GOOD PRACTICES

IN IDENTIFICATION AND REFERRAL OF FISTULA CASES IN GHANA

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GHANA

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AND REFERRAL OF FISTULA CASES IN GHANA

Ghana Health Service

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LIST OF ACRONYMS

AWC	Aberdeen Women's Centre
CCTH	Cape Coast Teaching Hospital
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CHAG	Christian Health Association of Ghana
CHO	Community Health Officer
CHPS	Community Based Health Planning and Services
DDNS	Deputy Director of Nursing Services
ECOWAS	Economic Community of West African States
GHS	Ghana Health Service
MoGCSP	Ministry of Gender Children and Social Protection
M-PESA	Mobile Money (Swahili)
NCCE	National Commission for Civil Education
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
OF	Obstetric Fistula
PHC	Population and Housing Census
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Obstetric Fistula (OF) can be said to be one of the most serious, tragic and devastating conditions that women suffer at childbirth. Women who suffer this condition often end up with stillbirth further compounding their plight. Majority of these women are young, poor, illiterate and mostly live in remote areas. The World Health Organization (WHO) estimates that globally about 2 million girls and women live with fistula particularly in Africa and Asia. A 2015 report on the assessment of obstetric fistula in Ghana estimated the incidence of obstetric fistula to be between 1.6 and 1.8 per 1,000 deliveries, amounting to between 711 and 1,352 new cases per year.

Since the launch of the Campaign to end OF in Ghana in 2005, significant efforts have been made by relevant stakeholders to create awareness and to address the challenge of identification of women with the condition for assessment and treatment. Some of these efforts have yielded significant results and need to be documented as good practices (if they meet the set criteria) and be recommended for replication. Documenting good practices, provides an opportunity to reflect on interventions undertaken by key stakeholders as well as processes and procedures used during their different stages of implementation, and to carefully examine their expected results and related strategies.

Objectives

The aim of this study was to identify and document good practices in the identification and referrals of OF in Ghana. The specific objectives were to:

1. identify the relevance, innovation, sustainability, results-orientation, and replicability of the potential good practices in OF programme in Ghana;
2. identify the methods/strategies used in identifying OF clients in communities;
3. identify methods used in referring identified OF clients for treatment;
4. document good practices from the above;
5. identify the successes, challenges and lessons learned in implementing the good practice.

Methodology

The process of documenting good practices adopted exploratory and descriptive approaches. The process started with a desk review of some relevant documents, followed by key informant interviews among individuals and stakeholders with knowledge and experiences in OF from Ghana Health Service, Mercy Women's Catholic hospital, United Nations Population Fund (UNFPA), Ministry of Gender, Children and Social Protection (MoGCSP), Ghana Red Cross, some NGOs and identified obstetric fistula survivors. Additional information was captured using the UNFPA Good Practice Template.

Results

The study revealed that the national celebration of international day to end obstetric fistula, free registration of clients under the national health insurance scheme (NHIS), training of obstetric fistula advocates, sensitization and awareness creation about obstetric fistula on district and community radios and establishment of hotlines, integrated community outreach and active case search and training of obstetric fistula management teams were the good practices identified to improve case identification and referral of clients for treatment in Ghana.

Challenges observed in implementing the good practices included : poor coordination of obstetric fistula activities in the country that leads to gaps in data on cases identified, referred and repaired across the country; poor coordination of activities of trained obstetric fistula advocates which affect their morale and enthusiasm; unreliable contact numbers given by some identified clients and their relatives which make it difficult to contact them; poor integration of obstetric fistula activities into the general maternal and child health activities in the country; inadequate support (financially and programmatically) for obstetric fistula activities and inadequate obstetric fistula repair teams across the country.

Recommendations

Recommendations are that: the Ghana Health Service (Family Health Division) should assume full ownership of the obstetric fistula programme in the country, ensure its full integration into the maternal and child health programme and make sure that all activities relating to obstetric fistula are streamlined and coordina-

ted by them; residency training in obstetrics and gynaecology should integrate obstetric fistula assessment and repair actively into their programme by letting residents work at the obstetric fistula repair centres for periods ranging from 1 to 3 months during their training.

This will ensure the building of adequate capacity to assess and repair simple fistula cases by the time they complete their training. In this way, the country can use these graduates to build a pool of obstetric fistula repair teams across the country; the Ministry of Gender, Children and Social Protection (MoGCSP) should be empowered to take the lead in coordination of the social reintegration activities, training of community-based obstetric fistula advocates and activities of the advocates; the obstetric fistula programme of the Mercy Women's Centre in Mankessim should be integrated into the national programme so that the institution can benefit comprehensively from all financial and programmatic support from all partners; with the support of community actors and development partners, community information centres should be set up in all communities in high burden areas to ensure that clients whose telephone numbers are unreliable, and all information concerning timetable for assessment and repair from the information centres should be obtained.

Conclusion

All these lessons learnt from the good practices need to be utilized to influence policy and enrich the obstetric fistula programme in Ghana.

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BACKGROUND

Obstetric Fistula (OF) can be said to be one of the most serious, tragic and devastating conditions that women suffer at childbirth. It is the presence of an abnormal hole created between the vagina and rectum (recto-vaginal fistula) or vagina and the bladder (vesico-vaginal fistula) as a result of prolonged obstructed labour (Wall, 2012). This leaves women with chronic urinary or faecal incontinence or both and with a persistent and offensive smell which usually leads to stigmatisation and social ostracization (Khisa & Nyamongo, 2012). It is estimated that about 80 percent of women who develop fistula also suffer chronic excoriation of the skin around the perineum (caused by direct irritation of urine), amenorrhea, vaginal stenosis, infertility, bladder calculi, urinary tract infection and foot-drop. Sadly, women who suffer this condition often end up with stillbirths further compounding their plight. Majority of these women are young, poor, illiterate and mostly live in remote areas (Browning, 2007).

The World Health Organization (WHO) estimates that globally about 2 million girls and women live with fistula particularly in Africa and Asia. It is also estimated that 50,000 to 100,000 are affected each year (World Health Organization, 2014). According to Nuertey (2013), even though it is acknowledged that OF is prevalent in Africa, its incidence is largely unknown. Estimates suggest that at least 3 million women in poor countries have unrepaired vesico-vaginal fistulas, and that

30,000 to130,000 new cases develop each year in Africa alone (Wall, 2006). The situation is described to be worse in sub-Saharan Africa, especially in West Africa. A recent conservative attempt to estimate the incidence of obstetric fistulas with a population based

survey of severe obstetric morbidity in West Africa concluded that there were probably at least 33,000 new cases each year in sub-Saharan Africa (Vangeenderhuysen, Prual, & el Joud, 2001).

A needs assessment carried out in 2003 revealed that the magnitude of OF was unknown in Ghana, although some repairs were being carried out in some health facilities including the two teaching hospitals (Korle-Bu and Komfo Anokye Teaching Hospitals) and some mission facilities. The assessment also noted that among policy and decision makers, fistula had not been prioritized as a public health issue and there was a lack of trained personnel able to undertake fistula repair, as well as a general lack of awareness of OF prevention and treatment within communities (UNFPA, 2003). Following the needs assessment, Ghana launched its response to the UNFPA Global campaign to end the problem of obstetric fistula in 2005, under a Project titled '*STRENGTHENING FISTULA PREVENTION ACTIVITIES AND ACCESS TO TREATMENT IN GHANA'*. The campaign focused on the three Northern Regions where the prevalence of the condition was believed to be quite high. Three main approaches were adopted towards addressing the problem: awareness creation; identification and treatment of victims; and rehabilitating and reintegration of repaired clients into society. The campaign was a collaboration between the Ministry of Health, Ghana Health Service (GHS), UNFPA,
Pathfinder Ghana, Tamale and Korle–Bu Teaching hospitals, Upper West and Upper East Regional Hospitals and the Baptist Hospital at Nalerigu.

In Ghana, there was inadequate data on the incidence of obstetric fistula, even though it was believed to occur in all the 10 regions, particularly in the three northern regions, central and western regions (Ghana Health Service, 2015). A 2015 report on the assessment of obstetric fistula in Ghana estimated the incidence of obstetric fistula to be between 1.6 and 1.8 per 1,000 deliveries, amounting to between 711 and 1,352 new cases per year (Ghana Health Service, 2015). Obstetric Fistula in Ghana is a relatively hidden problem, largely because it is highly stigmatized and affects the most marginalized members of society: young, poor, illiterate women in remote areas. Because of the stigma attached to the condition, people suffering from the condition are isolated and not very easy to locate.

