are given in a specialized hospital which serves 3.5-5 million people. Based on the international definition of signal function performance, health facilities are categorized as basic emergency obstetric and newborn care (EmONC) and comprehensive EmONC.

With regard to OF, the primary function of the three level health facilities or BEmONC/CEmONC type health facilities is to prevent occurrence, and to achieve the initiative of eliminating obstetric fistula. This can be accomplished by intensifying case identification, diagnosis and treatment of OF which ultimately reduce the backlog and totally prevent the occurrence of new cases of OF.

1.6. The prospect of financial protection for eliminating OF

The financial protection for both prevention and treatment of OF is a pressing concern. As noted earlier, OF is still a devastating disorder deeply embedded in poverty, harmful practices, home delivery, and inequalities in access to quality obstetric care . Apart from several sociocultural factors (including geographic barriers and gender based discrimination/inequality), financial constraint to accessing quality obstetric services may continue being the major barrier, and delaying factor for the prevention and elimination of the OF.

The financial support from donor agencies across the globe, unceasing commitment and dedication of the late Dr. Catherin Hamlin for more than 45 years is the ever best domestic

philanthropic organization that has enabled in establishing the OF treatment centers, and changed more than 50,000 of ostracized women's life by mobilizing adequate resources for the infrastructure expansion and treatment cost. Even this time, as there are more than ten cooperating organizations in different parts of the world and many more philanthropic trusts supporting Hamlin Fistula Organizations, the financial support for OF repair and rehabilitation services is predicted to continue until OF is eliminated from Ethiopia. Nevertheless, as a preparation for the post OF era and ensuring the continuity of OF treatment, experts in the field strongly recommend the support of the program with domestic financing.

Particularly for the prevention, a progressive cut down of financial support from donors for maternal health may challenge the sustainability of family planning and maternal health services unless the domestic financing is strengthened and the government's allocation for health is as per agreement signed in 2001 (15% of the annual expenditure as stipulated in Abuja declaration).

In particular, the expansion of community based health insurance (CBHI) and implementation of the social health insurance (SHI) are an indispensable remedy for the at risk external fund. While the country is aspiring low middle-income country by 2025, many representative partners have been expressing to and pressing the MOH and the Government at large to increase domestic health financing.

The financial pressure is coming while the country is aspiring UHC before the due date of the SDG; while the population grow annually by more than three million; and the reproductive health service demand of the population increased by more than 5-10 fold from the early 2000 baseline. Therefore, financial constraint may be more challenging for the prevention and treatment OF backlog. Moreover, to improve the efficiency from case detection to reintegration, the financial support from domestic resource and government owned funds will be augmenting the efforts and resources generated by partners working on OF .

The Global financing facilities (GFF) initiated in 2015 to catalyze domestic resources mobilization and to prioritize, focus on results, and to tackle the main system bottlenecks to impact at scale to achieving UHC is an exemplary initiative. It is an indicator linked funding mechanism with a domestic fund matching modality, that could be cascaded to

subnational for better utilization of the domestic resource and for sustainability of financial protection to the sexual and reproductive health services.

The SDG pool fund is also designed as an innovative modality funding of the health sector priority initiative (consistent with the “one plan, one budget and one report” of the HSTP), in which detection, treatment, rehabilitation, and reintegration of OF survivors could be supported by the government owned SDG budget, by taking eliminating OF as a top priority health issue.

2.1. Risk factor analysis

The risk factors for the development of OF in Ethiopia are socio-cultural barriers, deep-rooted poverty, and lack of access to sexual and reproductive health services for the majority of the population. According to the UN resolution, poverty is the main social risk factor for the occurrence of OF: “Interlinkages between poverty, malnutrition, lack of quality health-care services, early childbearing, early and forced marriage, violence against women and girls, sociocultural barriers, vulnerability, illiteracy and gender inequality are root causes of obstetric fistula”.¹⁸

Twenty to thirty years ago, 95-97% of Ethiopian women were giving birth at home without antenatal or postnatal care and they were not using contraceptive methods to avoid pregnancy. Furthermore, more than 90% of girls had FGM, more than 50% of them got married before the age of 18 years and more than 99% of girls who had OF had no formal education.²³⁻²⁵ This may signify the influence of cultural and traditional belief on maternal health practices.

The country has been struggling to achieve the current levels of access and use of sexual and reproductive health services. Hereunder, emphasis is given to some of the doable still existing gaps and major problems limiting the progress towards eliminating OF.

2.1.1. *Child malnutrition*

The importance of ensuring good nutrition starting from early childhood is recognized as one of the priorities for elimination of obstetric fistula. In Ethiopia, childhood malnutrition is one of the major underlying factor contributing to the high prevalence of OF.²⁶

Majority of children who suffer from child malnutrition tend to have stunted growth and a smaller pelvis; therefore, during their reproductive age, they will be at greater risk for development of labor abnormalities, obstructed labor and OF.

According to EDHS data, using three anthropometric indices, there was considerable reduction in the prevalence of undernutrition among children less than 5 years. Between 2000 and 2019 GC, stunting reduced from 52% to 37%, underweight from 47% to 21%, and wasting from 11% to 7%.^{1,25,27-29} Yet, all the three chronic malnutrition indicators are too far from the SDG target (ending all forms of malnutrition). The proportions of children with stunting and underweight, for instance, are much higher than the WHO very high prevalence thresholds ($\geq 15\%$)³⁰.

In general, the long-standing chronic malnutrition has probably contributed to the high prevalence of the OF, and may keep on being a contributing factor for the development of obstructed labor and OF among women who labor and deliver at home, partly implying the increasing demand for caesarean delivery. The increase in rate of caesarean delivery by itself may increase the risk of iatrogenic fistula. For instance, the higher the caesarean section rate, the more likely to have complications such as bladder and ureter injury, peripartum hysterectomy, uterine rupture and placenta accrete complex; this in turn increases the chance of bladder and ureter injuries and formation of iatrogenic fistula.

Certainly, the impact of better nutrition on emergency obstetric care may not be immediately noticeable. However, breaking the intergenerational malnutrition cycle through primary care, especially by preventing stunting and maldeveloped pelvic bones during childhood and short stature in adult women, is a long-lasting investment to prevent obstructed labor and OF. Therefore, emphasis should be given to improve maternal and child nutrition for them to have a multiplier effect.

2.1.2. Family planning service and total fertility rate

Family planning is a means to delay first birth, to space births apart, and to limit the number of children. In the interest of this strategic plan, family planning is one of the core methods of eliminating OF by preventing teenage pregnancy and unintended pregnancy. The low utilization of contraceptive methods by adolescents and women contributes to the increased proportion of teenage pregnancy and unintended pregnancy that directly or indirectly increase the risk of developing OF.

The progress in the use of modern contraceptive methods by the Ethiopian women over the last two decades was remarkable; the contraceptive prevalence rate (CPR) has increased by more than 5-fold (from 8% in 2000 to 41% in 2020), and the unmet need

for FP has reduced from 37% in 2000 to 22% in 2020. A significant change is observed among rural women in terms of modern contraceptive methods utilization; use of contraceptive methods has increased from 3% in 2000 to 38% in 2019, while in urban areas it increased from 28% to 48%. This increase in family planning methods utilization by the rural women helps to eliminate OF and alleviate several obstetric problems including preventing teenage and unintended pregnancy, abortion, delaying the first birth, and averting maternal deaths. Therefore, every effort should be put in place to improve access to quality family planning service.

2.1.3. Child marriage, teenage pregnancy and female genital mutilation

In Ethiopia there is still a high prevalence of child marriage, teenage pregnancy and FGM, which all have contributed to the high prevalence of OF. Despite the government's commitment and partners' engagement to end child marriage and FGM in the last two decades, the EDHS data has shown an insignificant decline in the prevalence of child marriage between 2000 and 2016 (a decline from 49% to 40%). Similarly, the prevalence of FGM in some regions (Somali and Afar) is almost universal (91%-99%), giving the national prevalence rate of 65% among women of 15-49 years. The promising achievement is that the national prevalence of FGM in children aged 0-14 years has declined to 16%, but Ethiopia is still far from ending FGM. The prevalence of FGM among those aged 15-19 years has also declined from 71% in 2000 to 47% in 2016.

The change in the proportion of teenage pregnancy from 2000 to 2016 was insignificant (a decline from 16% to 13%), which means that still about 400,000 pregnancies are occurring before the age of 18 years. Of which, more than 75% are occurring in rural areas, where access and utilization of obstetric service is limited, and risk of obstructed labor is higher.

There is a large body of evidence that showed an increased risk of obstructed labor and OF among young women, who got married and gave birth while they were less than 18 years.³¹⁻³³ A review of 19 studies (1987-2008) has shown that 58-95% of women labored at home (20-96% for more than 24 hours); 31% to 67% were primiparas; 9-84% were teenage; and 40%-79% were shorter than 150 cm.³⁴ These data indicate how risky the physical immaturity and lack of skilled person at the time of delivery are for the occurrence of OF.

The implication is that unless a progressive and intensive community-centered programs are implemented and unless much work is done to enhance girls' education, end child marriage and FGM; they (child marriage, teenage pregnancy and FGM) may continue as a contributing factor for labor abnormality, obstructed labor and OF among adolescents and women .

There are reports which have shown a reduction in obstetric complication (including OF) among countries which have eliminated FGM and early marriage. As the reduction in harmful traditional practices is commonly accompanied by a change in the community's behavior towards health service utilization, the observed reduction in obstetric complications may be attributed to several factors. In some old literature, it was suggested that eradication of FGM could end OF.³⁵⁻³⁷

In general, early marriage and childbirth compounded by FGM as well as lack of skilled personnel during delivery are huge problems that contributes to the occurrence of obstructed labor, increased risk of operative delivery and OF.

2.2 Inputs and Process Analysis

2.2.1 Health service delivery:

The PHCUs, primarily intended to give primary care services to the rural communities, consist of 17,550 health posts, 3,735 health centers, and 293 primary hospitals. Overall, hospital-based services are provided by 353 hospitals that are categorized into primary, general, and specialized hospitals. To improve access to emergency obstetric care services, 3,052 ambulances were also purchased and distributed, making the total number of ambulances more than 4000. However, still challenges exist that include poor coordination and referral linkages, inefficient facility management and weak accountability, sub-optimal regulation of hospitals, weak ambulance management system, and lack of ownership of pre-hospital services, sub-optimal implementation of hospital reforms, high turnover of hospital staff, shortage of senior staff, and low patient satisfaction.

Specific to health facilities capacity, according to the 2016 nationwide EmONC survey, only 370 health facilities were recognized as fully functioning EmONC facilities.³⁸ The

recommended EmONC facilities (sum of BEmONC and CEmONC) for a country is 5 per 500,000 population, one of the five being CEmONC health facility. At that time (based on the 2016 Ethiopian population estimate), the total required number of EmONC health facilities were 921 (leaving a gap of 551 or 60%). The number of CEmONC health facilities was 148, while the need was 184. The regional variation in the number of EmONC facilities was significant, ranging from the lowest in Gambella (4%) to the highest in Addis Ababa (25%).

The BEmONC and CEmONC disaggregation by the type of health facility has shown that only 45% of the 316 hospitals and 14% of MCH specialty centers were classified as CEmONC and BEmONC facility. Out of the total public hospitals, only 52% and 17% were recognized as CEmONC and basic BEmONC, respectively. Similarly, only 5% of the 3,426 health centers were categorized as a BEmONC health facility.

