Associazione Giorgio Giaccaglia Stegagnini UROLOGIA PER L'AFRICA

Proposal of collaboration with Sierra Leone

Introduction:

Obstetric fistula is a hole in the birth canal caused by prolonged labour without prompt medical intervention, usually a Caesarean section. The woman is left with chronic incontinence and, in most cases, a stillborn baby.

Fistula has virtually been eliminated in Europe and North America through improved obstetric care; women in sub-Saharan Afica suffer almost twice as much illness from sexual and reproductive health causes than women in the whole world. At least 2 million women in Africa, Asia and the Arab region are living with the condition, with about 50,000 to 100,000 new cases each year. These figures are based only on the number of women who seek treatment.

Reliable incidence and prevalence data on obstetric fistula are lacking, but the United Nations Population Fund (UNFPA) estimates between 2 and 4 million women suffer from obstetric fistula in low-income countries in Africa, south-east Asia and the Middle East, with another 50 000 to 100 000 women and girls developing the condition each year. Mariana Widmer from the department of Reproductive Health and Research at the World Health Organization (WHO), says the social stigma and misunderstanding that it inspires has led to significant under-reporting, making it a largely hidden condition.

In areas with high maternal mortality, fistula may occur at a rate of two to three cases per 1,000 pregnancies. About 15 per cent of all pregnancies results in complications that require emergency medical intervention. Only 58 per cent of women in developing countries deliver with the assistance of a professional (a midwife or doctor) and only 40 per cent give birth in a hospital or health centre. The persistence of fistula signals that health systems are failing to meet the needs of women.

Obstetric fistula occurs most often among impoverished girls and women, especially those living in regions without adequate medical services. Affecting the most powerless members of society, it touches issues related to reproductive health and rights, gender equality, poverty and adolescent reproductive health. In addition, the smell of leaking urine, faeces or both, is constant and humiliating, often driving the loved ones of patients away. If left untreated, fistula can lead to chronic medical problems including ulcerations, kidney disease, and nerve damage in the legs.

It has to be noted that obstetric fistula is preventable and treatable. Prevention is the key to ending fistula. The average cost of fistula treatment—including surgery, post-operative care and rehabilitation support—is $300, which is well beyond the reach of most women with the condition. However, after treatment former fistula patients can have a normal life again.

The Campaign to End Fistula, launched by UNFPA and partners in 2003 is now present in 50 countries across Africa, Asia and the Arab region.

Key strategies to address fistula:

1. Prevention of fistula
2. Surgical repair of fistula
3. Reclaimiming lives after fistula repair

1. Prevention of fistula

The two million or more women who await fistula repair were very nearly part of the grim statistics regarding maternal deaths in the world. They survived the physical and emotional trauma of obstructed labour to become living reminders of health system failures. All too often, however, these women have been hidden away and forgotten.

By working to prevent fistula, the Campaign to End Fistula aims to reduce the ongoing tragedy of maternal death and injury. The experiences of women who narrowly survived traumatic deliveries help us understand what is wrong with health services and impart urgency to the challenge of preventing this tragedy from recurring.

Fistula has received little attention in the past because it affects mainly the poorest and most powerless members of society. And because it is a 'woman's problem.' When fistula is eliminated in Africa and Asia, we will know that real progress has been made in promoting human rights and creating a safer and more equitable world.

The key to ending fistula is to prevent it from happening in the first place. Skilled attendance at birth, including swift surgical intervention if obstructed labour occurs, can prevent a fistula.

Prolonged obstructed labour puts a woman at risk for fistula and other serious injuries, including death. Unless she receives prompt medical treatment - usually a Caesarean section - the lack of blood flow can cause soft tissues to die, leaving a fistula, or hole, in her bladder or bowel [see diagram]. Fistula has all but disappeared in countries where women experiencing complicated deliveries have access to timely emergency obstetric care.