Since the launch of the Campaign to end OF in Ghana in 2005, significant efforts have been made by relevant stakeholders to create awareness and to address the challenge of identification of women with the condition for assessment and treatment. Strategies to assist fistula clients to come out and be identified have included community sensitizations, (including durbars, home visits and community theatre performances), media sensitization and advocacy by repaired fistula clients among others. Some of these efforts have yielded significant results and need to be documented as good practices (if they meet the set criteria) and recommended for replication.

Documenting good practices, provides an opportunity to reflect on interventions undertaken by key stakeholders as well as processes and procedures used during their different stages of implementation, and to carefully examine their expected results and related strategies.

It provides critical data for the assessment and consideration of potential streamlining options, which may influence future changes in internal policies, procedures and regulations.

A fistula-related good practice is a programme activity, technical or operational that is pertinent to the goal to Eliminate Obstetric Fistula and is relevant, innovative, sustainable, results-oriented and replicable. Ghana Health Service with support from UNFPA commissioned documentation on emerging relevant, innovative experiences, methods, techniques and practices being used for identification and referral of OF cases that proved to have had and/or are making an impact that are desirable and may need to be replicated. A key result of this documentation was to provide, among others, clearly defined suggestions and recommendations on how to enhance identification and referral of fistula cases. The knowledge documented will also serve as evidence for resource mobilization for the Obstetric Fistula programme.

The aim of this study was to identify and document good practices in identification and referrals of OF clients in Ghana. The specific objectives were:

1. To identify the relevance, innovation, sustainability, results-orientation, and replicability of the potential good practices in OF programme in Ghana.

2. To identify methods/strategies used in identifying OF clients in communities.

3. To identify methods used in referring identified OF clients for treatment.

4. To document good practices from the above.

5. To identify the successes, challenges and lessons learned in implementing the good practice.

LITERATURE REVIEW

Improving maternal health in general has become a global concern and as such several programmes have been implemented to reduce maternal morbidity and mortality significantly. Ending Obstetric Fistula (OF) is one of such programmes geared towards improving maternal health. Ending OF is a multi-stakeholder programme that involves several initiatives and campaign programs that seek to address the problem. These programmes are mainly interventions that aim at making OF a thing of the past.

They seek to create awareness of the condition, identify women with the condition and look for ways to help them get treatment and social reintegration. Many women are still unaware of the availability of treatment (Kalembo & Zgambo, 2012). The main reasons were lack of knowledge about treatment availability (Miller, Lester, Webster, & Cowan, 2005) and stigma. Because of the stigma attached to the condition, women who suffer from the condition are isolated and not very easy to locate. Many live with the condition for several years (Kalembo & Zgambo, 2012). Identification and referral of women suffering from obstetric fistula are important to ensuring that many get treated. Strategies for identification and referral of women living with the condition for treatment are described in literature.

Reaching communities with messages about fistula prevention and treatment has been done through radio announcements, community theatre performances, print media, and community education messages relayed in markets, schools, and community

gatherings (UNFPA, 2003). In some locations, women who had fistulas repaired serve as ambassadors to their communities, sharing information and organizing resources for women who are pregnant or who, also need repairs. Because of the extreme social isolation (and often, ostracism) experienced by women with OF, these ambassadors may be the most important persons in their lives as they speak with them, dismantle their shame, and facilitate their social reintegration once the fistula is closed (Acquire Project/engender health, 2005). In Niger, 62 women were identified within 11 months following public campaigns by obstetric fistula ambassadors, with 82% of them diagnosed as suffering from OF and more than half of these patients (66%) having a history of previous attempts for repair (Cam et al., 2010).

Alma Adler and colleagues described innovative ways of using community outreach and key informants to identify women with fistula in need of treatment in Nigeria and South Sudan (Adler, Fox, Campbell, & Kuper, 2013). Community-Based Distributors (CBD) and a network comprising village midwives and trained traditional birth attendants (TBAs) were used as key informants for identification and referral of OF patients. Five half-day training sessions were held, covering the causes and consequences of fistula, how to recognise a woman who may have fistula and how to discuss the issue sensitively and confidentially for these key informants. After training, key informants returned to their community to identify potential cases of women aged between 15-49 years with fistula, through their own knowledge and by talking to women; and asking them whether they or other women of their acquaintance experienced symptoms of fistula (including urine leakage or smell of urine). They informed their local coordinator of

any suspected cases, who then passed the information onto a project coordinator. Potential cases of fistula were verified through physical examination in a mobile clinic. Key informants told the potential cases of fistula when the mobile clinic would be at their local health clinic (Adler et al., 2013).

In Sierra Leone, a special toll-free hotline to provide information and care options for women and girls with fistula was created. This enabled women with fistula symptoms to call and speak with trained nurses to determine whether they needed fistula treatment. In October 2011, in collaboration with the largest mobile phone company in Sierra Leone, AIRTEL, and other partners, a national toll-free fistula hotline at Aberdeen Women's Centre (AWC- An obstetric fistula treatment centre) was established. This 24-hour hotline had a short, easily remembered number (555) and enabled women with fistula symptoms across the country, especially those living in isolated and remote areas, to call the toll-free number and speak with trained nurses for advice and information on available treatment. The nurses also provided information about the causes of fistula and how the condition could be prevented. Arrangements were made to provide transportation for likely fistula cases to be brought to AWC for assessment, fistula repair surgery, postoperative care and rehabilitation. AWC also sent screening teams to diagnose potential patients and brought those suffering with fistula to the Centre. To ensure that the initiative received national and widespread media coverage, radio messages were broadcast in the local Krio language and in English advertising the hotline, describing fistula, including information on prevention and symptoms, as well as encouraging affected women and girls to seek medical attention (UNFPA, 2013).

Another good practice that had been documented was the use of mobile phone money-transfer service that enabled women undergo fistula repair surgery in Tanzania. In collaboration with partners, a fistula repair centre, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) had been assisting women with fistula from poor and isolated communities, through a network of community-based volunteers consisting of doctors, nurses, health care workers and traditional midwives from various regions who served as "fistula ambassadors." These ambassadors identified and referred potential fistula patients for treatment to CCBRT through mobile phone text messages. Upon confirming the likely diagnosis, CCBRT, with support from Vodafone, sent money through SMS using the M-PESA mobile banking system (M for "mobile" and PESA for "money" in Swahili), to cover the transportation costs of the fistula patient and the caregiver, if needed. The fistula ambassador retrieved the money from a local M-PESA agent and paid for the bus fare of the patient, who travelled to Dar es Salaam where she is met at the bus terminal by a CCBRT driver. When the patient arrived at the hospital, the referring ambassador received a small incentive via the same M-PESA system. The patient received the necessary surgery
and then remained for a period of rehabilitation in fully catered, safe, and free accommodation (UNFPA, 2013).

In Ghana, a combination of strategies helped with identification and referral of clients for treatment. Community advocacy and awareness creation by celebrities like Miss Ghana @ 50 and trained repaired clients improved identification whilst free registration of identified clients under the national health insurance scheme facilitated self referral and access to treatment

by OF clients (UNFPA Ghana, 2011). According to a 2015 report on obstetric fistula, individuals (community members, relations and friends), volunteers, NGOs and government agencies are involved with OF identification and referrals. Among individuals, careful observation was needed to identify persons with fistula. Ways of knowing that someone had fistula are: the frequent need of urination, screams or changed facial expressions during urination and accompanied by scanty urine, wetting of clothes after being seated for a while, and the persistent smell of urine on the person. Persons with fistula are known to withdraw themselves from other people when they go out in public.

Among volunteers, identification of fistula clients takes the form of direct observation of possible symptoms (incontinence of urine and faeces), report of symptoms from family relations or neighbours, and direct inquiries from household members. Health volunteers report any identified case to the sub- district health coordinators who contact heads of household and patients to get them to seek free treatment, and possibly accompany them to the repair center.

Most NGOs provided funds for sensitizations through durbars at which public health staffs get the opportunity to talk about the causes and the problems associated with OF. It is after these talks that invitations are made for patients to come forward to designated offices /health posts for support in linking them up with treatment facilities. The people present at the sensitization durbars are also encouraged to bring their relations and neighbours who have the condition to the designated offices to be supported through treatment.