The survey noted that the majorities of the EmONC facilities are in urban areas, and recommended 4,158 health facilities for BEmONC and 1,001 health facilities for CEmONC services. In general, the progress from 11% in 2008 to 40% EmONC facilities is encouraging; however, the gap indicates that many of the available health facilities are not well equipped/functioning, and there is a huge gap (especially BEmONC facilities) to reach the rural population who are at higher demand for prevention of OF.

The 6 private for non-profit fistula centers/hospitals in the country, which are in essence dedicated for fistula repair and rehabilitation role in treating those women living with OF were not eligible for EmONC assessment. Three university hospitals (University of Gondar, Jimma University, Arsi University), which provide fistula repair, were included in the assessment.

To improve the laboring women access to a health facility, Ethiopia has initiated maternity waiting homes within the health facility's compound. They are residential facilities to accommodate a couple of pregnant women in their final weeks of pregnancy to bridge the geographic gap in obstetric care between rural and urban areas and areas with poor access to a health facility. The advantage of maternity waiting homes (MWHs) is that laboring women can be transferred soon to the same health facility or to another one for skilled birth (including operative delivery) and some other life-saving interventions when the need comes. Mothers and their newborns can also stay after delivery at the MWHs to ensure all is well before traveling long distances to return home.

The EmONC assessment has shown that out of 3,804 health facilities assessed, 2,001 facilities (53%) had a MWH or room; only 20% had stand-alone MWHs, whereas 32% had maternity waiting rooms. Fifty-six percent of health centers had either a MWH or room, followed by 27% of primary hospitals. Government facilities were more likely (54%) to have MWHs than private-not-for-profit facilities (29%). Fifty-five percent of health facilities in rural areas had MWHs or rooms compared to 48% in urban areas.

Regionally, 72% of health facilities in Amhara had MWHs or rooms, followed by SNNP and Oromia at 57% and 56%, respectively. Seven percent of facilities in Somali, Harari, and Addis Ababa had MWHs or rooms, and 6 percent in Afar. Gambella was the only region with no MWH. Occupancy in MWHs is much lower than capacity would allow (only 2 occupants on average when mean capacity was 7). It was noted that the most common barrier to the utilization of MWHs was: “no one to care for the children at home or to prepare food” when a woman is absent, and “husbands do not allow.”

As a working document, a list of national strategic documents and guidelines, including the HSTP, RH strategy, AYRH strategy, and OF training modules and algorithms for the identification, diagnosis and treatment of fistula for surgeons, midwives, nurses and HEWs are available in the Ethiopian public health system.

2.2.2. Trained human resources for obstetric service:

According to the 2020 National Health Workforce update, Ethiopia currently has 273,601 health work force employed in government facilities; of these, 181,872 (66.5%) are health professionals and the remaining 33.5% are administrative staff. As a result, the health worker density has increased from 1.74 in 2018 to 1.8 per 1000 population in 2020. Specific to physician to population ratio was 1: 10,734 in 2018.

As a capacity building strategy, Ethiopia started to implement continuing professional development (CPD) program, in which it will be implemented in selected disciplines (Medical laboratory, Medicine, Midwifery, Anesthesia, Pharmacy, Health Officer, and Nursing). This initiative is expected to improve the quality of health care at large.

The 2021-2025 human resource for health (HRH) strategic plan has emphasized on the development of quality human resource with equitable distribution of HRH for SRH services. Medical schools and health science colleges have been expanded significantly

and five priority initiatives (medical education, midwifery, integrated emergency surgical officers, anesthesia, and HEWs) were given special emphasis to improve the SRH services. According to the health workforce report from public health institutions, HEWs, nurses, and midwives accounted for 41826 (15%), 59063 (22%), and 18336 (7%), respectively. Pharmacy professionals, medical doctors and specialists, medical laboratory professionals, anesthesia professionals, number are as follows: 12504 (5%), 11,007 (4%), 10843 (4%), 1484 (0.54%) respectively. Over the last five years, 1100 midlevel health workers have been trained on OF case identification, diagnosis, and referral to treatment center. This has enabled smooth referral linkage of OF survivors among primary health care units.

However, the target for health workforce is not yet met; the current density of midwives, IESOs, general practitioners, obstetrician gynecologists do not enable adequate staffing of all healthcare facilities for SRH services. Moreover, available workforce is distributed inequitably with severe shortages in hard-to-reach and remote areas, particularly in the developing regional states. The MOH, with support from its partners, has trained thousands of different categories of health workers, including midwives and obstetrician and gynecologist in the provision of BEmONC and CEmONC services.

2.2.3. Reproductive health commodity security (RHCS)

Commodity security exists when a person is able to choose, obtain and use quality reproductive health supplies, including contraceptives, whenever s/he needs them. SRH commodities include not only a wide choice of contraceptive commodities for family planning, but also all essential drugs, equipment, reagents and consumables required for the efficient delivery of all SRH services. Reproductive health commodity security is affected, on one hand by national policies and regulations that bear on family planning/reproductive health, particularly on the availability of RH supplies, and on the other hand, broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, commitment, evidenced by in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for RHCS. It is the basis from which stakeholders invest, coordinate and develop the necessary capacities for RHCS. However, several challenges remain. For instance, a recent essential tracer medicines availability survey indicates that

nationally, 21.8% of hospitals and HCs fulfilled more than 80% of the storage conditions. Hospitals demonstrated better fulfillment of the storage conditions as compared to HCs and HPs.

According to SARA 2018, only seven percent of the health facilities had fulfilled all the tracer items for readiness to provide family planning services and 63% of the facilities had on average 5 tracer items out of eight.

Ethiopia still depends on external funds to fill the gap of RHCS. A few years back the government started to decentralize, regional managers recognized the importance of ensuring sufficient funds for contraceptives and committing their regional funds to finance contraceptives. Amhara, Oromia, SNNPR, and Tigray regions have used regional funds for contraceptive procurement since 2006. Ethiopia should scale up this and continue the domestic resource mobilization for reproductive health commodity security.

2.2.4. Finance

The government and the private sector, including insurance contribution to the health financing have slightly increased from 30% and about 1%, to 32% and 2%, respectively from the 2013/14 to 2016/17. The change is insignificant to ensure sustainability of financing for health. On the other hand, the overall contribution of donors (35%) and out of pocket expenditure (31%) have slightly increased to 36% and 33%, respectively during the same period.

Furthermore, the share of government spending on health out of total government expenditure slightly increased from 7.6% in 2013/14 to 8.1% in 2016/17 (far below the 15% specified in the Abuja commitment). Reproductive health accounted only 8% of total health expenditure in 2016/17. Similarly, critical RH service (antenatal care, postnatal care, delivery, prevention and treatment of infertility, prevention and management of complications of abortion and safe motherhood activities) accounted 16%, a decrease by 3% from 2015. In addition, donor support from family planning declined from 10% in 2015 to 8% and 9% in 2016 and 2017. Low middle-income countries are challenged due to limited resource, poor political commitment/leadership to mobilize resources and prioritize allocating domestic budget.

The government of Ethiopia has given emphasis to promote equity in health. The government has been implementing several strategies, including provision of high impact interventions free of charge; subsidization of more than 80% of the cost of care in government health facilities; implementation of CBHI schemes; and full subsidization of the very poor through fee waivers both for health services and for CBHI premiums. Despite these efforts, direct household payment to facilities during service use still remains unacceptably high.

2.2.5. Leadership, governance and management in OF and SRH

To reduce the burden of OF, Ethiopia has made significant changes in improving efficiency, collaboration and coordination in different MH programs. There has been a noticeable change in improving case identification, diagnosis, referral and access to treatment of OF. This includes governance reforms to manage retention and utilization of revenue for the exemption of fee for certain services including OF. The effect of this reform in ensuring access and utilization of quality maternal and newborn health services would largely improve the health of women and newborns, all contributing to the effort in the prevention and treatment of Obstetric Fistula.

The MOH reformed its structure to improve the leadership of the health system. The reform reorganized the departments in the ministry by program and operational areas with human resources under each area. Subsequently, eight case teams were organized under the Maternal, Child Health and Nutrition Directorate (Family planning, Maternal Health, Child Health, Adolescent and Youth Health, Expanded Program of Immunization (EPI), PMTCT, Nutrition, and Sekota Declaration) and there are also different established structures at the regional level. Obstetric Fistula is given focus under the Maternal Health program. Senior MOH experts are also assigned to lead and coordinate elimination of obstetric fistula initiative. A technical working group composed of maternal health case team staff from MOH, partners working on OF and experts from AA Hamlin Fistula Hospital established at national level. Some regions also established TWG.

The TWG helped to coordinate the technical and financial resources to end obstetric fistula and share experience from different actors. It also helped to advocate the agenda in different platform.

2.3. Outcome analysis

2.3.1. The status of maternal health care

As shown in Figure 1, Ethiopia has made a remarkable progress in maternal health service. The recommended four visits during antenatal care has increased by more than 4-fold, and the skilled person attended delivery has increased by about 10-fold in 20 years. At least one antenatal care visit was also reported in 2019 as 74%. The maternal mortality ratio (MMR) has declined by more than half in the same period.

Nevertheless, the country's performance is still half way behind the expectation. As it starts from a very low base line , the achievement is encouraging to further accelerate to make at least three-fourths of pregnant women utilizing the continuum of obstetric care before the SDG due date, and to reduce the MMR by more than half of the current estimate (401/100,000 live births). Above all, there is a green light to end OF as we approach the universal utilization of the obstetric service. MOH is ambitious to increase the continuum of care (from pregnancy to postnatal period) indicators to 95% by 2029.

Obstructed labor and uterine rupture are among the immediate severe complications of labor abnormality, and proxy indicators of the incidence of the OF and poor quality or lack of obstetric care. ^{1, 28}

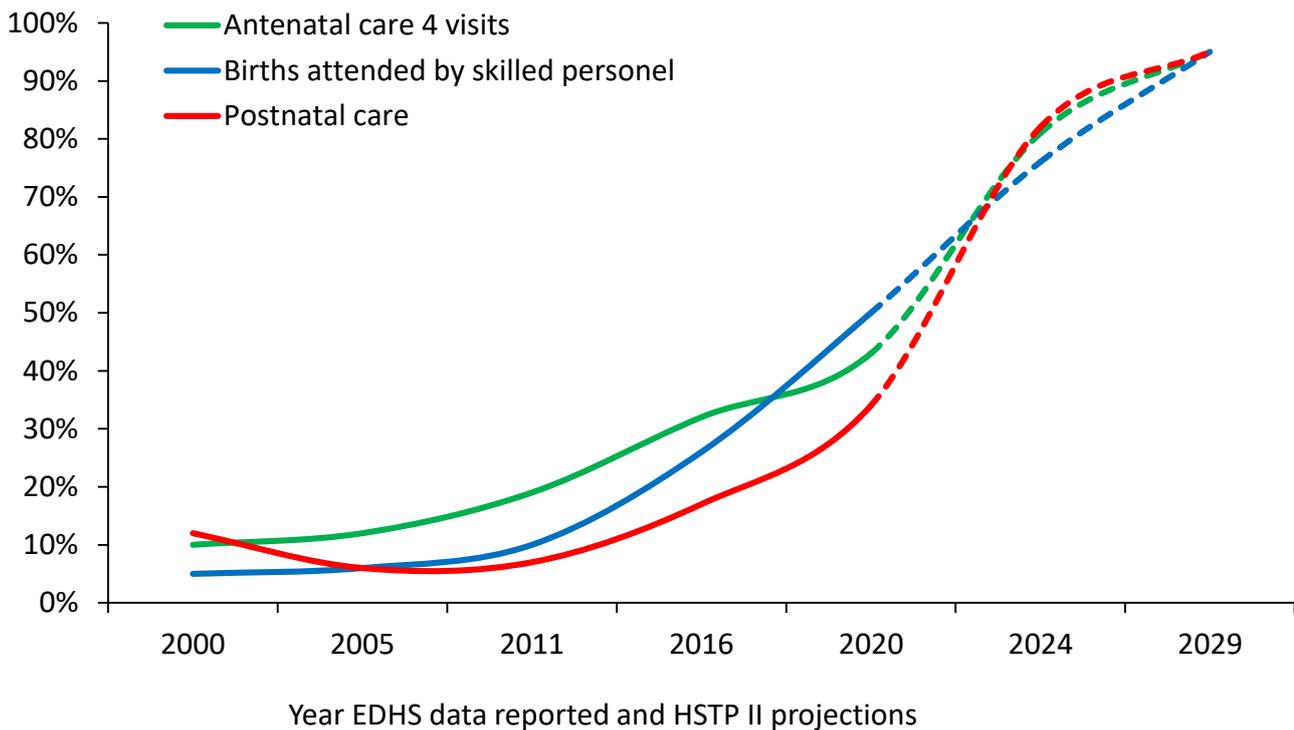


FIGURE 1. *The 20-year trend of antenatal care, skilled birth attendance, and postnatal care, and the prediction for 2024 and 2029 in Ethiopia. Compiled from EDHS 2000-2019 and HSPT II.*