The longer obstructed labour continues, the more likely it is to cause fistula or death. Delays - in the decision to seek medical attention, in reaching a health care facility, or in receiving emergency obstetric care at the facility - jeopardize both mothers and infants. A skilled attendant with obstetric training can help to recognize danger signs and treat certain complications. But women with obstructed labour need to get to an operating theatre quickly - so back up referral and transport to an appropriate facility also need to be organized ahead of time.

Longstanding customs may also limit a woman's access to obstetric care. In some cultures, women are expected to give birth at home, sometimes with no help, or with the help of traditional midwives. Husbands, male relatives or mothers-in-law may be the ones to decide what care a woman receives, and cost may play a large part in the decision.

In rural areas where fistula is most common, hospitals are spread out over vast distances and transportation systems are often rudimentary. Women often rely on traditional midwives, who

may fail to recognize danger signs in time and in any case do not have the medical skills or equipment to provide life-saving interventions in emergencies.

Some women in the throes of labour travel for many hours - or even days - by bus, donkey cart or on foot to reach a hospital or medical centre that can help them. Often by the time they get there, it is too late. Health care providers in Ethiopia estimate that it takes women 2.5 days on average to reach an operating room. By that time, the foetus will most likely have died and the woman will have undergone significant physical trauma.

Delaying early pregnancies, spacing births and limiting total pregnancies are all ways to significantly reduce fistula as well as other maternal and infant injuries and deaths.

Teenage pregnancies are risky, and the younger the girl, the higher the risk. Girls under 15 are five times more likely to die in childbirth than women in their twenties. Many of those who survive obstructed labourhave a stillborn baby and tragically end up with fistula. Thus, delaying a girl's first pregnancy is a critical strategy for reducing fistula and maternal deaths.

The dangers associated with early pregnancy are the reason the Campaign also advocates for alternatives to child marriage. Young married girls are often pressured to get pregnant soon after marriage and may face a variety of barriers to accessing voluntary family planning services. In spite of laws against early marriage, 82 million girls in developing countries will be married before they turn 18. About half of all teenage girls will have their first child by the time they turn 18.

Too many pregnancies, or closely spaced births, are also detrimental to women's reproductive health and can result in complicated pregnancies, fistula, other injuries or death. Meeting the existing demand for family planning services would reduce maternal deaths and injuries by at least 20 per cent. However, in many of the countries where fistula is common, use of contraceptives is very low.

Poor reproductive health and poverty are part of a vicious cycle. Poverty makes it difficult for women to protect their reproductive health, and poor health drags them deeper into poverty.

Extreme poverty prevails in many of the countries where fistula is most common, and undermines entire health systems. The HIV/AIDS epidemic has made matters worse. As a result, health centres and hospitals are often short-staffed, poorly equipped and unable to provide an adequate level of care. This poor quality of care is a reason some pregnant women avoid seeking medical attention: they associate hospitals with illness and death.

Early marriage is linked with poverty. In poor households, girls may be considered an economic liability and married off at a very young age, often without their consent. But early marriage tends to perpetuate the cycle of poverty. Conversely, girls who are educated are more likely to marry and start childbearing later and have smaller and healthier families.

Eradicating poverty, as called for by the Millennium Development Goals, is an overarching aim of many international organizations. UNFPA and its partners in the Campaign to End Fistula focus on

tackling poverty primarily through interventions to improve women's reproductive health and rights. Reproductive health interventions also have far-reaching and inter-generational effects in terms of reducing poverty, and have been shown to be cost-effective entry points to ending the cycle of poverty.

2. **Fistula can be surgically repaired**

Fistula cases require specialized surgery. Costs vary, but are usually well beyond the means of most women with fistula.

Fistula surgery is essentially the mending of a hole in the bladder or rectum. It can usually take place through the vagina without a major incision. Success rates can be as high as 90 per cent for experienced surgeons working in well-equipped facilities. **But the operation is delicate, and specially trained surgeons and support staff are required.** Two or more weeks of post-operative care is also essential.