For government agencies like the MoGCSP, contacts are made with their regional offices nationwide and charged to go into their designated districts and communities to identify people living with OF. The regional officers make announcements on local radio stations, churches, during seminars and programmes organized by the ministry and also to regional hospitals for health staff to provide contacts of patients. These regional officers are sometimes assisted by national service personnel attached to the regional offices or district health offices. After clients are identified, funds are sent from the ministry to the officers to mobilize and transport them to the fistula center at Mankessim after prior arrangement is made with doctors on feasible dates to receive patients for assessment and repairs.

METHODOLOGY

The study sites

The study covered five regions of Ghana, where obstetric fistula incidence and prevalence were estimated to be higher, according to the GHS report on the burden of OF in 2015. The regions are Upper East, Upper West, Northern, Central and Western.

Northern region

The region has a total population of 2,479,461 with 1,249,574 females and 1,229,887 males. The population of the region increased by 36.2 percent between 2000 and 2010 making it the third fastest growing region in the country after the Central (38.1 %) and Greater Accra (38.0 %) regions. Tamale Metropolitan Assembly is the capital and the most populous metropolis in the region, with a population of 371, 351 (representing 15 percent of the region's population).

The Yendi Municipality with a population of 199,592 (representing 8% of the region's population) is the second largest in the region. The least populous districts are Chereponi (53,394) and Saboba (65,706) representing 2.2 percent and 2.7 percent of the region's population respectively. The Northern region has a predominantly rural population of nearly 70% with Tolon Kumbungu, Saboba and Kpandai having a little over 90% of their population being rural. The total fertility rate (TFR) for the region is 3.5 with West Gonja,

Kpandai, Savelugu, Nanton and Chereponi Districts having the highest rate of slightly over 4 per woman in the region.

The lowest TFR (2.9) can be found in Zabzugu, Tatale and Karaga (Ghana Statistical Service, 2010).

Upper West region

Upper West is the region with the lowest population in the country, with a population of 702,110 comprising 341,182 males and 360,928 females. The districts in the region are Wa Municipal with the highest population size of 107,214 constituting about 15.3 percent of the total population, Sissala West, with the smallest population share of about 7.1 percent. The remaining areas are Wa West, Wa East, Sissala East, Nadowli, Jirapa, Lambussie Karni and Lawra. The rural population constitutes about 83.7 percent. The average total fertility rate is about 3.45 with the Sissala West district having the highest rate of 3.9 and Wa Municipal the lowest with a rate of 2.4.

Upper East region

The Region is located in the north-eastern corner of the country; it is bordered to the north by Burkina Faso, the east by the Republic of Togo, the west by Sissala District in the Upper West region and the south by West Mamprusi District in Northern Region. It is one of the two regions that were carved out of the upper region during the era of Provisional National Defence Council (PNDC). It has a population of 1,046,545, which is about 4.2 percent of the national population (comprising 506,405 males and 540,140 females).

The region has nine administrative districts including; Builsa, Bawku Municipality, Kasena Nankana West, Kasena Nankana East, Bolgatanga Municipality, Talensi Nabdam, Bongo, Bawku West and Garu Tempane. Bawku Municipality is the most populous with a population of 217,791 constituting about 20.8 percent of the regional population. Kasena Nankana West on the other hand has the lowest population of 70,667 (6.8%), the population is primarily rural with about 79 percent of the people living in rural areas. The TFR for the Region is 3.43 births per woman. The current rate indicates a decline from 4.19 in the year 2000.

Central region

The Central region is the third smallest region in the country. With a population of about 2,201,863 which constitutes 8.9 percent of the population of Ghana (comprising 1,050,112 males and 1,151,751 females), the region has seventeen administrative districts with varying population sizes. Gomoa East has the highest population of 9.4 percent of the regional population. The next two most populous districts are Mfantsiman and Ewutu Senya, each with 8.9 percent followed by Cape Coast with 7.7% of the population. Upper Denkyira West recorded the lowest percentage share of the regional population with 2.7 percent of the population. The proportion of the population in the region living in urban areas is 47.1 percent. The most urbanized district in the Region in 2010 is Effutu with 93.3 percent of the population living in urban localities. However, Assin South and Upper Denkyira west, have no urban populations. According to the 2010 census the region recorded a TFR of 3.60. The childlessness percentage is about 7.1 in the region.

Western region

The population of the region as enumerated in the 2010 Population and Housing Census was 2,376,021; with 1,187,774 males and 1,188,247 females. The proportion of the population that is urban is 42.4 percent. There are 17 administrative districts in the region. Among the districts, Sekondi-Takoradi Metropolis has the highest share of 23.5 percent of the population, whilst Nzema East Municipal has the lowest share of 2.6 percent. Over 40 percent of the people living in the region can be found in the urban areas; however the concentration has been in the Sekondi – Takoradi metropolis and Shama district. Apart from these two districts, the remaining is primarily rural. The region had a TFR of 3.57. However, Sekondi-Takoradi metropolis recorded a rate of 2.82 while Wassa Amenfi West had 4.43, Sefwi Bibiani Ahwiaso Bekwai recorded 3.19 and Tarkwa Nsuaem 3.23.

Study design and data collection techniques

The process of documenting good practices adopted exploratory and descriptive approaches. The process started with a desk review of documents (see bibliography) to situate the study in the context of what already exists. Some good practices from the sub-region and Ghana was documented (see literature review).

Interview guides were used to conduct key informant interviews among individuals and stakeholders with knowledge and experiences in OF from Ghana Health Service, Mercy Women's Catholic hospital, United Nations Population Fund (UNFPA), Ministry of Gender, Children and Social Protection (MoGCSP),

Ghana Red Cross, some NGOs and identified obstetric fistula survivors.

Additional information was captured using the UNFPA Good Practice template which detailed methods and strategies used in identification and referrals, cost implications and sustainability, replicability, challenges and lessons learned.

Target population and sampling

The target population comprised UNFPA Programme Specialists and Analysts, Programme and Regional Directors of Ghana Health Service (GHS), Deputy Directors in Charge of Public Health at the GHS, Medical Superintendents of selected hospitals where OF cases are managed, Regional and District Public Health Nurses of GHS, doctors and nurses in charge of OF management, Representatives of NGOs involved in OF management and repaired OF clients.

The sampling procedure was purposive and snowballing. Purposive sampling was used to sample representatives from GHS, UNFPA, Hospitals and NGOs, whilst snowballing technique was used to select repaired clients.

Management, Coordination and Ethical Issues

The study was commissioned by the Director-General of the Ghana Health Service and facilitated by the Family Health Division of the GHS with agreed Terms of Reference. Funding was provided by the UNFPA Ghana Country Office. Letters were written to the Regional Health Directorates of the GHS in the Northern, Upper East, Upper

West, Western and Central regions and the MoGCSP to inform them about the study. A letter of introduction was also written to facilitate entry by the consultant into the various institutions and facilities to document good practices in the field. Verbal informed consent was obtained from each respondent after the aims, objectives and benefits of the study were explained to them and clarifications to questions about the study were provided. Once they consented, interviews commenced. Interviews were conducted in places that guaranteed maximum comfort and privacy (especially for the repaired OF clients). Clinical Psychologists were contacted and put on standby should any of the repaired clients, especially have emotional problems from the interviews.

Fieldwork and implementation

The fieldwork started from the central region where interactions were held with the Regional Director of Health Services, GHS; the Medical Superintendents of the District hospitals in Abura Dunkwa, Agona Swedru and the Mercy Catholic hospital in Mankessim (Southern Sector Fistula Centre) and repaired fistula clients at the Catholic hospital. An interaction was also held with one of the Obstetrician/Gynaecologists of the Cape Coast Teaching Hospital (CCTH). These occurred from 24th to 27th November 2015. In the Western region, Contacts were made with the Regional Director of Health Services, GHS and an Obstetrician/Gynaecologist of the Effia Nkwanta Regional Hospital on 25th November 2015. Interactions between representatives of Family Health Division of GHS; UNFPA and MoGCSP were scheduled on 7th and 8th December 2015 in Accra.