2.3.2. Overview of obstetric fistula case identification, referral, and treatment

The spectrum of care for OF includes case identification, diagnosis, referral for treatment, management, rehabilitation and reintegration. The World health organization recommended any national fistula program to include three key interventions:

- 1) Prevent women from developing OF through health promotion and awareness, and availing quality basic and comprehensive maternal health services to all
- 2) Ensure easy and early access to the nearby fistula repair center and/or refer complex cases to the next level treatment
- 3) Ensure that each girl's and woman's right to health, including reproductive rights, which are closely linked with the prevention of OF, are recognized and protected by the provision of an enabling policy and regulatory environment.

Identification, referral and treatment in Ethiopia was not as expected due to different reasons. Mainly the cultural barriers to be overcome include enabling women to seek care without the need for her to get consent from her family or community members.²⁴

Although obstetric fistula is prevalent in Ethiopia, its magnitude and distribution is not well studied. The estimated number of women of childbearing age with untreated Obstetric fistula in 2016 was 31,961 cases and 6 districts have had more than 200 untreated fistula cases in the same year 2016.¹⁰

As the major contributing factors for obstetric fistula are: poverty, lack of awareness, poor-health seeking behavior, poor health, weak referral system, poor transportation , scarcity of skilled birth attendants, and inadequate obstetric care services, the ministry of health tried to address contributing factors.

During the last five years, MOH launched adolescent nutrition as a priority, awareness raising of obstetric fistula through different, safe motherhood campaign, including “no motherhood before adulthood” movement in Ethiopian fiscal year 2010. Furthermore, the use of family planning, antenatal care focusing on early initiation, skilled birth attendance, including access to an emergency cesarean section, postnatal care and postpartum family planning has increased over the strategic plan period. However, still one in five adolescent aged 15-19 years have unmet need for family planning, skilled birth attendance is 50%, and cesarean section is only 4% which indicate far to go to achieve ‘eliminating OF’ initiative .

It is obvious that the best strategy to address obstetric fistula is to prevent prolonged and obstructed labor by providing safe and timely emergency obstetric care including cesarean section. On the second pillar, early access to the nearby fistula center remained a critical area for intervention; the major gap remains around identification, referral and transportation of women with obstetric fistula to the treatment center. This mainly because women with OF usually isolates themselves from their community due to the social ostracization and the stigma that accompanies OF. Efforts has been made for OF case identification, like integrating OF identification with the national polio campaign, by training health care workers and health extension workers on OF case identification and by preparing and distribution of quick reference to community case definition and referral cards.

A guideline also developed in collaboration with the Ethiopian public health institute to introduce obstetric fistula surveillance and response and make OF as one of the reportable health condition in the PHEM system. In addition, the MOH developed a training manual for 952 hotline workers and OF is also incorporated in the module. Over

the last decade, thousands of suspected OF cases have been identified, diagnosed and referred for treatment through trained health care workers and HEWs. Despite all these efforts, it is assumed that there are a number of hidden fistula cases at community level.

Although the treatment centers are capacious, the average annual fistula repair had not been more than 3000 per year. This means with this rate of treatment 11 years is needed to complete the current estimate of 31,961 obstetric fistula cases. It is, therefore, critical to strengthen the identification and referral of OF cases and an innovative approach should be sought.

Rehabilitation and reintegration have got attention over the last strategic plan period and a few partners like hilling hands of joy support the government in Rehabilitation and reintegration. During the Rehabilitation phase of OF treatment, the fistula survivors need psychological, emotional, spiritual and economic support like Income Generating skills and provide micro-loans to start a small business. Like the OF identification, a lot has to be done on rehabilitation and reintegration part too.

2.4. Impact analysis (incidence and prevalence of OF)

Because of lack of regular national surveillance and lack of confidence to disclose by many rural women (who probably were stigmatized and discriminated), estimating the incidence and prevalence of OF is not an easy task in Ethiopia. The available community based primary prevalence studies are the EDHS 2005 and 2016, which has shown a 1% (out of the total deliveries) and 0.4% (out of the total women aged 15-49 years) respectively. In the 2016 data, the estimated prevalence of OF among the total deliveries was 0.6%.

However, in a country aspiring to eliminate and thereby end OF, the actual number of cases with untreated OF is more important than the proportion. Some secondary analyses from the EDHS data have shown that the treated and untreated OF case is estimated to be 40, 572 and 31,961, respectively (Derbie). A proxy estimate is made by the number of maternal deaths; some experts estimated that the case pattern of OF follows the MMR of a particular geographic area/country. This may imply that the high MMR in Ethiopia and the low skilled person attended delivery may indicate that OF is still occurring.

According to EmONC 2016 EDHS report, out of the total health facility deliveries, the proportion of obstructed labor/prolonged labor (OL/PL) cases (as proxy indicator) was close to 2% (36,394/1,924,330), and 18% of the 200,892 obstetric complications. At that time the total delivery at the national level was estimated to be 2,928,303. Thus, the estimated OL/PL was around 55,381.

Therefore, the 2020 OF incidence estimated by considering the following assumptions:

- Total population growth rate = 2.07% (CSA);
- Crude birth rate = 2.95% (MoH OF strategic plan, 2015-2020);
- Estimated total population for 2020 = 101,000,000 (HSTP II)
- Estimated total deliveries for 2020 = 2,979,500
- Estimated OL/PL for 2020 = 2% = 59,590 (assuming that the OL/PL is still 2%)
- Caesarean section (CS) rate for 2020 = 4% (HSTP II) = 119,180
- CS for OL/PL = 13% of CS (EmONC 2016 EDHS) = 15,493 (less this time)
- Neglected OL = OL/PL-CS for OL/PL (MoH OF strategic plan, 2015-2020) = 44,097
- OF = 2.15% of neglected OL (MoH OF strategic plan, 2015-2020) = 948

948 new OF cases in 2020, which is estimated to be about 1.6% of the total estimated OL/PL, and 0.03% of the total estimated deliveries.

The other evidence that supports the estimated incidence is the OF case flow rate over the past years (2016-2019). Between 2010 and 2013, the number of fistula cases treated in Ethiopia was between 1500 and 1800 per annum. As presented in Figure 2 and 3, while surgeries for non-fistula cases (such as pelvic organ prolapse) nearly doubled between 2016 and 2019, the overall number of fistula surgeries (including iatrogenic fistula) plateaued. This is despite the number of fistula treatment centers that have increased from six to nine. When the total number of fistula surgeries (6304) performed in four years period are evenly distributed to the number of weeks and number of fistula treatment centers, each center was performing to the maximum of 3-4 cases per week. As the fistula surgeons and obstetricians pointed out, in 2020 in particular, there were small number of fistula cases in all centers; the COVID-19 has probably contributed to the reduced patient flow.

In short, the number of treated OF cases (6304) decreased by nearly 4-fold than the 2015-2020 OF elimination strategic plan (23,000) for 2016-2019. This is attributed to either limitation to reach to women with OF or remarkable reduction in the surgical backlog and incidence of OF during the previous strategic plan period. Until proven otherwise, the current strategic plan takes into account the nearly one thousand cases of OF per annum.

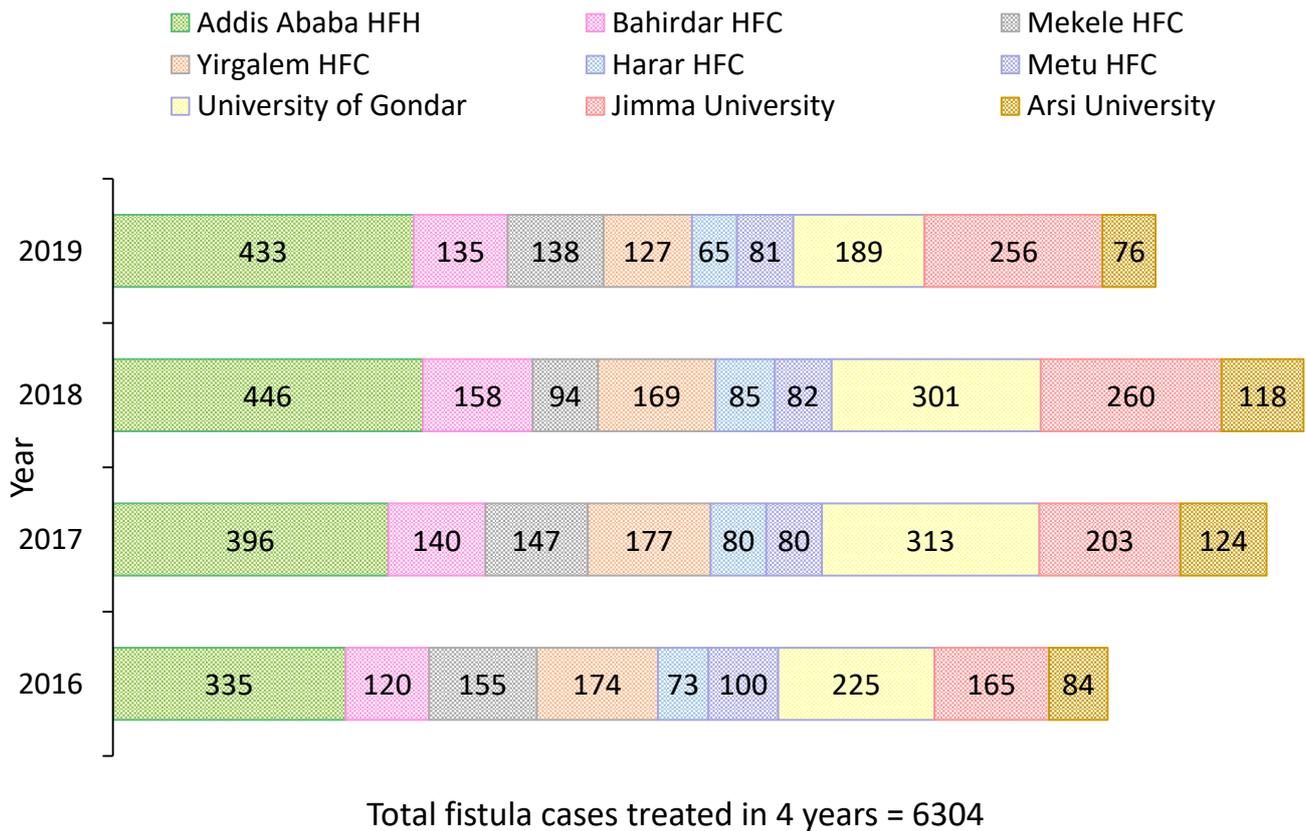


FIGURE 2. The four-year performance of the 9 fistula treatment centers (2016-2019).