Some women are so debilitated when they arrive for treatment that they need weeks or months of care before they are strong enough to undergo the operation. Sometimes women have also suffered nerve damage and need extensive physical therapy. Counselling to address emotional trauma and social support is often necessary for complete healing.

Many women with fistula also have suffered nerve damage to the legs and require extended physical therapy. In some cases, injury to the internal organs is so extensive that more than one surgery is required. Some women are so badly damaged that they cannot be cured, but need continual care. New surgical techniques are being pioneered to improve results and address more severe tissue damage.

Many of those who live with the condition do not know that treatment is available. Once they find out, many girls and women show remarkable determination in mobilizing scarce resources to get help. Sadly, this often means borrowing or selling land or precious assets.

The Campaign supports all aspects of expanding treatment, from training doctors and nurses to equipping and upgrading fistula centres or wards. The Campaign is also mobilizing funding to provide free or subsidized fistula repairs. And it has encouraged more networking among providers, which has led to the sharing of new treatment techniques and protocols.

Training more practitioners is essential!

Skilled and dedicated doctors and nurses, with the support they need to be effective, are central to the challenge of treating women with fistula. But doctors and nurses with the skills and experience to treat fistula are in short supply, partly because the work is poorly paid and emotionally challenging. Some doctors who do have the requisite skills to treat fistula are overwhelmed by the demand -- or are less effective than they could be -- due to a lack of operating rooms, essential drugs, supplies or hospital beds.

Special training for doctors is critical, both to increase their numbers and improve their skills. An unsuccessful repair, after a woman has invested all her savings, hope and dreams in its outcome, can be devastating for both the woman and the surgeon. Because post-operative care is critical, specialized training for nurses is also extremely important for successful outcomes. In some fistula centres, former patients provide sensitive and compassionate nursing care.

In some countries, the shortage of skilled local surgeons has created a reliance on teams of visiting doctors. Treatment centres report they are reluctant to advertise these visits - when the word gets out, sometimes so many women show up for treatment that many have to be turned away. One of the lessons learned in the Campaign is that publicity is good, but needs to be complemented by appropriate services so as not to raise false hopes.

Successful fistula repair depends on teams of skilled practitioners to support one another and deliver a continuum of care. In many countries, general and obstetric hospitals try to create specialized services to treat obstetric fistula. However the lack of trained doctors, facilities and supplies limit the ability of most fistula treatment centers.

Although all options should be considered, creating centers exclusively for obstetric fistula treatment can be costly and difficult to maintain over time. In addition, general hospitals supporting fistula surgery can help reduce the stigmatization of women living with the condition, treating them like other patients. It seems that a good solution is that women living with fistula are taken care of in hospitals or maternity clinics with an adequate treatment framework and bed-space exclusively for them, ensuring that they have access to the operating rooms in an equitable manner.

Dedicated centres also help raise awareness and understanding about fistula. The very presence of a fistula centre helps bring the condition to wider attention. Doctors and staff at the centres develop a deep understanding of fistula, and often become powerful advocates for its prevention and treatment.

For women who live in remote rural areas, limited transportation options make it difficult to get emergency care when complications of labour arise. Expensive and arduous journeys are also barriers to women getting repaired.

In areas where fistula is prevalent, roads and transportation are often rudimentary, and hospitals and health centres are spread over wide distances. In areas of steep terrain, small donkeys or carts may be the only transportation options, and distance is measured out in hours or days rather than miles or kilometres. From some rural villages, it can take up to five days for a woman to get to a hospital that can perform an emergency Caesarean section, and by then it is often too late to save the baby or prevent a fistula. All too often, the mother dies as well.