From Wednesday 9th to Saturday 19th December 2015, field work was carried out in the Upper West, Upper East and Northern regions. In the Upper West region, interactions were held with the Regional Public Health Nurse at the Regional Health Directorate, DDNS in Charge of the Wa Regional Hospital, Regional Gender Desk Officer (MoGCSP), District Director Sissala West at Lawra, and Medical Superintendents at the Catholic Hospitals in Jirapa and Nandom and a fistula client. In the Upper East region interactions were held with Deputy Director in charge of Public Health, the regional Public Health Nurse, Obstetrician/Gynaecologist at the District hospital in Bawku, the Obstetrician/Gynaecologist (fistula surgeon) at the Regional hospital Bolgatanga and three repaired fistula clients, representatives of the Ghana Red Cross, an NGO (integrated Youth Needs and Welfare) and MoGCSP. The Northern Region was the last region visited. Discussions were held with the Regional Director of Health Services, GHS, the Regional Public Health Nurse, the Medical Superintendent, Tamale Central Hospital (which hosts the northern sector fistula centre), Nurses at the Tamale fistula centre and officials of the Medical records unit of the Tamale Central Hospital. Interactions were also held with the District Director at Zabzugu and the District Public Health Nurse at Kpandai (See appendix 1 for the list of persons contacted).

Data processing and management

The data recorded were cleaned by clarifying issues with the respondents at the time of the interview or later through telephone contacts provided by respondents. Information recorded were transcribed verbatim and subsequently organized into themes corresponding to the stated objectives of the assignment. The data obtained was inspected for completeness

before being subjected to review by a three-man panel made up of an obstetrician / gynaecologist, a public health physician and a development practitioner.

FINDINGS

Methods/ strategies used in obstetric fistula identification

United Nations Population Fund

Since the launch of the Obstetric Fistula Programme in 2005, UNFPA has supported the Ghana programme through the establishment of a field office in the Northern part of the country (Tamale) where the prevalence of the condition is believed to be high. To facilitate prompt repairs, UNFPA supported the refurbishment of an old dilapidated building in the Tamale Central hospital into a fistula repair centre. Identification of obstetric fistula clients is supported by UNFPA through various methods and strategies. These are highlighted in following paragraphs.

In 2012, the UN General Assembly instituted 23rd of May every year as the International Day to End Obstetric Fistula. The commemoration of the day, which began in 2013 in most affected countries including Ghana and championed by UNFPA, is one strategic method for creating public awareness about the condition and the need to end stigmatization. During these celebrations, public education about the condition is presented, sites for repair are advertised, theatre performances to create awareness are held, whilst testimonies are given by survivors of the condition. These activities serve as major rallying points for identifying obstetric fistula clients. The national launches in Kpandai in 2014 and Wa West in 2015 recorded increases in the number of OF clients identified and treated.

The free registration of OF clients under the National Health Insurance Scheme (NHIS) is another strategy that UNFPA Ghana employs indirectly to improve identification. Under this strategy, information about the free registration is disseminated by the Ghana Health Services through their community networks, budgets for premiums are budgeted for annually in their work plans and as many clients that are identified are registered under the scheme at designated districts. This facilitates repair by increasing financial accessibility for clients and motivates other clients to seek treatment.

Training of obstetric fistula repair teams (including nurses, anaesthetists and surgeons) facilitated by UNFPA ensures timely repair of identified clients and increases accessibility to treatment. The timely repair of survivors motivates clients to come out to be identified, knowing that their condition would also be treated promptly. Since the launch of the programme in 2005, about 10 surgeons and 4 anaesthetists have been trained in various aspects of Fistula repair. These were trained locally during outreaches by more experienced surgeons or in FIGO accredited fistula training facilities in Nigeria, Tanzania and Ethiopia. A total of 5 nurses has also been given training on post-operative care.

On an annual basis, UNFPA supports skills training for an average of 55 repaired fistula clients. The training equips them with income generating skills including entrepreneurship, soap making, bead making, baking & confectionary, and tie-and-dye making among others to facilitate their reintegration back into their communities. The clients are additionally trained as advocates for obstetric fistula. Between 2012 -2015, two hundred and forty-three survivors were trained. The advocates act as ambassadors for the programme by creating awareness and actively searching

for victims in their communities. Their activities markedly improve identification of clients for referral and repair.

Upper West Region

The Upper West region has actively supported the obstetric fistula programme since its launch in Ghana. Support to the programme has been facilitated mainly through the Regional Health Directorate of the Ghana Health Service with support from CHAG (Catholic hospitals), UNFPA and the Department of Gender under the MoGCSP in the region. The strategies employed to identify clients in the communities are the following:

Sensitization and awareness creation through community radio stations have been the main method/strategy used in the Upper West region. On Quarterly basis discussions are held on radio stations in Wa (Radio Upper West), Nandom (Von Radio) and Tumu (Radford Radio). Education and awareness creation about obstetric fistula are first provided by the public health nurses or doctors, after which discussions are held with the use of discussion guides developed and led by the host of the programme.

Listeners to the programme are allowed call in and ask questions and seek clarifications. During the programme, community support is solicited to spread information about the condition and telephone hotlines provided to enable clients and their relatives to call for support. Each programme lasts for an hour and is held mostly in Dagare and English. Regularly, survivors of the condition are also made to share their experiences during the programme as discussants. Clients who call the hotlines are directed to the nearest CHPS or health centres for subsequent referral to the Regional hospital for screening.

Active case search using volunteers and repaired clients is the means employed by both GHS and MoGCSP in collaboration with Department of Social Welfare in the region to identify OF clients. These are employed mainly in the Sissala West, Sissala East, Wa West and Nandom districts. During active case search, trained volunteers and repaired advocates move from house to house in the communities and engage family members, describe the symptoms of the condition and inform them about opportunities for repair. Identified clients are sent to the GHS facilities to be referred for assessment and repair.

Use of churches for sensitization, awareness creation and education are mainly employed in Jirapa and surrounding areas as an adjunct to identifying clients.

Upper East region

The Upper East region got involved actively in the fistula programme in 2007. The programme is facilitated mainly by the Regional Health Directorate in collaboration with the Ghana Red Cross, some NGOs, the Media, MoGCSP and Celebrities. Various strategies have been employed in the region to identify clients for treatment.

In 2007, Miss Ghana @ 50 (a national celebrity) travelled extensively within the region to create awareness, sensitivity and educate communities about the condition. Activities she engaged in included engagement with chiefs and opinion leaders to solicit their support for the programme, media sensitization and awareness creation, community durbars to educate communities about the condition, resource mobilization to fund registration of identified clients under the NHIS and support for treatment of

clients. Through her efforts, increased numbers of women suffering from the condition began to report at the regional hospital to seek treatment.

Community outreaches and durbars have been major strategies used for mobilizing clients for treatment in the region. Ghana Red Cross works together with community health nurses to educate and create awareness about obstetric fistula during routine community outreaches by the community health nurses. In addition, regular community durbars are also undertaken to complement the outreach efforts. During these community engagements, personal contacts are made with heads of families and opinion leaders who are encouraged to send suspected clients from their families and communities to the nearest CHPS and health centres for review or call hotlines provided by the CHOs and the Red Cross. In addition to these efforts, health volunteers from the Red Cross in Nabdam do house- to -house sensitization and active case search to identify clients for referral.

Sensitization and awareness creation through community radio stations have also been employed on a quarterly basis as one of the strategies used in the Upper East region. Education and awareness creation about obstetric fistula are first provided by the public health nurses or doctors, after which discussions are held with the use of discussion guides developed and led by the host of the programme. Listeners to the programme are allowed to ask questions and seek clarifications. During the programme, community support is solicited to spread information about the condition and telephone hotlines provided to enable clients and their relatives call for support. Each programme lasts for an hour and is held in the local dialect. Regularly, survivors of the condi-

tion are also made to share their experiences as discussants during the programme.

Clients who call the hotlines are directed to the nearest CHPS or health centres for subsequent referral to the Regional hospital for screening.

Integrated Youth Needs and Welfare, an NGO involved in adolescent reproductive health and advocacy work, as part of their community engagement, educate community members about obstetric fistula through a repaired client that they have employed. They encourage community members to report or send suspected cases to the nearest CHPS or health centres.

Ministry of Gender Children and Social Protection in the Upper East region through the regional office and the district gender desk officers working in collaboration with the Ghana Health Service embark on education, sensitization and advocacy campaigns on radio. Through this medium, potential clients are told where they can get help. Within the two year period, 19 women with OF were mobilised and 16 repaired.