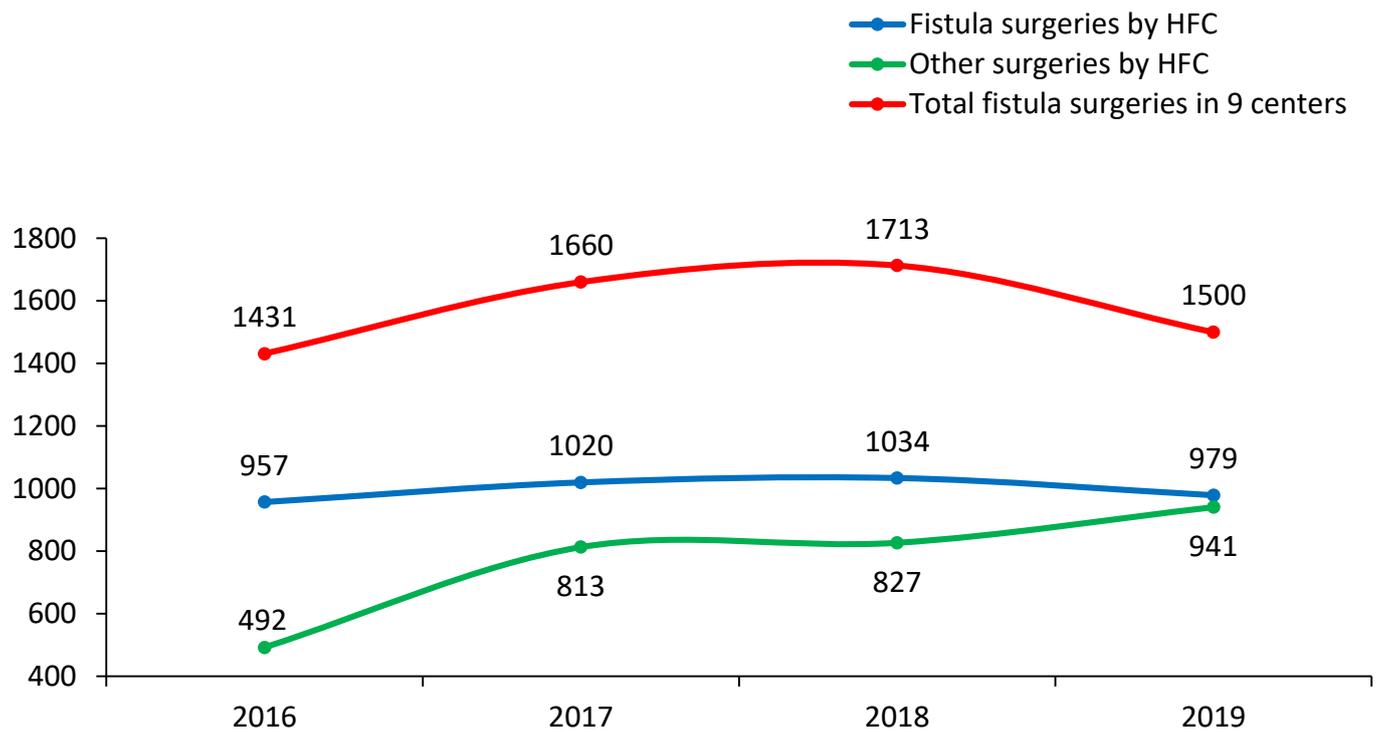
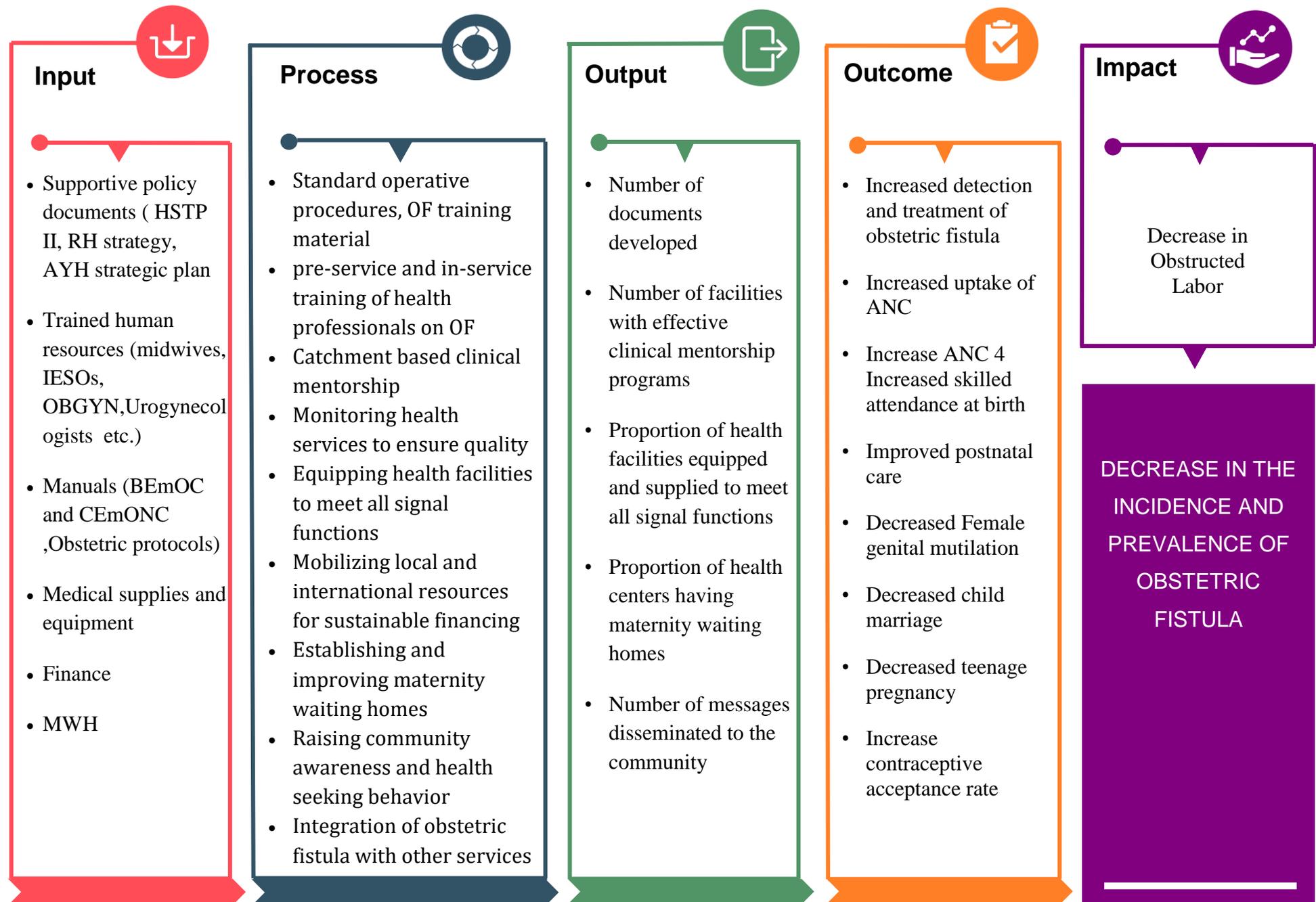


FIGURE 3. *The trend of fistula surgeries and other surgeries in 6 Hamlin fistula centers, and the total fistula surgeries in 9 fistula treatment centers (2016-2019). HFC = Hamlin fistula hospital and five centers.*

Many fistula surgeons from different centers have been expressing their concern over the increasing iatrogenic fistula, which may be related to an injury to the bladder and/or ureter commonly during CS or peripartum hysterectomy. Over five years (2015-2020), the Hamlin Fistula Hospital has reported 100 cases of fistula due to iatrogenic ureteric injuries.



2.5. A review of progress on the last five-year strategic plan

The progress towards achieving the targets put in the last Elimination of OF (EOF) strategy are summarized in the table below.

TABLE 1 A review of the performance of the strategic plan for elimination of obstetric fistula (2015-2020)

Objective 1		Improved equitable delivery of quality integrated MNCH services at all levels to prevent obstetric fistula			
Strategies	Baseline (2015)	Target (2020)	Achievement	Description	
<p>Strategy 1.1:</p> <p>Raise community awareness about OF, its causes and how to prevent it: to reduce stigma and mobilize communities for prevention, identification and rehabilitation of women treated for fistula</p>	50%	100%	39% (EDHS 2016)	<p>Although there has been awareness raising activities like use of mass media and local community structure, there is still a huge gap.</p> <p>Over 457 community awareness sessions on OF and an estimated 956,044 people attended. These sessions took place at market places; schools and during pregnant women conferences. Use of local media (Radio) and distribution of brochures with important OF messages</p>	
<p>Strategy 1.2:</p>				Scaling up and improving quality of BEmONC at HCs has been a priority for MOH. Focusing on in service and pre-service training,	

Continue to scale up and improve quality of BEmONC at HCs				mentoring, ISS (specifically introducing BEmONC as part of the exit requirement for graduate students was among the strategy implemented). However, the quality of pre-service training needs improvement.
Strategy 1.3 Continue to improve the functionality of HCs to provide quality BEmONC	56%	100%	53% (SARA 2018)	Only 14 percent of expected deliveries took place in EmONC facilities, which means most facilities were not ready or not accessible to adequately treat obstetric emergencies.
Strategy 1.4 Continue to scale up CEmONC services				Availability of CEmONC in hospitals increased from 73 percent in 2016 to 97 percent in 2018. However, the service was decreased from 7 percent in 2016 to 3 percent in higher clinics in 2018 (SARA 2018)
Strategy 1.5 Continue to strengthen the obstetric referral system at all levels				Mentorship guideline and referral system guideline developed and implemented for strengthening the capacity and referral system at all levels. Nevertheless, the referral system is still weak and contributing for maternal morbidity and mortality.
Strategy 1.6				In 2016 the CPR is 32% among adolescent age 15-19 years but the unmet need is 21% for the same age group. The mean age for a rural adolescent for first sex is 15.9 years but they start using contraceptive at 24.2 years of age. The gap between first sex and first

Continue to expand access to quality family planning (FP) services with special emphasis on rural adolescents				contraceptive use among rural women is 8.3 Years while only 3.6 years for urban counterparts. Expanding access to quality family planning (FP) services with special emphasis on rural adolescents are yet to be realized.
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Objective 2

Suspected cases of obstetric fistula identified and appropriately referred for timely diagnosis and treatment

Strategies	Baseline (2015)	Target (2020)	Achievement	Description
<p>Strategy 2.1</p> <p>Rapidly scale up accelerated identification of all potential OF cases with the aim of declaring Woredas 'FistulaFree'</p>				A 'Fistula Free' woreda guideline was developed but the implementation was braked off due to lack of verification means. As there was no active data source to report the OF cases, it becomes difficult to verify the 'Fistula Free' woredas. So the intervention was not implemented.
<p>Strategy 2.2</p> <p>Use the HEP at community and household level to identify all women with leakage of urinary for referral to HCs for OF screening.</p>				A job aid was developed and distributed to HEWS. It was integrated with house-to-house national polio campaign to identify suspected fistula cases and referral. Using the training manual developed for HEW, they were trained on case identification and referral in selected regions. Integrating obstetric fistula in to the routine work of HEWs could improve identification and referral of OF cases. HEWs has a lion

				share in the prevention of Obstetric fistula. It is clear that HEWs contributed a lot to make MNH services accessible however, their contribution for obstetric fistula identification and referral were less significant.
Strategy 2.3				
Refer all women identified as having OF at HC level, to the appropriate fistula repair center for treatment and care.				Case identification and referral to the treatment centers was intensified with the support of partners working on OF by covering the transportation cost. The ministry of health integrated OF identification in to the polio campaign. However, there is still a gap in case identification, referral and transportation.
Strategy 2.4				
Accelerate the expansion of WDA to all regions.				Using WDA were a priority of the last five-year strategy. Meanwhile consider other means of reaching all households in those areas where the WDA is not yet fully functional specifically the developing regions where OF burden are thought to be higher.
Strategy 2.5				
Advocate for the Ministry of Education to incorporate OF into the pre-service curriculum of relevant health cadres.				This was not implemented.