When women with fistula hear about the possibility of a cure, they often make heroic efforts to get help. Some women travel for weeks or months, often across forbidding terrain, by foot, donkey cart or bus in search of treatment. Taxis or buses sometimes refuse to let them ride. Often they have to sell precious livestock, their only capital, or borrow money to make the trip. Some of these 'fistula pilgrims' exhaust their resources getting to treatment centres and rely on

contributions to make their way home.

Transportation strategies are recognized as being crucial to ending fistula, both in terms of getting women to obstetric care to prevent fistula from occurring and in getting them treated once they have the condition. In several countries, UNFPA has supported the purchase of ambulances or 4-wheel drive vehicles, as well as two-way radios to reduce the time it takes for women in labour to reach emergency obstetric care. UNFPA also promotes incentives to get more doctors and midwives working in rural areas.

3. Reclaiming lives after treatment

Without treatment, fistula often leads to social, physical, emotional and economic decline. Although some women with fistula display amazing courage and resilience, many others succumb to illness and despair.

The misery of fistula is relentless. In spite of one's best efforts to stay clean, the smell of leaking urine or faeces is hard to eliminate and difficult to ignore. The dampness causes rashes and infections. The cleaning up is constant, and pain or discomfort may be a continuous as well. The grief of losing a child and becoming disabled exacerbates the pain. The courage many women show in the face of these challenges is extraordinary.

The injury leaves women with few opportunities to earn a living, and many have to rely on others to survive, or turn to begging or commercial sex. In some communities they are not allowed to have anything to do with food preparation and may be excluded from prayer or other religious observances. Although many women with fistula have supportive families, the smell can drive even loving husbands and friends away. For many women, the profound social isolation is worse than the physical torment.

The pain and loneliness associated with fistula is often compounded by a sense of shame and humiliation. In some communities, the condition is seen as a punishment or a curse for an assumed wrongdoing, rather than as a medical condition. The stigma associated with the condition keeps many women hidden away. Some go into deep physical and emotional decline and may resort to suicide. And because so many women with fistula remain marginalized and out of sight, many policy makers - and even some health providers - have failed to recognize the scope and severity of the tragedy.

Discussing fistula openly can help reduce the stigma associated with it. And learning that the condition is treatable can transform the lives of those who had lost hope.

In many places, fistula is so misunderstood that there is not even a word that precisely describes the condition: it is referred to as simply the 'urine problem' or 'the childbirth injury'. Women with fistula have been called 'destroyed women' or 'she who is no longer a woman'. Correcting myths about fistula, and providing accurate information about its causes and cure, can help prevent it from occurring, encourage compassion for those who endure it and lessen the stigma that is often attached to it.

Many of the girls and women with fistula are isolated, with little news of the outside world. Those who do not find out that a cure is possible may become resigned, demoralized or deeply depressed. The knowledge that fistula can be cured can transform the lives of those on the verge of giving up.

Word of fistula treatment often spreads rapidly even in remote areas. By talking about her experiences, a woman who has been treated for fistula can motivate others to seek care as well. Some treatment centres are reluctant to advertise fistula repair beyond word of mouth because they fear having to send patients away without treatment.

Surgical repair of their medical condition offers women with fistula the chance to return to a full life. In some cases, however, the disability has eroded their social and economic status, or worn away their self-esteem. Some fistula centres are able to provide basic education, training in income generating skills, and psychosocial support to help clients reintegrate into their communities.

Health education and counselling are key components of post-operative care. Women are advised on when it is safe to resume sexual activity and get pregnant. They are provided with or referred to family planning services. In areas with high HIV prevalence, prevention counselling is also encouraged. Following surgery, women are sometimes provided with a booklet or card describing their medical history and the need for a Caesarean section in the event of another pregnancy. Support for social reintegration is a component of several initiatives supported by UNFPA and its partners.

Once they have been surgically repaired, many women can go on to enjoy rich lives and bear healthy children.