Repaired obstetric fistula clients or survivors have increasingly become important in identification of fistula clients in the region. The three survivors interviewed had benefitted from the reintegration training supported by UNFPA. They had been offered livelihood skills and trained as advocates for obstetric fistula. The strategies they use in identifying potential clients for repairs are: house-to- house visits to educate and sensitize households about the condition, active case search based on identified symptoms, sensitization and education in churches and mosques, during community durbars and radio talk shows. Each of them had been

able to mobilize an average of 5 clients each since they were repaired and trained.

Northern region

The Northern region has championed the obstetric fistula programme since its inception in 2005 in Ghana. This has been facilitated by the Regional Health Directorate of the Ghana Health Service, working in collaboration with CHAG health facilities (Baptist Hospital in Nalerigu), the Tamale Teaching Hospital, MoGCSP and obstetric fistula ambassadors. The areas most affected are along the eastern corridor. They include Zabzugu, East Mamprusi, Bumkpurugu yonyoo, Kpandai, Saboba, Chereponi, Nanumba South, Nanuba North, Daboya, Tolon and Savelugu. Various strategies have been employed to identify potential OF clients. These include house-to-house sensitization visits, active case search, radio talk shows, community durbars and outreaches, and use of survivors as fistula advocates.

In Kpandai, the strategies used in identification are mostly through durbars, home visits and active case search by public health nurses. Health volunteers also do active house- to- house case search. In 2014 about 10 cases were identified and referred to Tamale through this means whilst in 2015 about 20 cases were identified and referred.

In Zabzugu community durbars, radio discussions, active case search, and use of repaired clients as advocates are methods used to identify clients. In the last quarter of 2015, about 34 cases were identified and referred to the Tamale fistula centre through a combination of these strategies.

Central region

The Central region has also supported the obstetric fistula programme since its launch in 2005 in the country. The Regional Health Directorate working actively through the Mercy Women's Catholic hospital in Mankessim (the main centre supporting obstetric fistula activities in the southern centre of the country) has provided support to the national efforts at eradicating obstetric fistula. Some support is provided by the Cape Coast Teaching Hospital in terms of providing treatment.

The various strategies employed in the identification of cases include the mobilisation through outreach programmes and use of repaired clients as advocates. During the outreach programmes, community members are educated about the disease and telephone hotlines provided. Community members are reassured that privacy and confidentiality are assured and so they should feel free to call the hotlines. They are also encouraged to disseminate the hotlines as widely as possible in their various communities. They are also told treatment is free and their transportation to the facility where they will be treated will also be reimbursed. Repaired clients are also made to share their story at various outreach programmes.

After treatment, clients are made to share their stories with each other, on the condition and how it has affected their lives. The nurses then educate them about the causes of the condition and entreat each of them to bring at least 10 people for them to be treated. They are able to do this through their conversation with people.

"I started my campaign against fistula through a conversation in the car I took back home after I was treated'. People are encouraged to come for treatment even if they have lived with the condition for a very long time. I always tell such people I lived with the condition for 24 years yet, I have received treatment and I no more live in that condition again. Telling them my story gives them hope and they come for treatment. I have since identified ten clients for treatment."

Repaired Fistula Client and Advocate

There are no collaborators or NGOs helping the hospital. The Cardinal Turkson Fund for Education and health is what is used to support the programme. The MoGCSP has also been supporting with the help of the ECOWAS Gender Fund. The hospital occasionally receives support from UNFPA.

Western region

There is no elaborate obstetric fistula identification and referral programme, on –going in the Western region. Most of the cases seen at the Effia Nkwanta regional hospital are mainly self-referrals. It was, however observed from reports of the Mercy Catholic hospital in Mankessim that cases are mostly referred to the centre from Tarkwa and Takoradi. Cases referred from Tarkwa are due to prolonged obstructed labour whilst those referred from Takoradi are mainly iatrogenic from hysterectomies.

Methods and strategies used in obstetric fistula referrals

Prompt referrals are important to ensure successful treatment of cases identified. It forms the main link between obstetric fistula identification and treatment. Various strategies and methods have been employed in the various regions.

In the Upper East region, clients identified are made to report at the various CHPS and Health Centres to be registered; the health volunteers of Ghana Red Cross or the community health nurses then inform the district health directorates who in turn organize transport for the clients to be conveyed to the regional hospital or the district hospital at Bawku (for those close to Bawku) to be assessed. There is an approved system in the region that reimburses the few clients who pay for their transport to the hospitals to be assessed. A similar system is employed by the Upper West and Northern regions, but in addition, there is a parallel system of providing some identified clients with transport fares to find their own means of transport and reimbursing those who use their own means to get to the Tamale fistula centre and Wa regional hospital respectively. The reimbursements for referrals are mainly supported by funds from UNFPA and Ghana Health Service.

In the Central region, clients identified are encouraged to report to the Mankessim Mercy Women's Catholic hospital for assessment. Once they get to the hospital their transportation costs are fully reimbursed from funds mobilized by the Catholic secretariat for the Mercy Women's Catholic hospital.

The MoGCSP is also actively involved in obstetric fistula identification and referral. For cases identified in the regions through their support, vehicles are organized by the ministry to transport the women mainly to the Mankessim Mercy Women's Catholic hospital or to the Tamale fistula centre for assessment and repairs.

GOOD PRACTICES IN OBSTETRIC FISTULA IDENTIFICATION AND REFERRALS

Celebration of International Day to End Obstetric Fistula (IEOF) Improves Identification of Clients Suffering from Obstetric Fistula

Introduction

The International day to end Obstetric Fistula was designated by the UN General Assembly in December 2012. It is celebrated on May 23rd every year in most affected countries including Ghana and championed by UNFPA. It is a major opportunity for bringing together a wide range of fistula identification strategies / methods /activities to a bigger platform and to a wider audience. Wider public awareness about the condition and the need to end stigmatization are created because the activities are telecast on national television and carried on national and local radio. In Ghana, the celebration commences with the launch of activities in designated districts in a rotating manner, often in areas where the prevalence is suspected to be high. The first launch of the celebration in Ghana was held in Accra in 2013. Subsequently, it has been held in Kpandai in the Northern region (2014) and Wechau in the Wa West district of the Upper West region (2015).

Implementation Strategy

Pre-launch activities in the form of radio advertisements, discussions and sensitizations are carried out by the district

coordinating council in collaboration with the media, district directorate of the Ghana Health Service and UNFPA. During the celebrations, public education about the causes and effects of the condition is done, hotlines and sites for repair are advertised, dramas to create awareness are held, whilst testimonies are given by survivors of the condition. Policy makers, Development Partners, Champions, Chiefs and Opinion leaders make statements to affirm or re-affirm their support for the national OF programme. These activities serve as major rallying points for sensitization and identifying obstetric fistula victims. The launches in Kpandai in 2014 and Wucheau in 2015 recorded increases in the number of victims identified and treated.

Progress and Results

1. During the launch in Kpandai in 2014, ten (10) cases were identified whilst 20 more were later identified and referred in 2015. Seven cases were also identified during the launch in 2015 at Wechau.

2. Launch of the IEOF has created a rich pool of collaborators and advocates, including District Assemblies, Chiefs, Opinion leaders, fistula survivors, women's groups and some community networks and the Media.

3. The launch has brought about the institution of an OF surveillance system that tracks identification, repairs and reintegration.

Lessons Learned

1. The annual launch of IEOF creates an enabling environment to implement a wide range of fistula identification strategies / methods simultaneously, on a bigger platform and to a wider audience.
2. The fact that repaired clients are able to share their experiences live to a wider audience reduces stigma about the condition, offers hope for unrepaired clients and motivate unidentified clients to report for assessment and repair.
3. Launch activities improve and strengthen support by policy makers, development partners and other players for the Obstetric Fistula Programme.
4. Launch activities have the tendency to increase the pool of collaborators and advocates for the programme.
5. Launch activities if held at several districts most affected by the condition simultaneously could have a bigger impact.

Replicability and Sustainability

The fistula identification strategies/methods implemented during the launch are easily replicable anytime during the year because the structures required to organize the activities exist in the district. It is sustainable because the activities are owned and organized by the district and national systems.

Collaborators

Ministry of Health, Ghana Health Service, Ministry of Gender, Children and Social Protection, Ministry of Local Government and Rural Development, Regional and District Coordinating Councils, Media and UNFPA.