<p>Strategy 2.6</p> <p>Expand training of women treated for OF as 'Safe Motherhood Ambassadors' ensuring linkages with HEWs and HCs to support identification and referral.</p>				<p>Some of OF survivors were trained. They became champions to end fistula movement. About 1,506 Safe Motherhood Ambassadors and they identified over 292 OF cases and transferred to the treatment center.</p>
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Objective 3

Quality treatment and appropriate care provided to every woman with obstetric fistula

Strategies	Baseline (2015)	Target (2020)	Achievement	Description
<p>Strategy 3.1</p> <p>Scale up the number of OF repairs at fistula centers, in response to increased referrals; Provide male and female condoms to women and partners in all MNCH facilities and at the community level by HEWs.</p>				<p>The report showed that about 10,063-fistula repair was performed from 2016 to 2020 in 9 fistula treatment centers. The treatment centers capacity has improved but they are performing under their capacity due to low case flow to the respective centers.</p>

<p>Strategy 3.2</p> <p>Develop national guidelines, training material for treatment of OF for surgeons, midwives and nurses</p>				<p>OF training materials and National OF Communication guidelines developed on case identification, diagnosis and pre-referral care of obstetric fistula</p>
<p>Strategy 3.3</p> <p>Recruit and provide skill training to 15-20 additional Obs/Gyn and surgeons and 30-40 midwives/nurses in fistula treatment</p>				<p>The fistula treatment centers are training midwives/nurses in fistula treatment. Over 20 additional ObGYN and surgeons and over 40 nurses were trained in fistula treatment. Some of fistula treatment centers started urogynecology subspecialty training(Hamlin Fistula Hospital, Jimma university and university of Gondar) with advanced training on OF management and other urogynecological problems (urinary incontinence and pelvic organ prolapse surgery)</p>
<p>Strategy 3.4</p> <p>Standardize quality of care requirements at all existing fistula centers</p>				<p>Hamelin fistula center is one of the best Fistula treatment center in the world has been providing continues mentorship and coaching for continuous quality improvement and better treatment outcome. Moreover, the treatment centers at the three university hospitals have been mentored by experienced fistula surgeons to improve quality OF treatment. However, A quality standard was not developed yet</p>

Objective 4

Appropriate rehabilitation support provided for each fistula patient according to her specific needs

Strategies	Baseline (2015)	Target (2020)	Achievement	Description
<p>Strategy 4.1</p> <p>Assessment required for rehabilitation/reintegration support to all women treated for OF and individualized holistic plan developed for distribution and storage capacity</p>				The rehabilitation/reintegration services are mainly being done by HFC and HHJ. As described above, this is a gray area to strengthen.
<p>Strategy 4.2</p> <p>Support restoration of psycho-social status of those women who have been treated for OF</p>				Over 1,506 women rehabilitated at three rehabilitation centers of healing hand of joy. This is still an area which require more investment and collaboration.
<p>Strategy 4.3</p> <p>Create economic independence opportunities for women treated for OF, (based on need)</p>				Economic support given to 717 women through HHJ.

<p>Strategy 4.4</p> <p>Implement 'Special' approach for women who are not cured through surgery</p>				
<p>Objective 5</p>	<p>Strengthened leadership, management and partnership to deliver coordinated, effective and efficient services at national, regional, zonal and Woreda levels to achieve obstetric fistula elimination</p>			
Strategies	Baseline (2015)	Target (2020)	Achievement	Description
<p>Strategy 5.1</p> <p>Strengthen management capacity and resource mobilization for comprehensive health programs.</p>				<p>The ministry of health introduced innovative funding modalities like SDG pool fund and mobilizing resources for the overall health program.</p>
<p>Strategy 5.2</p> <p>Enhance partnership with relevant sector ministries, NGO, CBO, FBO, private sector, partners and international organization</p>				<p>Technical working group on EOF to coordinate partners working on EOF.</p>

<p>Strategy 5.3</p> <p>Strengthen organizational and managerial capacity of national, regional, zonal and Woreda to coordinate, obstetric fistula program using MNCH platform</p>				<p>Strengthen organizational and managerial capacity of national, regional, zonal and Woreda to coordinate, obstetric fistula program using MNCH platform</p>
<p>Objective 6</p>	<p>Strengthened Monitoring and Evaluation of OF and research for evidence based decision making</p>			
<p>Strategies</p>	<p>Baseline (2015)</p>	<p>Target (2020)</p>	<p>Achievement</p>	<p>Description</p>
<p>Strategy 6.1</p> <p>Strengthened Monitoring and Evaluation of OF and research for evidence based decision making</p>				<p>EDHS 2016 incorporated EOF indicators. Few Manuscripts has also been published on OF.</p>
<p>Strategy 6.2</p> <p>Develop and implement operational research, surveillance, surveys and</p>				<p>The treatment centers use their available program data for improving the services delivery. However, there is no national survey yet to guide the national OF program. The ministry of health has also</p>

program data analysis to guide program evaluation				tried to integrate the obstetric surveillance in to the existing PHEM system that is not yet implemented.
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Objective 7

A comprehensive OF communications guide and plan developed and implemented

Strategies	Baseline (2015)	Target (2020)	Achievement	Description
<p>Strategy 7.1</p> <p>Employ all key communications channels to support implementation of the strategic plan including the use of community based communications channels and the mass media.</p>				The ministry has developed a communication guide to facilitate the SBCC work on EOF. Different experts provided public awareness on national media. Radio/TV spot has been launched.

S

Strengths

1. Government commitment to eliminate OF
2. Availability of a standalone strategy for elimination of OF, communication guide, annual review
3. Availability of the best fistula treatment centers, 45 years experience
4. Excellent capacity of fistula treatment centers to treat cases including backlogs
5. Partners commitment to extend the support for the fistula care
6. Referral linkage between health posts and health centers
7. Increased access to antenatal care and skilled birth attendant services
8. Initiation of hotline counseling services
9. Trained health workers on OF case identification and diagnosis.

W

Weaknesses

1. Lack of updates and representative data on OF incidence and prevalence.
2. Weak monitoring and evaluation
3. Weak identification and referral system, including poor transport support
4. Low institutional delivery and low caesarean delivery
5. Significantly reduced performance of fistula centers/due to low patient flow/
6. High prevalence of FGM, child marriage, teenage pregnancy, and unmet need for family planning and diagnosis.

Opportunities

1. HSTP priority and government commitment to end OF
2. Existence of Criminal Law and Family Code for prevention of child marriage and FGM
3. Technology advancement and mobile phone penetration to trace OF cases
4. The presence of health extension program and WHDA for case identification and surveillance
5. Availability of hotline system/952/

O

Threats

1. Effect of pandemic diseases on the health system
2. Limited resources for identification, referral, and rehabilitation
3. The global financial crisis
4. The progressively declining donor support
5. The East African geopolitical instability

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IV Strategic framework

4.1 Vision

- Obstetric Fistula Free Ethiopia

4.2. Goal

- Eliminating obstetric fistula in Ethiopia by 2025

4.3. Objectives

1. Preventing OF by leveraging the driving values of the community
2. Improving access to quality obstetric care
3. Implementing innovative approaches to identify, diagnose, refer and treat women with OF
4. Improving the rehabilitation and reintegration of women with OF

4.4. Impact, outcome and process targets

Impact Targets:

- Reduce obstetric fistula prevalence from 0.4% to 0.02%
- Reduce obstetric fistula incidence from 953 (0.03%) to 520(0.016%)

Outcome Targets:

- Increase antenatal care 4 contacts from 43% to 81%
- Increase skilled birth attendance at birth from 50% to 76%
- Increase C/S rate from 4.1. % to 8%
- Increase CPR from 41% to 50%
- Decrease proportion of teenage pregnancy from 13 % to 7%
- Increase identification of OF cases to 100%
- Increase community awareness of OF from 39% to 95%

- Increase proportion of rehabilitation of OF survivors to 100%
- Increase proportion of reintegration of OF survivors to 95%

Input and process Targets:

- Increase coverage of BEmONC services to 100%
- Increase coverage of CEmONC services to 100%
- Increase proportion of probable OF cases from the community to health facility to 100 %
- Increase proportion of confirmed OF cases linked to treatment centers to 100 %
- Increase proportion of health facilities providing EmONC services from 40% to 95%

4.5. Guiding principles

- **Community engagement:** It entails the active participation of the community in preventing, identifying, referring, rehabilitation and reintegration efforts of the health sector to end OF.
- **Holistic approach:** In addition to the multilevel actions to prevent, identify, diagnose, and treat OF, the intervention includes providing physical, psychosocial, and reproductive health and assisting OF survivors in the process of reintegration and economic independence.
- **Quality of care:** Providing safe, effective, patient-centered, timely, efficient, and equitable health care for women with OF and all other obstetric clients
- **Innovation:** This strategic plan has given due emphasis to innovative approaches for OF prevention, case identification and post-treatment socialization and productivity.
- **Partnership and multi sectoral responses:** It refers to strong collaboration among different government and non-governmental stakeholders (including law enforcement bodies, ministry of education, and ministry of women, children and youth etc.) in the prevention, case identification, treatment and reintegration of OF survivors to jointly achieve the elimination of OF and improve the quality of their life.

- **Evidence-informed approach:** It means to design, implement and improve eliminating OF interventions based on the existing evidence and generate an updated prevalence and incidence of OF at the national level.
- **Domestic financing:** It means making the obstetric fistula prevention, treatment, rehabilitation, and reintegration locally affordable and accessible to all by designing a pooled funding mechanism, scaling up of health insurance, and government contribution, by applying the principles of UHC.
- **Integration:** Integration of obstetric fistula prevention and identification services within the existing primary and referral care systems. Integrating the OF surveillance and response to the PHEM system in order to eliminate OF.
- **Transformation:** This strategic plan aspires that 1) all fistula treatment centers to be women's health and wellbeing centers/urogynecology center, and 2) all OF survivors' quality of life is improved by increasing their productivity and reestablishing their overall health and wellbeing.

4.6. Strategic issues

1. Quality antenatal care
2. Skilled emergency obstetric care
3. Iatrogenic fistula
4. Engaging the community
5. Referral and transportation
6. Rehabilitation and Reintegration
7. Integration at all levels
8. Girls and women's empowerment
9. Harmful traditional practices
10. Government commitment
11. Domestic financing
12. Obstetric fistula surveillance and response
13. Innovations

STRATEGIC DIRECTION 1

ACCELERATING PREVENTION OF OBSTRUCTED LABOR AND OF IN THE COMMUNITY AND IN THE HEALTH FACILITY

DESCRIPTION:

This strategic direction focus on accelerating the prevention of obstructed labor and OF through promoting institutional delivery and preventing harmful traditional practices by engaging the community. It also striving to optimize the availability and accessibility of quality basic and comprehensive obstetric care through institutionalizing the integration of SRH service programing to prevent obstetric fistula.