Some women who have gone through the suffering of fistula and the loss of a child never want to experience labour again. However, in many cultures, motherhood and childbearing are central to women's identity and social status, and many of the young women who are treated for fistula still have long lives ahead of them. Often, they desperately want to marry – or return to their husbands – and bear children. In most cases they can, so long as the pregnancy is closely monitored to prevent the possibility of complications. Usually a Caesarean section is recommended.

Post-operative medical counselling is critical. Women are advised on when it is safe to resume sexual activity and get pregnant. They are provided with or referred to family planning services. For women who do not want to go through another pregnancy, contraceptives should be made available. In areas with high HIV prevalence, counselling on prevention is encouraged. Information on how to avoid infection and condoms should be offered. After surgery, women might also receive a booklet or card explaining their medical history and the necessity of Caesarean sections for future pregnancies.

Situation in Sierra Leone

From 1991 – 2002 civil war in Sierra Leone has resulted in tens of thousands of deaths and the displacement of 2 million of its inhabitants. Although the nation is currently at peace, the people of Sierra Leone are still struggling against these issues, they still have many other difficulties to confront and recover from.

Sierra Leone is among the most dangerous places in the world to bear children, with one of the highest rates of maternal mortality. In Sierra Leone, 1 woman out of 8 in their lifetime, dies during childbirth. Through out Africa it is estimated that 2-3 million women suffer from obstetric fistula, a condition often resulting from labor complications.

In 2010 the Sierra Leonean government announced that antenatal, postnatal, and delivery care would all be free of charge, so the current challenge is to meet the demand for services without sacrificing quality. Rural women often struggle to access health services, for example lacking the means for transportation to health clinics when emergency care is needed.

Most villages in Sierra Leone don't have medical facilities to assist pregnant women. The nearest hospital is generally several hours drive away. Many cannot afford to pay the cost of public transportation. Some pregnant women walk many miles to reach the closest health facility, often putting at risk their health as well as the health of their baby. For women experiencing obstructed labor, the lack of medical care often results in the loss of the child and, in severe cases, of the mother.

The Government of Sierra Leone through the Ministry of Health and Sanitation and its health development partners have recently developed a five (5) years strategic plan aimed at ending Fistula in Sierra Leone.

This was revealed by the Acting Deputy Chief Medical Officer in the Ministry of Health and Sanitation, Dr. Sarian Kamara who doubles as Manager of the Reproductive Health Care Unit in the ministry on Monday 20th May 2013, at a news conference held in the Ministry's Conference Room in Freetown. The conference was part of activities marking the commemoration of the International Day to End Fistula, which is slated for 23rd May each year.

Dr. Kamara said the launching ceremony is in line with government's commitment to address the issue of Fistula as a national concern under the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) initiative and to take a multi-sectoral approach to the prevention and treatment of Obstetric Fistula.

She further disclosed that in Sierra Leone, Obstetric Fistula constitutes the most serious maternal morbidity that occurs among mothers surviving obstetric emergencies and that survivors are generally poor and have limited access to skilled health workers or birth attendants. Fistula repair in Sierra Leone, Dr. Kamara said, have been ongoing and that from 2002 to April 2013 a total of 3,425 fistula surgeries have been done by the Aberdeen Women Center and the West Africa Fistula Center in Bo.

Majority of the Fistula cases, she noted, comes from the North around Kabala and more prevalence rates are also found in Kono and Kenema. She said the official launching will also be done alongside the launch of the five years strategic plan developed to end Obstetric Fistula in Sierra Leone.

To help victims of fistula in Sierra Leone, USAID partnered with Engenderhealth and started the Aberdeen Women's Centre in Freetown, which provides the only comprehensive fistula repair service in Sierra Leone and has the capacity to treat up to 600 fistula patients per year. The $700,000 activity provides surgical services designed to reverse the effects of fistula. Since 2008, the activity has provided surgical interventions for more than 1,000 women. In addition, the program trains surgeons and nurses in caring for women with childbirth injuries. The activity also addresses the cause of fistula by working with local health providers, communities, and NGOs to counter the cultural practice of child marriage, which often leads to early pregnancies and fistula.