Free Registration of Clients under the National Health Insurance Scheme (NHIS) Improves Access to Care, Identification and Referral of Obstetric Fistula Clients

Introduction

The NHIS was established by an act of parliament (NHI Act 2003, Act 650) to replace the cash-and- carry system of health financing. Under the scheme all the following were exempted from paying enrolees contributions: SSNIT contributors (who pay through their SSNIT contribution); SSNIT pensioners; Children under 18 years of age; Pregnant women; Elderly, 70 years of age or older; and Indigents (unemployed with no visible source of income, homeless, and have no identifiable support from another person).

Exemption for pregnant women under the scheme (introduced since 2008) includes up to four prenatal visits, coverage for delivery, and one postnatal visit, as well as all other minimum medical benefits needed during the 12 months following initial registration. Obstetric fistula clients did not qualify within the extended postpartum period of 12 months following delivery under the scheme, neither did they qualify as indigents and so had to pay premiums (contributions) to be enrolled under the scheme. These unfortunate circumstances meant that obstetric fistula clients would have to suffer silently or if lucky had treatment when there were outreaches for free repair of fistulae.

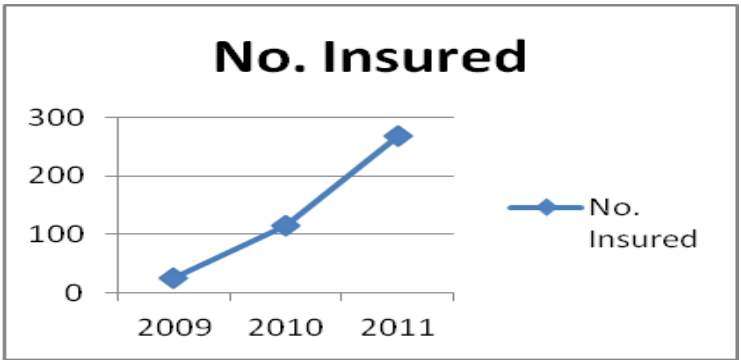
Implementation strategy

During awareness creation and sensitization efforts in the communities and on radios about obstetric fistula, awareness about free registration of clients identified is created. Clients who get registered under the scheme also help to spread the message about free registration in their communities. Once clients are identified, they are supported to register under the scheme by UNFPA, MoGCSP, District Assemblies, Philanthropists, Celebrities, and any other funding sources available. Some few clients, whose family members can afford, register them under the scheme. The registration under the scheme makes it possible for the clients to access treatment from any of the designated repair centres across the country at any time throughout the year instead of waiting for an occasional treatment outreach.

Progress and Results

1. Out of 30 clients repaired in 2009 in Bolgatanga Regional Hospital, 25 were registered free under the NHIS to help them undergo treatment. By 2010, an additional 91 were registered free under the scheme with support from UNFPA, making a total of 116. In 2011, 268 clients were identified (79 treated and 189 assessed) all of whom had been insured. UNFPA had to pay for 32 of the clients who were uninsured then.

Figure 1: Number of fistula clients insured 2009-2011



Source: Gandau 2009-2011 Fistula Annual Reports

2. Free registration of fistula clients under the NHIS helped increase treatment access to many more clients compared to that offered by the occasional treatment outreaches. This helped maximize the limited resources available for treatment.

3. Once registered free under the NHIS and treatment is accessed, these clients, motivate unidentified, unregistered and unrepaired clients in their communities to report for free registration under the scheme and also access treatment (A snowball effect). The evidence is seen with annual increases in numbers of registered clients.

Lessons Learnt

1. Free registration of clients under the NHIS improves access to repair throughout the year compared to the occasional treatment outreaches.

2. Free registration of clients facilitates treatment and motivates unidentified, unregistered clients to come out of hiding to proactively seek help to access treatment.

3. NHIS registration in combination with community sensitization and awareness creation yielded a more than 100% increase in service uptake.

4. Free registration under the scheme is mostly donor-dependent and therefore a more sustainable system like the Livelihood Empowerment Against Poverty (LEAP) programme by government may need to be explored.

Replicability and sustainability

The NHIS is a strategic national social protection intervention that is pro-poor in character and which has replaced the cash-and carry system and is replicated across the country. This has saved UNFPA and other collaborators, resources formerly earmarked for paying treatment, promoted country ownership of obstetric fistula care because the cost of registering clients under the scheme is far lower than the cost incurred during the treatment outreaches. This has yielded a more holistic and sustainable outcome for reducing vulnerability.

Collaborators

Ministry of Health, Ghana Health Service, Ministry of Gender, Children and Social Protection, Ministry of Local Government and Rural Development, Regional and District Coordinating Councils and UNFPA.

Training of Obstetric Fistula Advocates improves Identification and referral of Obstetric Fistula Clients

Introduction

The efforts of women and men's groups, social workers and most importantly repaired clients are very essential in spreading the information to the communities most affected by the condition as well as mobilizing support and resources from the community leadership, District Assemblies and other stakeholders. Indeed, the community, social workers and other identified stakeholders need to be equipped with accurate information and knowledge on the causes, prevention, opportunities for treatment and rehabilitation to galvanise the required support and resources for the elimination of fistula and promotion of maternal health in general and also incorporate rehabilitation/reintegration components of obstetric fistula into district and regional programs. It is on this basis that Ghana Health Service and UNFPA have supported advocacy training of obstetric fistula survivors and other community actors since 2009.

Implementation strategy

Objectives were initially set out as follows: To train repaired /treated clients to act as advocates for prevention, treatment and rehabilitation; to train women and men's support groups in the districts to be competent with the development and dissemination of messages for fistula prevention and Family Planning and to Advocate incorporation of rehabilitation/reintegration components

of obstetric fistula into district, regional and national programmes with community support and involvement.

Participants selected for the initial training in 2009 were 59 and included:

1. Twenty (20) motivated repaired fistula clients with 8 from the Northern region, 6 each from the Upper East and West regions respectively.
2. Social Workers from agencies such as the National Commission for Civic Education (NCCE), Department of Social Welfare, Department of Gender, MoGCSP, Religious and Traditional leaders selected from religious groupings (Local Council of Churches) and the regional house of chiefs respectively from the three Northern regions.
3. Men and women selected from various community support groups. These were selected from Assemblymen/women, community-based Mother/ Father Support Groups and Community-based Health Volunteers.

The training is fully participatory, with discussions centered on Leadership, Reproductive Health and Rights, Causes and Prevention of fistula, Advocacy, Social Mapping and Networking among others. In addition, the repaired clients underwent livelihood training on how to make soap, tie-and-dye, pastries and cosmetics. Basic entrepreneurship training with some seed capital is provided the survivors to help them set up their own businesses.

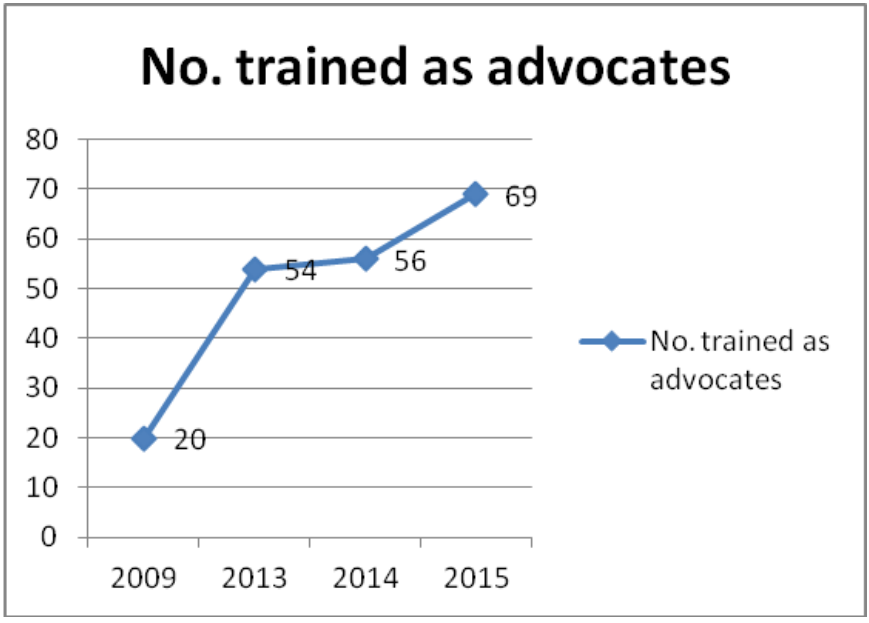
In order to sustain interest in the advocacy activities, a network of participants was created and a brief on how to coordinate activities of the trained advocates, the coordination mechanism,

and specific outcomes with indicators for monitoring and evaluation developed. A governmental agency from each of the regions that participated was selected to coordinate the activities of the regional networks. Beyond 2009, training has been for only repaired clients.