Strategic Initiative1.1. Enhancing community awareness about obstructed labor and OF prevention

MAJOR ACTIVITIES:

- Strengthen community awareness on OF prevention by using existing community structures and mass media
- Promote Skilled birth attendance
- Increase awareness of the community on the consequences of HTP such as early marriage, teenage pregnancy, and FGM
- Reaching the community through digital platform and hotline for awareness creation on OF prevention

Strategic initiative 1.2. Enhancing community engagement in the prevention of obstructed labor and OF

MAJOR ACTIVITIES:

- Strengthen community mobilization platform (HEW, Pregnant woman conference, WDA, safe motherhood ambassadors, community and religious leaders).
- Establish community mobilization platform in hard-to-reach areas or in villages where it is not yet established
- Strengthen multisectoral collaboration on OF prevention intervention (WYCA, Woman Association, law enforcement body, Youth associations, education sector, communication office)
- Integrate OF activities with other health services (PNC, EPI, FP, AYH and other RH services)
- Strengthen demand creation for ANC and institutional delivery

Strategic initiative 1.3. Preventing the occurrence of obstructed labor and OF in the health facility

MAJOR ACTIVITIES:

- Strengthen compassionate and respectful maternity care service.
- Integrate OF and obstructed labor prevention in the continuum of care (FP, ANC, Delivery, PNC)
- Provide quality FP, ANC, delivery (including proper use of partograph) , and PNC service
- Strengthen maternity waiting home service
- Increase the number of Motivated, Competent and Compassionate (MCC) health work force
- Strengthen facilities to provide EmONC services as per the standard

Strategic Initiative 1.4. Institutionalizing the integration of SRH service programming at the inter-directorate and health facility levels to better utilize the opportunity for OF prevention

MAJOR ACTIVITIES:

- Streamlining the practice of integration in all portals of SRH service provision

- Building the health workers' capacity on the principles and practice of SRH service integration
- Applying the “one plan, one budget, and one report” direction of the MOH at the inter-directorate level to avoid duplication of efforts and resource fragmentation

Strategic Initiative 1.5. Improving the surgical care to prevent OF and iatrogenic fistula

MAJOR ACTIVITIES:

- Ensure the surgical safety in all obstetric surgical procedures by developing and implementing standard operating procedures (SOP) including early detection of and management of iatrogenic injury.
- Provide operative delivery for women with labor abnormality timely
- Conduct facility based obstetric surgery quality audit and response

STRATEGIC DIRECTION 2

IMPROVING THE IDENTIFICATION, DIAGNOSIS, REFERRAL AND TREATMENT OF OBSTETRIC FISTULA

DESCRIPTION:

This strategic direction focuses on strengthening obstetric fistula case identification, diagnosis, referral and treatment by enhancing case identification from the community, diagnostic capacity of health facilities, referral linkage to the fistula treatment centers and treatment capacity..

Strategic Initiative 2.1. Strengthening the OF case identification and linkage to health facility

MAJOR ACTIVITIES:

- Promote OF case identification by increasing the public awareness about OF
- Introduce innovative approaches to identify women with OF, including establishing free call (like 952) for OF case notification

- Integrate OF case detection in the house-to-house/community health programs (immunization, health extension service, WDA)
- Increase the number of trained ‘Safe Motherhood Ambassadors’ to support identification and linkage OF cases to a health facility
- Incentivize WDA, safe motherhood ambassadors and others for their contribution to OF case detection
- Reinforce the fistula detection in the community by distributing job aids (algorithms) and IEC materials
- Capacitate health extension workers, and health care providers on OF case identification and linkage
- Enhance Adolescent and youth engagement in OF case identification in and out of school

Strategic Initiative 2.2. Improving diagnosis and referral of Obstetric Fistula cases

MAJOR ACTIVITIES:

- Building the health facility’s diagnostic capacity including continuous supply of diagnostic kits
- Strengthen the pre-referral care
- Strengthen OF case referral system with communication between health facilities
- Provide free of charge back and forth transportation for OF treatment

Strategic Initiative 2.3. Improving the capacity of obstetric Fistula case treatment

MAJOR ACTIVITIES:

- Capacity building for OF treatment health care providers
- Revitalize OF treatment facilities
- Initiate outreach OF treatment programs
- Equip OF treatment facilities with basic equipment and supplies
- Integrating OF case treatment with routine obstetric and Gynecologic services

STRATEGIC DIRECTION 3

STRENGTHENING THE REHABILITATION AND REINTEGRATION SERVICES FOR OF SURVIVORS

DESCRIPTION:

This strategic direction describes reversing the physical injury (closing the fistula and bringing about physical strength with physiotherapy) alone makes OF treatment incomplete. Providing psychoeducation, psychotherapy and supporting the social reintegration and ensuring productivity and economic independence will raise survivors' self-esteem and morale, making them productive with reestablished family by establishing conducive foundation for OF survivors.

Strategic Initiative 3.1. Enhancing rehabilitation and reintegration services for OF survivors

MAJOR ACTIVITIES:

- Provide Physical rehabilitation for OF cases
- Provide tailored psycho-social support (life skill training, basic maternal health training, psychological counselling, and basic business skill training)
- Involve male partner/family in the rehabilitation, and re-integration.
- Ensure individualized re- integration support and follow-ups at grassroots level
- Ensure the economic empowerment of OF survivors
- Train OF treated survivors as Safe Motherhood Ambassadors

STRATEGIC DIRECTION 4

STRENGTHENING LEADERSHIP AND GOVERNANCE FOR OF CONTINUUM OF CARE

DESCRIPTION:

This strategic direction emphasizes taking OF as an agenda by political leaders and program managers and stakeholders at all levels to accelerate its elimination through prevention, identification , diagnosis, referral, treatment, rehabilitation and reintegration process.

Strategic initiative 4.1 Sustaining the leadership commitment and good governance towards OF elimination at all levels

MAJOR ACTIVITIES:

- Conduct advocacy session on OF elimination for leader at all levels
- Provide support at all levels in the implementation of obstetric fistula strategic plan
- Strengthening leadership and governance for mobilization of the human, material, and financial resources for the elimination of OF
- Ensure the implementation of SOP and quality assurance measures in the OF continuum of care.

STRATEGIC DIRECTION 5

STRENGTHENING PARTNERSHIP/MULTISECTORAL ENGAGEMENT AND RESOURCE MOBILIZATION FOR OF ELIMINATION ACTIVITIES

DESCRIPTION:

This strategic direction focuses on Strengthening partnership/multisectoral engagement and increase funding from different sources such as increasing the government's health expenditure, NGOs, community contributions, and expanding the health insurance schemes to eliminate OF.

Strategic Initiative 5.1. Strengthening partnership/multisectoral engagement for OF elimination

MAJOR ACTIVITIES:

- Advocacy session for parliament and relevant government sectors
- Integrate OF with other existing MNCH taskforce at different levels
- Involve stakeholders in planning, implementation and evaluation activities

Strategic initiative 5.2. Scale up financial resource mobilization for OF elimination activities

MAJOR ACTIVITIES:

- Ensure adequate budget allocation for the implementation of OF elimination plan including OFSR
- Leverage government and partners resources for evidence generation
- Resource mapping
- Including the OF elimination in the bilateral and multilateral funding support agreements
- Including the OF elimination costing in the community based health insurance schemes

STRATEGIC DIRECTION 6

STRENGTHENING THE DELIVERY OF LOGISTICS AND SUPPLIES FOR OF CONTINUUM OF CARE

DESCRIPTION:

This strategic direction focuses on ensuring a sustainable delivery of medical equipment and consumables for OF prevention, diagnosis and treatment through a coordinated governance and leadership in planning and timely procuring.

Strategic Initiative 6.1. Ensuring necessary logistics and supplies for OF continuum of care

MAJOR ACTIVITIES:

- Conduct joint planning, forecasting, quantification, and procurement
- Timely distribution of medical equipment and consumables
- Strengthen the supply chain management system at the central and regional levels
- Ensure the availability of the minimum standard list of surgical equipment and consumables to perform obstetric surgical procedures

STRATEGIC DIRECTION 7

ESTABLISHING AN OF MONITORING, EVALUATION AND REPORTING SYSTEM

DESCRIPTION:

This strategic direction focuses on establishing obstetric fistula monitoring, evaluation, reporting system by introducing obstetric fistula surveillance and response system into the public health emergency system and strengthening obstetric fistula monitoring and evaluation platform.

Strategic initiative 7.1. Introducing Obstetric Fistula Surveillance and Response system

MAJOR ACTIVITIES:

- Ensure the integration of obstetric fistula surveillance and response (OFSR) system to the PHEM system
- Strengthening the capacity building of health providers about OFSR
- Installing reporting and response mechanism based on the surveillance results at all levels

Strategic initiative 7.2. Strengthening an OF monitoring and evaluation platform

MAJOR ACTIVITIES:

- Conducting regular supportive supervision for assessing the case identification, diagnosis, and transfer efficiency
- Conducting regular review meetings (at least biannually)
- Conduct baseline, midline and end-line evaluation for the strategic plan
- Integrate the OF elimination agenda in the national and regional quarterly review meetings
- Strengthen data management system
- Explore the community perception, values, and attitudes towards FGM, child marriage, and teenage pregnancy
- Conducting a national representative hospital based retrospective study on obstructed labor and uterine rupture as a proxy indicator of OF

Goal

Eliminate obstetric Fistula

Objectives

Preventing OF by leveraging the driving values of the community

Improving access to quality obstetric care

Implementing innovative approaches to identify, diagnose, refer and treat women with OF

Improving the rehabilitation and reintegration of women with OF

STRATEGIC DIRECTIONS

Accelerating prevention of obstructed labor and OF in the community and in the health facility

Improving the identification, diagnosis, referral and treatment of Obstetric Fistula women with OF

Strengthening the rehabilitation and reintegration services for OF survivors

Strengthening leadership and governance for OF continuum of care

Strengthening partnership/multisectoral engagement and resource mobilization for OF elimination activities

Strengthening the delivery of logistics and supplies for OF continuum of care

Establishing an OF monitoring, evaluation and reporting system

VI Implementation plan

Eliminating obstetric fistula strategy implementation requires the availability of appropriately skilled professionals, adequate supplies, commodities, and equipment, proper information management systems, sound governance and management, a sustainable financing mechanism, appropriate quality improvement, and service delivery outlets. The “end obstetric fistula” strategy and its service provision indicators need to be integrated into the planning and reporting systems (DHI2 or equivalent) for routine evaluation and monitoring. Therefore, the following specifications for implementation are proposed.

Planning and implementing financial resource mobilization

In order to eliminate the obstetric fistula, the Woreda administration through revenue collection and support from MoH should take the responsibility of the budget allocation to identify and transfer obstetric fistula cases to the treatment center. Woreda administrations should mobilize resources from the community, private sectors and NGOs which may strengthen the implementation of the strategy. Many aspects of the end fistula strategy are already being implemented like FP, ANC, SBA, PNC etc through different departments of MoH. Therefore, the costing will only include specific costs to the implementation of “end obstetric fistula” strategy such as: revising the postnatal care guideline to include OF screening, training of health professional on OF, costs related to transporting mothers to the treatment center, etc.