The main focus of the activity, however, is on the holistic care for the women. During the recovery time following corrective surgery, women receive instruction in simple literacy and arithmetic and enjoy spending time with each other doing arts and crafts. For many, this is the first time they have come into contact with women who share their own experience and sense of isolation.

More than 100 babies are safely delivered each month and the Centre has an approved training programme for local midwives which will contribute to the development of long-term, sustainable maternity care in the country. In addition, the Aberdeen Women's Centre runs a children's clinic which treats more than 12,000 children each year, providing a primary care facility for children in the surrounding community aged 12 and under, including immunisations and health education.

In October 2011, the Centre launched its own free HOTLINE which has proved extremely successful in identifying women from across Sierra Leone who are suffering from fistula. This is a partnership with telecommunications company Airtel and is the first of its kind in the country.

Fistula Care supports the AWC to raise awareness about fistula in local communities throughout the country, explaining how to prevent the injury and referring women for treatment. Women who have had a fistula repair are offered family planning counseling, physiotherapy, and the opportunity to participate in basic life skills programs to ease their reintegration back into society and improve their chances for better economic livelihoods. In Sierra Leone, Dr. Alyona Lewis, who performs fistula repair at AWC, is the only doctor in the country to do so routinely. Prevention is therefore a critical step to stemming this tide.

Increasing access to emergency obstetric care is a vital missing step to improving maternal health and preventing fistula. By current global estimates, the number of new fistula cases far outpaces the existing capacity for repairs.

While new clinical management guidelines promise better treatment outcomes for women with obstetric fistula, more needs to be done to prevent this debilitating condition in the first place.

Steve Arrowsmith, a surgeon who has worked on fistula internationally for the past 25 years and currently trains surgeons in fistula surgery on board the Africa Mercy, a ship providing medical care in western African ports, says it is difficult to find surgeons who have both a high level of surgical expertise, but also the drive to practise in resource-poor countries. This can result, he

says, in failed repairs. “Despite everyone's hopes to the contrary, fistula repair is difficult surgery that spans the boundaries between surgical disciplines – urology, plastic surgery, colorectal surgery and gynaecology,” he says, noting that more and more women are coming forward with post-operative issues, suggesting that fistula repair is being attempted by unqualified doctors.

The Campaign to End Fistula is trying to get governments more involved in efforts to eradicate obstetric fistula, notably by encouraging them and, in particular, health ministries, to ensure that a national strategy is in place for obstetric fistula as part of the Sexual Reproductive Health National Plan, Slinger says. “Another key element is to ensure that a minister of health-led national task force for fistula exists, involving partner organizations working on all aspects of fistula in each affected country,” she adds. Thus far, results have been mixed. While good progress has been made in some countries such as Liberia, many governments have been slow to respond.

For Arrowsmith, tackling obstetric fistula requires the political will and the resources to right the glaring inequity between those who have access to good obstetric care and those who do not. “We need politicians to address the problems of use of resources on national scales, and to face the reality that obstetric fistula is an issue of basic human rights,” he says.

Association Giorgio Giaccaglia Stegagnini: our project in Sierra Leone

The Italian no-profit association named Giorgio Giaccaglia Stegagnini, Urologia per l’ Africa was founded in April 2012, following Dr. Giorgio Giaccaglia Stegagnini’s will after his death, happened in April 2011.

Dr. Giorgio (Italian senior anaestesiologist and surgeon) spenta t least 10 years of his life in Africa, working in hospitals in different countries, providing his contrbution especially for the poorest of the poor. During his long African experience, he worked hand in hand with local doctoris and nurses and trained them in many different fields. He realized that there is an enourmous need to improve the local technical skills for the appropriate management of urological problems. Therefore he decided to dedicate a special effort in offering a service and training the local staff in this field, which represented his major interest.