Progress and results

1. From the initial 20 survivors who were trained in 2009, many more have been identified and treated and an increasing number undergone advocacy and livelihood training.

Figure 2: Number of fistula clients trained as advocates- 2009-2015



Source: UNFPA Ghana Standard Obstetric Fistula Reports

2. These empowered survivors assist with community sensitization, awareness creation and identification efforts in churches and mosques, at market places and community durbars, on buses/vehicles and during discussions on Community radio stations. They also undertake house-to-house visitations and active case search for obstetric fistula clients and act as main contact points for identification and referrals. Through these voluntary advocacy efforts stigma for the condition is reduced significantly and each client is able to mobilize an average of 3 to 8 clients per year for repair.

3. Training of advocates from other government agencies has increased the pull of collaborators and improved multi-sectoral collaboration, supported local resource mobilization and strengthened programme sustainability efforts.

For example, the NCCE at the district levels have incorporated obstetric fistula education, sensitization and awareness creation into their routine programmes, whilst the MoGCSP has integrated obstetric fistula into their programming, mobilized funds from the ECOWAS Gender Fund and are engaging the communities actively with the support of community volunteers and Social Welfare to sensitize, create awareness and identify clients for treatment. For example, the MoGCSP has been able to identify 57 clients (28 in 2013 and 29 in 2015) from the three northern regions for treatment in the past two years at the Mercy Women's Hospital in Mankessim.

Lessons learnt

1. Empowering repaired clients and using them as advocates reduces stigma and improves identification and referrals.
2. Using community actors and government institutions as advocates improves multi-sectoral collaboration and sustainability efforts.
3. Livelihood training for repaired clients empowers the women, contributes to poverty reduction, fosters community re-integration and reduces vulnerability.

Replicability and Sustainability

Although the livelihood training has some cost implications, it can be replicated easily because there is adequate expertise across the country to support the training of the survivors. The fact that community actors and government agencies are actively involved as advocates improves ownership of the programme and enhances sustainability.

Collaborators

UNFPA, MOH/GHS, MoGCSP, Social Welfare, Community Volunteers, Empowered Obstetric Fistula Survivors, Chiefs and Opinion leaders.

Sensitization and awareness creation about obstetric fistula on district and community radios and establishment of hotlines improve access to treatment

Introduction

Media pluralism was legislated in Ghana nearly twenty years ago. Since then, several public and private radio stations in the regions, districts, towns and communities have been established across the country. Information dissemination, health education, discussions, dramas and other messages are largely conducted the radio stations.

Sensitization, awareness creation and education on Obstetric Fistula has benefitted tremendously over time.

Implementation strategy

Sensitization and awareness creation through district and community radio stations have been the main method/strategy used in all the regions and the most affected districts. On quarterly basis discussions on obstetric fistula are held on radio stations. Education and awareness creation about obstetric fistula are first provided by the public health nurses or doctors, after which discussions are held with the use of discussion guides developed and led by the host of the programme. Listeners to the programme are allowed to ask questions and seek clarifications. During the programme, community support is solicited to spread information about the condition and telephone hotlines provided to enable clients and their relatives to call for support. Each programme lasts for an hour and is held mostly in the local

languages and in English. Regularly, survivors of the condition are also made to share their experiences during the programme.

Clients who call the hotlines are directed to the nearest CHPS or health centres for subsequent referral to the repair centres for screening and subsequent repair.

Progress and results

1. In Bawku in the Upper East region, a single radio sensitization and discussion were able to help mobilize 18 obstetric fistula clients for screening in 2015. In Zabzugu and Kpandai in the Northern region 34 cases in the last quarter of 2015 and 30 cases in 2014/2015 respectively were identified through this means.

2. The announcement of hotlines during the radio discussions where clients and family members could call for assistance facilitated the identification process. Almost all the clients identified in Zabzugu and Kpandai were through the use of the telephone hotlines.

Lessons learnt

1. Use of mass media, especially the community-based ones are effective in disseminating important information about health issues to target audience and elicits needed response.

2. Use of hotlines reduces stigma and protects the identities of clients who suffer stigma related conditions.

Replicability and sustainability

Radio stations are widespread in almost all districts and communities in the country and therefore discussions and sensitization drives can be replicated easily across the country.

Community ownership and patronage of these radio programmes make them sustainable.

Collaborators

UNFPA, MOH/GHS, Media, community actors, and obstetric fistula advocates.

Integrated community outreach and active case search facilitate patient identification and access to treatment

Introduction

Community outreaches have been used by community health officers and volunteers to provide maternal and child health services to communities that are hard-to-reach. These have been documented severally to be efficient in augmenting facility-based services and increasing coverage of life-saving interventions. Obstetric fistula identification and referral have benefitted from such outreach approaches.

Implementation strategy

Routinely, community health nurses in the various health centres and CHPS zones carry out weekly community outreaches to provide child welfare services such as weighing and immunizations, health promotion and health education, treatment of minor ailments and some maternal health services. Additionally, quarterly community health durbars are held by/and for the communities. During these outreaches and durbars, the community health nurses provide education about the causes and prevention of obstetric fistula and sensitize them about the availability of treatment and stigma reduction. Repaired clients are also made to share their experiences and to motivate and encourage clients who have not sought treatment to do so.

During the training of volunteers and repaired clients as advocates, they are taught the causes and consequences of fistula, how to recognise a woman who may have fistula and how to discuss the

issue sensitively and confidentially with them. Equipped with this knowledge, they go into the communities talking to women and asking them whether they or other women of their acquaintance experience symptoms of fistula (including excessive washing of clothes, urine leakage or smell. Once they identify potential clients, they refer them to the health centres and CHPS zones for further action by the community health nurses.

Progress and results

1. Through these integrated efforts and radio discussions, about 170 cases had been identified and referred from the Upper West region in the past two years, whilst close to 70 had been identified from Kpandai and Zabzugu in the Northern region in the past two years.

2. These efforts easily disseminated information to the very doorstep of the community at minimal cost to the health service because of its integration into normal activities, reduced stigma and strengthened community participation in maternal health.

Lessons learnt

Integration of fistula activities within outreach services is cost-effective, strengthens community participation and reduces stigma.

Replicability and sustainability

Outreaches and durbars are routine activities carried out by community health nurses at all districts and therefore replicating the experience should be easy. Sustainability is guaranteed because

the campaign is integrated into routine activities of the service at minimal cost.

Collaborators

UNFPA, MOH/GHS, MoGCSP, District Assemblies, community actors, and obstetric fistula advocates

Training of Obstetric Fistula Management Teams improve access to Routine Treatment and Facilitates Identification and Referral of Clients

Introduction

Obstetric fistula management has not been fully streamlined into the activities of many gynaecologists in the country due to inadequate expertise in its management. Historically, many clients, especially those living in areas where the condition is most prevalent had relied heavily on outreaches to get treatment. Most of these were carried out at the Baptist centre at Nalerigu in the Northern region of Ghana by a Ghanaian and expatriate surgeons and by expatriate surgeons on the Mercy ship, the MV Anastasis. As the incidence of the condition was increasing, there was the need to train local repair teams to meet the demand for repairs.