Conducting national survey on OF and obstructed labor

The current burden of obstetric fistula is not established yet. The technical working group at the national level and experts attending related consultative meetings have agreed to conduct a national survey the soonest possible. The survey will serve as an end term evaluation of the last strategic plan and as baseline for the current strategic plan. This

national survey will be carried in 2021. The main objective is to determine prevalence and incidence of obstetric fistula in Ethiopia. In addition, the opportunity will be used to evaluate the level of achievement of the last strategic plan objectives and its impact on reducing the OF morbidity and mortality. The survey's result can also be used to revise the current OF strategic plan.

This is the time to know the actual magnitude of OF in Ethiopia and make a decision on the future plan, including the fistula treatment centers. While keeping the elimination interventions momentum on, galvanizing the development partners support for conducting the national survey is imperative. Methodologically, as fistula is a highly stigmatized problem with high probability of hiding it, measuring the prevalence of OF may need a systematic approach. Adaptation of the sibling-based method may be used as an alternative method.³⁹

Amendment of the strategic actions as per the M/E findings

A continuous monitoring and evaluation should be done and the finding of the national survey can be taken as an input for a revision of the strategic actions. In addition, a midterm evaluation in 2023 will be conducted to evaluate the implementation progress and identify the bottlenecks; This will provide a basis for review of the plan, as appropriate, to attain the ultimate target of the strategic plan.

VII Roles and Responsibilities

The roles and responsibilities of different stakeholders in the implementation of the strategic plan are summarized as below

1. MOH, Parliament and Political Leadership

- The political leadership should take the responsibility at all levels
- Foster effective collaboration and synergy between jMNCH constituencies around the goals of decreasing maternal and child mortality.
- Ensure actual implementation of the strategic plan to eliminate OF.
- Foster and support implementation of the strategic plan to establish efficient institutional and management systems at all levels, Ministry of Health will provide overall policy and technical leadership, guidance, , resource allocation, monitoring and evaluation for the implementation of the Plan.
- Federal and regional health bureaus will coordinate multi-sectoral collaboration with other relevant line ministries such as education, justice and communication.
- MOH will prepare national OF management guidelines, SOPs and various training manuals.

2. National EOF Task Force

- Provide technical support and advice to the MOH for the implementation of the Plan at national level and where possible at regional and Woreda levels.
- Ensure that national and sub-national plans, guidelines and protocols are endorsed and implemented by all stakeholders.
- Support the implementation of the Plan
- support mobilization of resources for the implementation of strategic plan.
- Provide technical support in the preparation of guidelines, protocols and training manuals.

3. Regional Health Bureaus (RHBs)

- RHBs will adopt the strategic plan to Eliminate OF and coordinate its translation into a context specific regional Plans.
- RHBs coordinate technical support implementation of the National EOF strategic Plan.
- The RHBs are responsible for planning, resource allocation, management, supervising and monitoring all OF activities RHBs will coordinate and ensure quality training and mentoring of health care providers about OF at the Zonal and district level
- Disseminate and use reports and data on OF from the districts/councils and send to the national level.
- RHBs will coordinate and conduct supportive supervision and clinical mentoring visits to hospitals and health centers.

4. Zonal and Woreda Health Office

- Develop and implement a context specific Woreda Plan to Eliminate OF (including monitoring/supervision and evaluation).
- The Woreda based plans will include RMNCAYH and OF targets and detailed scale-up plans, as well as ensuring adequate allocation of human and financial resources.
- Provide support for quality Obstetric fistula services and referral. This includes establishing effective follow-up mechanisms to the community level for OF, through involvement of HEWs, WHDT, Women's Associations and With relevant sector offices

5. Health Facilities (Hospitals, Health Centers)

- Set clear targets for RMNCAYH and obstetric fistula, for their catchment area population. Identify ways to make the implementation of the national policy on free MNCH services effective, through consultations with service providers, partners, civil society and communities, including HEWs and WHDTs

- Ensure availability of supplies and motivated staff to undertake quality EmONC services
- Ensure availability of supplies and motivated staff to undertake diagnosis of OF
- Engage in conducting community-based case finding and diagnosis of OF cases in close collaboration with HEWs and the WHDT.
- Diagnose OF and provide Pre referral care
- Each facility should put in place active referral and tracking mechanisms to ensure that OF cases are referred and receive all the necessary services when moving from one level of care to the next.

6. Health Extension Workers (HEWs)

- Facilitate community engagement activities for prevention, and identification of obstetric fistula.
- Organize WHDTs, Women's Associations, religious leaders and opinion leaders to promote RMNCAYH services, including OF, for active case finding and referral.
- Work to identify local barriers to accessing RMNCH services.
- HEWs, in collaboration with the WHDT, will support the rehabilitation and reintegration of fistula survivors at community level.
- HEWs will support fistula survivors to actively participate in active case finding of women with OF.

7. Development Partners, Donors and Implementing Partners

- Support funding, coordination, and provide technical support for the implementation of the national OF elimination plans.
- Development and implementing partners will strengthen coordination among themselves at national, regional and Woreda level Implementing partners will also support capacity building activities to enable RHBs and Woredas to effectively plan, manage, implement and monitor the program.

- Provide funding through a variety of modalities, including direct budget or pooled support and through support to projects that focus on OF research and studies as part of comprehensive RMNCAYH services.
- Strengthening the health system

8. Universities and Academic Institutions

- Support pre and in-service training in RMNCAYH, including OF
- Inclusion of OF in pre and in-service training curricula.
- Ensure trainers have adequate knowledge and skills in RMNCAYH and OF
- conduct research and survey to generate evidence

9. Media and Communications

- Engage in social mobilization, demand creation, and stigma reduction activities .
- Standard messages and effective communication channels will be used for different audiences
- OF elimination champions will be identified to support social mobilization and Behavior Change Communication (BCC) activities.

10. Ministry of Education

- promote improved girls access to quality education,
- support implementation of the National Nutrition Strategy focusing on improving girl's nutrition throughout their life cycle,
- Delaying age of marriage and advocating for implementation of the revised Criminal Law and Family Code.

11. Ministry of Women, Children and youth Affairs

- Promote to elimination of Obstetric Fistula predisposing factors like child marriage and FGM

- Support the identification and referral of suspected OF cases using the existing system
- Advocate for Delaying age of marriage and implementation of the revised Criminal Law and Family Code.
- Support for Girls and women empowerment
- Support on the prevention of teenage pregnancy

VIII Indicative work plan

TABLE 2 : Indicative work plan for elimination of obstetric fistula (2021-2025)

Strategic Direction 1: Accelerating prevention of obstructed labor and OF in the community and in the health facility					
Strategic initiative 1.1	Implementation year				
	2021	2022	2023	2024	2025
Enhancing community awareness about obstructed labor and OF prevention					
1. Strengthen community awareness on OF prevention by using existing community structures and mass media	█	█	█	█	█
2. Promote Skilled birth attendance	█	█	█	█	█
3. Increase awareness of the community on the consequences of HTP such as early marriage, teenage pregnancy, and FGM	█	█	█	█	█
4. Reaching the community through digital platform and hotline for awareness creation on OF prevention	█	█	█	█	█

Strategic initiative 1.2. Enhancing community engagement in the prevention of obstructed labor and OF	Implementation year				
	2021	2022	2023	2024	2025
1. Strengthen community mobilization platform (HEW, Pregnant woman conference. WDA, safe motherhood ambassadors, community and religious leaders).	■	■	■	■	■
2. Establish community mobilization platform in hard-to-reach areas or in villages where it is not yet established	■	■	■	■	■
3. Integrate OF activities with other health services (PNC, EPI, FP, AYH and other RH services)	■	■	■	■	■
4. Strengthen demand creation for ANC and institutional delivery	■	■	■	■	■
Strategic initiative 1.3 Preventing the occurrence of obstructed labor and OF in the	Implementation year				
	2021	2022	2023	2024	2025
1. Strengthen compassionate and respectful maternity care service.	■	■	■	■	■
2. Integrate OF and obstructed labor prevention in the continuum of care (FP, ANC, Delivery, PNC)	■	■	■	■	■
3. Provide quality FP, ANC, delivery (including proper use of partograph) , and PNC service	■	■	■	■	■

4. Strengthen maternity waiting home service																										
5. Increase the number of Motivated, Competent and Compassionate (MCC) health work force																										
6. Strengthen facilities to provide EmONC services as per the standard																										
Strategic initiative 1.4 Institutionalizing the integration of SRH service programing at the inter-directorate and health facility levels to better utilize the opportunity for OF	<table border="1"> <thead> <tr> <th colspan="5">Implementation year</th> </tr> <tr> <th>2021</th> <th>2022</th> <th>2023</th> <th>2024</th> <th>2025</th> </tr> </thead> <tbody> <tr> <td colspan="5">  </td> </tr> <tr> <td colspan="5">  </td> </tr> <tr> <td colspan="5">  </td> </tr> </tbody> </table>	Implementation year					2021	2022	2023	2024	2025															
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2. Building the health workers' capacity on the principles and practice of SRH service integration																										
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Strategic initiative 1.5 Improving the surgical care to prevent OF and iatrogenic fistula	<table border="1"> <thead> <tr> <th colspan="5">Implementation year</th> </tr> <tr> <th>2021</th> <th>2022</th> <th>2023</th> <th>2024</th> <th>2025</th> </tr> </thead> <tbody> <tr> <td colspan="5">  </td> </tr> </tbody> </table>	Implementation year					2021	2022	2023	2024	2025															
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2021	2022	2023	2024	2025																						
																										
1. Ensure the surgical safety in all obstetric surgical procedures by developing and implementing standard operating procedures (SOP)including early detection of and management of iatrogenic injury.																										

2. Provide timely operative delivery for women with labor abnormality					
3. Conduct facility based obstetric surgery quality audit and response					
Strategic Direction 2: Improving the identification, diagnosis, referral and treatment of Obstetric Fistula					
Strategic initiative 2.1	Implementation year				
Strengthening the OF case identification and linkage to health facility	2021	2022	2023	2024	2025
1. Promote OF case identification by increasing the public awareness about OF					
2. Introduce innovative approaches to identify women with OF, including establishing free call (like 952) for OF case notification					
3. Integrate OF case detection in the house-to-house/community health programs (immunization, health extension service, WDA)					
4. Increase the number of trained 'Safe Motherhood Ambassadors' to support identification and linkage OF cases to a health facility					
5. Incentivize WDA, safe motherhood ambassadors and others for their contribution to OF case detection					

6. Reinforce the fistula detection in the community by distributing job aids (algorithms) and IEC materials	
7. Capacitate health extension workers, and health care providers on OF case identification and linkage	
8. Enhance Adolescent and youth engagement in OF case identification in and out of school	
Strategic initiative 2.2	Implementation year
Improving diagnosis and referral of Obstetric Fistula cases	2021 2022 2023 2024 2025
1. Building the health facility’s diagnostic capacity including continuous supply of diagnostic kits	
2. Strengthen the pre-referral care	
3. Strengthen OF case referral system with communication between health facilities	
4. Provide free of charge back and forth transportation for OF treatment	
Strategic initiative 2.3	Implementation year
Improving the capacity of obstetric Fistula case treatment	2021 2022 2023 2024 2025
1. Capacity building for OF treatment health care providers	

2. Revitalize OF treatment facilities	
3. Initiate outreach OF treatment programs	
4. Equip OF treatment facilities with basic equipment and supplies	
5. Integrating OF case treatment with routine obstetric and Gynecologic services	

Strategic Direction 3: Strengthening the rehabilitation and reintegration services for OF survivors

Strategic initiative 3.1

Enhancing rehabilitation and reintegration services for OF survivors

Implementation year

2021	2022	2023	2024	2025
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1. Provide Physical rehabilitation for OF cases	
2. Provide tailored psycho-social support (life skill training, basic maternal health training, psychological counselling, and basic business skill training)	
3. Involve male partner/family in the rehabilitation, and re-integration.	
4. Ensure individualized re- integration support and follow-ups at grassroots level	
5. Ensure the economic empowerment of OF survivors	
6. Train OF treated survivors as Safe Motherhood Ambassadors	