Association founded in his name has the main objective to continue his effort of improving the clinical management of urological diseases in Africa. The Association, directed by President Dr. Paola Bacchetti, coagulates voluntary members with technical skills in Urology discipline (medical doctors, nurses, and other HCWs) with/without previous working experience of Africa and voluntary members who can contribute to Association’s activities with sensitization, advocacy, fund raising and enthusiasm.

In this framework, considering the high demand of skills and facilities Urology field in Sierra Leone combined with the Ministry of Health plan to tackle the fistula, the Association Giorgio Giaccaglia Stegagnini decided to offer its contribution to Ministry of Health of Sierra Leone.

Overall objective of the association

1. Contribute to improvement of the management of urological problems in African Countries

Objectives specific for Sierra Leone

1. Expansion of the access to urological surgey to repair fistula and other urological conditions in Sierra Leone
2. Strenghtening of local staff's skills in surgical competencies and clinical management of fistula and other urological problems
3. Contribute to prevent fistula onset with appropriate management of delivery and obstetric complications

Specific activities

The Association "Giorgio Giaccaglia Stegagnini - Urologia per l'Africa" developed a plan of specific activities in collaboration with the Association Amici della Sierra Leone, located in Parma, which has been actively working for long time in the country, in particular in Makeni and Lunsar Hospital.

	Activity	Who	Timeline
1	Preliminary visit to Sierra Leone, meeting with local authorities and partners at central level, first assessment of the needs in Makeni and Lunsar Hospital	Association Giorgio Giaccaglia Stegagnini President and vice-president	Sep-Oct 2013 (dates to be confirmed)
2	Procurement of material needed (surgical instruments/equipment/etc)	Association Giorgio Giaccaglia Stegagnini	Sep 2013- Mar 2014
3	Involvement of specialists in Urology discipline available to offer their service in Sierra Leone during 2014 and composition of small teams, coordinated by Association President and Vice-President	Association Giorgio Giaccaglia Stegagnini	Sep 2013- Mar 2014
4	4 missions to Sierra Leone in small teams (medical doctors, nurses, other voluntaries): urology OPD activities surgical activities training of local staff meeting with local authorities and partners	Association Giorgio Giaccaglia Stegagnini and other voluntaries	Jan-Dec 2014
5	1 year project evaluation: meeting with local authorithies and partners	Association Giorgio Giaccaglia Stegagnini Board	Sep-Dec 2014

Activities will be carried out in Makeni and Lunsar Hospitals, run by ……., starting from September-October 2013 afterwards. The proposed activities cover the period September 2013-

December 2014. After the first year and a comprehensive project evaluation, activities for the second year will be proposed, based on project results.

The entire cost of missions to Sierra Leone as well as needed material and equipment will be covered by Association Giorgio Giaccaglia Stegagnini. No cost will be charged to Association Amici della Sierra Leone and local partners.

Estimated budget:

Activity	**Description**	**Unit cost**	**Budget**
1	Preliminary visit to Sierra Leone, meeting with local authorities and partners at central level, first assessment of the needs in Makeni and Lunsar Hospital	2 persons x 14 days (flight: 800 Euro + accomodation/meals: 150 Euro/week/person)	2,400 Euro
2	Procurement of material needed (surgical instruments/equipment/etc) + shipment (if needed)	As needed	10,000 Euro
3	Organization of small teams available to travel to Sierra Leone during 2014 for 3 weeks		0 Euro
4	4 missions to Sierra Leone in small teams in 2014	4 persons/team x 21 days x 4 teams (flight: 800 Euro + accomodation/meals: 150 Euro/week/person)	20,000 Euro
5	1 year project evaluation by Association Board	4 persons x 14 days (flight: 800 Euro + accomodation/meals: 150 Euro/week/person)	4,400 Euro
Total			**36,800 Euro**