Implementation strategy

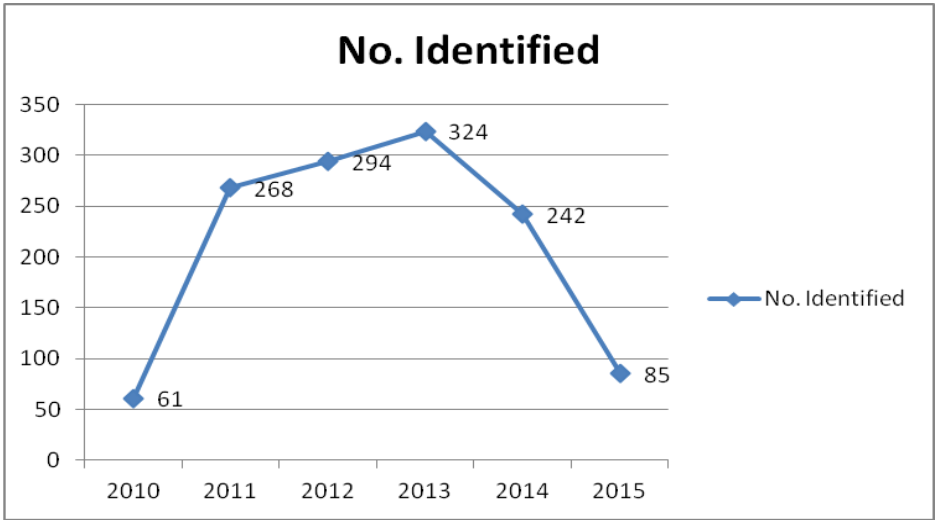
Two gynaecologists (from Korle-Bu and Tamale Teaching Hospitals) and two nurses (from Tamale Teaching Hospital) were sent to Northern Nigeria with support from UNFPA, Ghana Health Service and other partners to train as Obstetric fistula repair and management team from March to April 2006. Upon their return, the team organized treatment outreaches at the Regional hospitals in the Upper East and Upper West regions in 2007, where they trained two gynaecologists, two theatre nurses, four anaesthetists and ward nurses in the repair and management of obstetric fistula. A gynaecologist was also trained at the Korle-Bu Teaching Hospital subsequently. Between 2008 and 2015, three more gynaecologists

and some nurses have been trained to manage the condition in the Northern, Upper east and Upper west regions. By the training of these fistula management teams, especially in the Northern, Upper East and Upper West regions, obstetric fistula management has been streamlined into the activities of the regional health facilities instead of solely relying on outreaches.

Progress and results

1. Following the training of fistula management teams and the setting up of the Tamale fistula centre, the number of cases identified and referred to the centre for screening and management, for example, increased tremendously from 61 cases in 2010 to a peak of 324 in 2013. The numbers as expected, started decreasing to 2015 as more cases got identified and registered.

Figure 3: Number of fistula clients identified and referred to Tamale Fistula Centre-2010-2015



Source: Health Information Unit, Tamale Central Hospital

2. The fact that fistula management teams have been trained at the various regional hospitals make it easier for repairs to be carried out as part of the routine service provision instead of waiting for scheduled outreaches in the past.

3. The expertise at the regional level is strategic because they can also do downstream training for young gynaecologists who will be posted to the various districts to handle very simple cases.

Lessons learnt

Prompt treatment of obstetric fistula cases improves case identification and referrals.

Collaborators

UNFPA, GHS, and the Teaching Hospitals (Korle-Bu and Tamale)

CHALLENGES

1. Poor coordination of obstetric fistula activities in the country leads to gaps in data on cases identified, referred and repaired across the country. For example, data at the regional levels are inconsistent with those at the district and repair centres.

2. Activities of trained obstetric fistula advocates are poorly coordinated and thus affect their morale and enthusiasm to carry out their activities. The few interviewed admitted they worked independently of any existing network of advocates.

3. Contact numbers given by some identified clients and their relatives are unreliable, thus making it difficult to contact them. This has led to high attrition of identified clients in some cases.

4. Poor integration of obstetric fistula activities into the general maternal and child health activities in the country contributes to poor coordination and may affect the sustainability of the obstetric fistula programme.

5. The obstetric fistula activities of the Mercy Women's Hospital lack adequate support financially and programmatically. The Cardinal Turkson Fund for Education and Health is the main support for the programme. Collaboration with NGOs is also non-existent.

6. Obstetric fistula repair teams across the country are inadequate. Not all regional hospitals have repair teams to support repairs of identified clients. The obstetricians in some regional hospitals still refer their clients or rely on occasional outreaches to their hospitals by fistula surgeons.

CONCLUSION

Several good practices have been identified in Ghana which have helped improve identification, referral and treatment of obstetric fistula clients. It is important for all stakeholders in obstetric fistula programming to replicate and upscale these practices to further improve the current situation. Some of the identified practices have the potential to influence policy; therefore policy makers in reproductive health in Ghana should critically review good practices and utilize the information to influence policy change.

RECOMMENDATIONS

1. The Ghana Health Service (Family Health Division) should assume full ownership of the obstetric fistula programme in the country, ensure its full integration into the maternal and child health programme and make sure that all activities related to obstetric fistula are streamlined and coordinated by them.

2. Residency training in obstetric and gynaecology should integrate obstetric fistula assessment and repair actively into the programme by letting residents work at the obstetric fistula repair centres for periods ranging from 1 to 3 months during their training. This will ensure the building of adequate capacity to assess and repair simple fistula cases by the time they complete their training. In this way, the country can use them to build a pool of obstetric fistula repair teams across the country.

3. The Ministry of Gender, Children and Social Protection (MoGCSP) should be empowered to take the lead in coordination of the social reintegration activities, training of obstetric fistula advocates and activities of the advocates.

4. The obstetric fistula programme of the Mercy Women's Centre in Mankessim should be integrated into the national programme so that they can benefit comprehensively from all financial and programmatic support from all partners.

5. With the support of community actors and development partners, community information centres should be set up in

all communities to ensure that clients whose telephone numbers are unreliable obtain all information concerning management timetable for review and repair from the information centres.

6. The possibility of registering fistula clients free under the NHIS for them to access treatment should be explored under the government's pro-poor LEAP programme to ensure long-term sustainability.

7. All the lessons learnt from the good practices need to be utilized to influence policy and enrich the obstetric fistula programme in Ghana.

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APPENDIX 1: List of persons contacted

REGION	PERSON CONTACTED	ORGANISATION
UPPER EAST		
	Md. Agnes Azuri	Ghana Red Cross Society
	Mr. James Twene	MoGCSP
	Dr. Joseph Opare	DDPH
	Dr. Baffor	Bolgatanga Regional Hospital
	Dr. Oppong	District Hospital Bawku
	Md. Rofina Asuru	DDNS, Regional Health Directorate
NORTHERN		
	Md. Abiba Iddi	GHS, Kpandai
	Md. Elizabeth Kopri	GHS, Zabzugu
	Md. Abiba Amadu	Regional Public Health Nurse
	Dr. Mahamadu Mbinwoya	Med. Sup. Tamale Regional Hospital
	Dr Mahama	Director, Regional Health Directorate, GHS
	Dr Gandau	Tamale Teaching Hospital
	Mr. Abdallah	Information Centre, Tamale Regional Hospital
	Ms. Bushira Alhassan	MoGCSP
	Mr. Kwesi Owusu Poku	UNFPA Decentralised Office
	Mr. Jude Domosie	UNFPA Decentralised Office
CENTRAL		
	Dr.Felix Bowuo	Mercy Women's Hospital, Mankessim
	Dr. Danso	District Hospital, Abura Dunkwa

	Dr. Dzodzegbe	Municipal Hospital, Swedru
	Dr Joseph Adu Amoah	UCCSMS, COHAS, University of Cape Coast
	Dr. Yamoah	Formerly of Mercy Women's Hospital
	Dr. T. Quarshie	Director, Regional Health Directorate, GHS
UPPER WEST		
	Md. Sophia Nyireh	Regional Public Health Nurse
	Md. Nusrata Issah	DDNS, Regional Hospital
	Md. Juliana Issaka	MoGCSP
GREATER ACCRA		
	Mrs Gladys Brew	Family Health Division, GHS
	Erika Goldson	Deputy Rep. UNFPA
	Dr. Ismail Ndifuna	Chief Technical Specialist UNFPA
	Dr Robert Mensah	Programme Specialist, UNFPA
	Ms Bridget Asiamah	Programme Analyst, UNFPA
	Doris M. Aglobitse	Program Analyst, UNFPA
WESTERN		
	Dr Tenkorang	Director, Regional Health Directorate, GHS
	Dr. Agyemang	Effia Nkwanta Regional Hospital

NB: Repaired clients from Central, Northern, Upper East and Upper West regions were also contacted. However, for the purposes of confidentiality and anonymity we are unable to provide their contact details.

APPENDIX 2: UNFPA Good Practice Template

Title of good practice :
Location:
Thematic area:
Other:
Executive summary:
Contact person at the organisational unit:
Primary keywords:
Description of Problem/issue and context:
Implementation/Strategy used:
Results:
Conclusions/Recommendations:
Challenges:
Lessons learned:

Sustainability:	
Replicability:	
Cost:	
Partners/Collaborators:	
Supporting documents	
Sources and links	
Independent review of the documentation	