Strategic Direction 4: Strengthening leadership and governance for OF continuum of integration					
Strategic initiative 4.1	Implementation year				
	2021	2022	2023	2024	2025
Enchasing leadership and good governance					
1. Conduct advocacy session on OF elimination for leader at all levels	█	█	█	█	█
2. Provide support at all levels in the implementation of obstetric fistula strategic plan	█	█	█	█	█
3. Strengthening leadership and governance for mobilization of the human, material, and financial resources for the elimination of OF		█	█	█	█
4. Ensure the implementation of SOP and quality assurance measures in the OF continuum of care.	█	█	█	█	█
Strategic Direction 5: Strengthening partnership/multisectoral engagement and resource mobilization for OF elimination activities					
Strategic initiative 5.1	Implementation year				
	2021	2022	2023	2024	2025
Strengthening partnership/multisectoral engagement for OF elimination					
1. Advocacy session for parliament and relevant government sectors		█	█	█	█
2. Integrate OF with other existing MNCH taskforce at different levels		█	█		

3. Involve stakeholders in planning, implementation and evaluation activities					
Strategic initiative 5.2 Scale up financial resource mobilization for OF elimination activities	Implementation year				
	2021	2022	2023	2024	2025
1. Ensure adequate budget allocation for the implementation of OF elimination plan including OFSR					
2. Leverage government and partners resources for evidence generation					
3. Resource mapping					
4. Including the OF elimination in the bilateral and multilateral funding support agreements					
5. Including the OF elimination costing in the community based health insurance schemes					
Strategic Direction 6: Strengthening the delivery of logistics and supplies for OF continuum of care					
Strategic initiative 6.1 Ensuring necessary logistics and supplies for OF continuum of care	Implementation year				
	2021	2022	2023	2024	2025
1. Conduct joint planning, forecasting, quantification, and procurement					
2. Timely distribution of medical equipment and consumables					

3. Strengthen the supply chain management system at the central and regional levels					
4. Ensure the availability of the minimum standard list of surgical equipment and consumables to perform obstetric surgical procedures					
Strategic Direction 7: Establishing an OF monitoring, evaluation and reporting system					
Strategic initiative 7.1	Implementation year				
Introducing Obstetric Fistula Surveillance and Response system	2021	2022	2023	2024	2025
1. Ensure the integration of obstetric fistula surveillance and response (OFSR) system to the PHEM system					
2. Strengthening the capacity building of health providers about OFSR					
3. Installing reporting and response mechanism based on the surveillance results at all levels					
Strategic initiative 7.2	Implementation year				
Strengthening an OF monitoring and evaluation platform	2021	2022	2023	2024	2025
1. Conducting regular supportive supervision for assessing the case identification, diagnosis, and transfer efficiency					
2. Conducting regular review meetings (at least biannually)					

3. Conduct baseline, midline and end-line evaluation for the strategic plan	
4. Integrate the OF elimination agenda in the national and regional quarterly review meetings	
5. Strengthen data management system	
6. Explore the community perception, values, and attitudes towards FGM, child marriage, and teenage pregnancy	
7. Conducting a national representative hospital based retrospective study on obstructed labor and uterine rupture as a proxy indicator of OF	

TABLE 3 Obstetric fistula (OF) case load estimation for the years 2021-2025

Characteristics	2020	2021	2022	2023	2024	2025
Total population (2.07%)	101,000,000	103,090,700	105,224,678	107,402,828	109,626,067	111,895,326
Crude Birth Rate-decrease by 0.5%/year	2.95%	2.90%	2.85%	2.80%	2.75%	2.70%
Total delivery	2,979,500	2,989,630	3,051,516	3,114,682	3,179,156	3,244,964
Increase SBA from 50% in 2020 to 76% by 2025	1,489,750	1,685,035	1,880,322	2,075,609	2,270,896	2,466,180
CS rate from 4% in 2020 increase to 8% by 2025	119,180	179,378	244,121	311,468	381,499	454,295
Reduce OL/PL from 2% to 1% of the total delivery	59,590	53813	48824	43605	38149	32449
OF incidence (1.6% of OL/PL)	953	861	781	698	610	520
OF untreated backlog and new cases (50% treated every year)	2403	1031	906	802	706	613

Note: Total population growth rate of 2.07% (CSA), crude birth rate of 2.95% (MoH elimination of OF previous strategic plan), EmONC 2016 survey, the initial total population size reported in HSTP2, and the fistula treatment facilities capacity were considered for estimating the change in OF cases over the coming five years

IX Budgeting The Strategic Plan

TABLE 4. Financial breakdown for elimination of obstetric fistula strategic plan implementation (2021-2025)

Strategic Direction 1: Accelerating prevention of obstructed labor and OF in the community and in the health facility						
	2021	2022	2023	2024	2025	Total
Strategy 1.1. Enhancing community awareness about obstructed labor and OF prevention	34,182,460	8,737,500	9,182,460	8,737,500	2,500,000	63,339,920
Strategy 1.2. Enhancing community engagement in obstructed labor and OF prevention endeavors	14,499,440	67,010,640	8,647,440	8,647,440	8,647,440	107,452,400
Strategy 1.3. Preventing the occurrence of obstructed labor and OF through access to health facility	19,840,000	19,840,000	-	-	-	39,680,000
Strategy 1.4. Improving the surgical care to prevent OF and iatrogenic fistula	89,461,600	83,278,000	83,278,000	83,278,000	77,326,000	416,621,600

Strategic Direction 2: Improving the identification, diagnosis, and referral for both prevention and treatment of OF						
	2021	2022	2023	2024	2025	Total
Strategy 2.1. Improving the inter-facility communication and referral	4,100,000	2,400,000	2,400,000	2,400,000	2,400,000	13,700,000
Strategy 2.2. Institutionalizing the integration of SRH service programming at the inter-directorate and health facility levels	167,000	167,000	167,000	167,000	167,000	835,000
Strategy 2.3. Strengthening the OF case identification and linkage	35,641,743	53,271,893	18,939,693	4,255,000	4,255,000	116,363,330
Strategic direction 3: Strengthening the rehabilitation and reintegration services for OF survivors						
	2021	2022	2023	2024	2025	Total
Strategy 3.1. Enhancing the physical and psychological rehabilitation services for OF survivors	2,083,520	2,083,520	1,668,580	1,668,580	1,668,580	9,172,780
Strategy 3.2. Supporting the reintegration process and ensuring the productivity of OF survivors	19,167,000	19,000,000	19,000,000	19,000,000	19,000,000	95,167,000

Strategic direction 4: Strengthening leadership and governance for OF prevention, case identification, rehabilitation, and reintegration						
	2021	2022	2023	2024	2025	Total
Strategy 4.1 Sustaining the leadership commitment and good governance towards OF elimination interventions at all levels	2,324,600	251,000	-	-	-	2,575,600
Strategy 4.2: Strengthening coordination at all levels and improving performance through regular reviews	2,326,100	364,400	364,400	364,400	364,400	3,783,700
Strategy direction 5: Strengthening mobilization of financial support for OF prevention, case identification, diagnosis, referral, treatment, rehabilitation, and reintegration services.						
	2021	2022	2023	2024	2025	Total
Strategy 5.1. Securing adequate funds for OF prevention, treatment, and reintegration	583,000	-	-	-	-	583,000
Strategic direction 6: Strengthening the delivery of logistics and supplies for OF prevention, case identification, and reintegration						
	2021	2022	2023	2024	2025	Total

Strategy 6.1. Ensuring necessary logistics and supplies for OF prevention, case identification, and reintegration	-	-	-	-	-	-
Strategic direction 7: Establishing an OF monitoring and evaluation structure						
	2021	2022	2023	2024	2025	Total
Strategy 7.1. Introducing Obstetric Fistula Surveillance and Response system	10,289,000	2,000	2,000	2,000	2,000	10,297,000
Strategy 7.2. Strengthening an OF monitoring and evaluation platform	8,208,000	1,919,600	1,919,600	1,919,600	3,919,600	17,886,400
	242,873,463	258,325,553	145,569,173	130,439,520	120,250,020	897,457,730
	6,071,836.58	6,458,138.83	3,639,229.33	3,260,988.00	3,006,250.50	22,436,443.25

TABLE 5 Result Framework for the Elimination of OF in Ethiopia

Indicators	Baseline	Target	Frequency	Verification means	Assumptions
<i>Strategic initiatives 1.1. Enhancing community awareness about obstructed labor and OF prevention</i>					
1. Percentage of community awareness on OF prevention	39% (EDHS 2016)	95%	end term	Survey	
2. Proportion of teenage pregnancy	13%	7%	midterm and end term	Survey	
<i>Strategic initiatives 1.3. Preventing the occurrence of obstructed labor and OF in the health facility</i>					
3. Percentage of women that received antenatal care four contact during the current pregnancy	43%	81%	Annually	Admin report	
4. Proportion of births attended by skilled health personnel	50%	76%	Annually	Admin report	
5. Proportion of health facility providing BEmONC service	5%	100%	Annually	Admin report	

6. Proportion of health facility providing CEmONC service	75%	100%	Annually	Admin report	
<i>Strategic initiatives 1.4. Improving the surgical care to prevent OF and iatrogenic fistula</i>					
7. Proportion of women with CS delivery	4.1%	8%	Annually	Admin report	
<i>Strategic initiatives 2.1. Strengthening the OF case identification and linkage to health facility</i>					
8. Proportion of probable OF cases identified from the community		100%	Annually	Admin report	
<i>Strategic initiatives 2.2. Improving diagnosis and referral of Obstetric Fistula cases</i>					
9. Proportion of health facilities with trained health care providers on OF prevention, identification and referral		100%	Annually	Admin report	
10. proportion of confirmed OF cases linked to treatment centers		100 %	Annually	Admin report	
<i>Strategic initiatives 2.3. Improving the capacity of obstetric Fistula case treatment</i>					
11. Number of general/tertiary hospitals integrated OF treatment service		20	Annually	Admin report	
<i>Strategic initiatives 3.1. Enhancing rehabilitation and reintegration services for OF survivors</i>					
12. Proportion of OF survivors rehabilitated		100%	Annually	Admin report	
13. Proportion of OF survivors reintegrated		100%	Annually	Admin. report	

Strategic initiatives 4.1. Sustaining the leadership commitment and good governance towards OF elimination interventions at all levels

14. OF included in MNH score card	0	1	Annually	Admin report	
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Strategic initiatives 5.1. Scale up financial resource mobilization for OF elimination activities

15. Mobilized budget for OF elimination strategic plan implementation		95%	Annually	Admin report	
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Strategic initiatives 7.1. Introducing Obstetric Fistula Surveillance and Response system

16. Proportion of suspected OF cases linked to health facility for diagnosis		100%	annually	admin report	
17. Proportion of confirmed OF cases linked to treatment		100%	annually	admin report	

Strategic initiatives 7.2. Strengthening an OF monitoring and evaluation platform

18. Number of baseline survey conducted	0	1	midterm and end term	Survey	
19. Number of midterm evaluation conducted	0	1	midterm and end term	Survey	
20. Number of endterm evaluation conducted	0	1	midterm and end term	Survey	

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When I die, this place will go on for many, many years until we have eradicated fistula altogether - until every woman in Ethiopia is assured of a safe delivery and a live baby. ”

Dr. Catherine Hamlin
(1924 – 2020)