

annual report *2008*



CAMPAIGN TO END FISTULA

THE YEAR IN REVIEW





G.M.B. Akash, Panos Pictures / UNFPA
16-year-old Banu waiting for her pre-operation
medical evaluation in the operating theatre of a
Dhaka Hospital in Bangladesh.

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Contributors: Zeynep Basarankut, Luc de Bernis, Christian Delsol, Mary Finalborgo, Katie Gifford, Katja Iversen, Yahya Kane, Anne Pettigrew-Nunes, Kate Ramsey, Magali Romedenne, and Christina Vrachnos.

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Cover: Fistula patient Zana Abubakar, age 22, waits for surgery at Babban Ruga VVF Hospital in Nigeria. She suffered with fistula for eight years.



Svenn Torfinn, Panos Pictures / UNFPA
Machakos Hospital, Kenya: Patients await
treatment for obstetric fistula.

OBSTETRIC FISTULA: A YEAR IN REVIEW

Obstetric fistula is a debilitating condition that has left—and continues to leave—hundreds of thousands of women suffering in solitude and shame. Fistula is the result of prolonged and obstructed labour. It renders survivors incontinent and frequently isolated from family and community. All but eliminated from the industrialized world, fistula continues to destroy the lives of some of the most marginalized women and girls living in some of the poorest regions in the world.

Obstetric fistula is a visible reminder of maternal health inequity. The highest rates of maternal death and disability are concentrated in the least developed countries—with obstetric fistula as perhaps one of the most tragic examples of unequal access to quality obstetric care.

Fistula survivors are women and girls who have lived to tell their story. Old and young, they offer a unique perspective and can be powerful advocates for maternal health. Their living testimony can raise awareness and attract resources. Their courage can inspire other survivors while their willingness to share their suffering can contribute to a more just and equitable world.

In 2003, the Campaign to End Fistula began work in 12 countries, with the aim of eliminating fistula by 2015 in line with the Millennium Development Goals (MDGs). Within five years, the Campaign has quadrupled in size and is now operating in more than 45 countries in Africa, Asia and the Arab States. With the support of UNFPA, governments and partners, increasing numbers of women and girls are accessing the care necessary to prevent and treat fistula—and to return to full and productive lives.

Since the Campaign's inception in 2003, UNFPA has secured almost US\$30 million in contributions to support countries. To date:

Figure 1

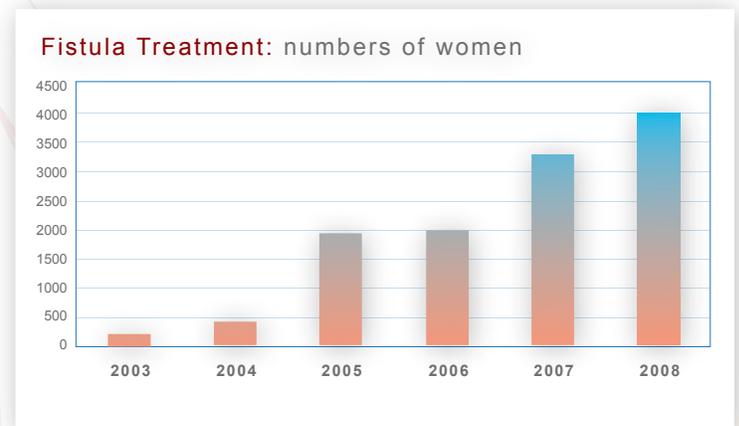
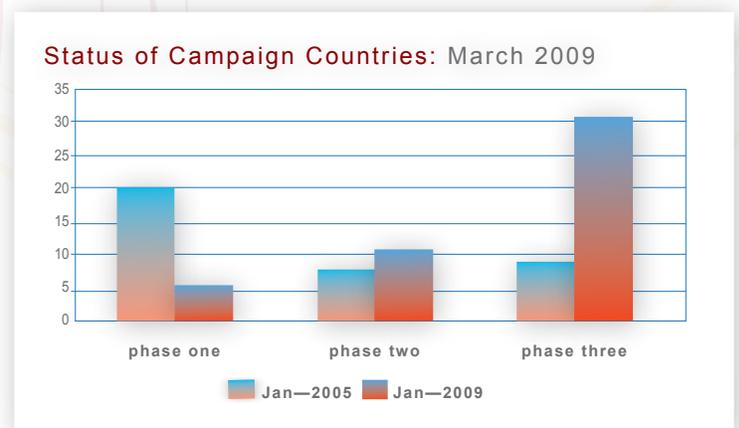


Figure 2



- At least 38 countries have completed a situation analysis concerning fistula prevention and treatment
- More than 25 countries have integrated fistula into relevant national policies and plans
- More than 12,000 women have received fistula treatment and care with support from UNFPA.¹

At the very beginning of the Campaign, many countries conducted needs assessments and then began the national planning process. As the Campaign has matured, the majority (approximately 66 per cent) are implementing

¹ Treatment services supported by UNFPA may have also received support from governments and other partners.



Chris De Bode, Panos Pictures / UNFPA

Katsina State, Nigeria: The instrument table at the fistula operating theatre at Babban Ruga VVF Hospital.

programmes and actively working to prevent and treat obstetric fistula. These countries are also assisting women to reintegrate into their communities following treatment. This shift not only illustrates the momentum and demand gathering at country level, but also highlights the fact that more resources will be required to support countries to achieve full programme implementation.

In 2008 UNFPA:

- Supported 4,000 women to receive fistula treatment;
- Supported 109 health facilities in 21 countries to strengthen capacity to manage and treat fistula;
- Trained more than 2,000 healthcare personnel in fistula prevention and management—including over 220 doctors, 530 nurses and midwives, more than 400 social workers and paramedical staff, and more than 850 community health workers.

That same year:

- United Nations Secretary-General, Ban Ki-Moon presented the first-ever report to Member States that examined the causes, consequences and key recommendations required in order to end fistula and to achieve MDG5.² Issued in response to a General Assembly request, the Secretary-General's report was presented in October.

- The United Nations Development Programme (UNDP) granted an award of excellence to the Campaign to End Fistula for its work championing South-South cooperation. The award committee also commended the Campaign for its innovative approach.
- Thirteen Campaign countries supported fistula survivors to advocate for improved maternal health at both the community and national levels, sensitize communities and provide peer support.
- The Campaign focused on fistula in conflict and post-conflict situations by highlighting the unique vulnerabilities of women in these complex contexts. Expanded programmes in countries such as **Afghanistan**, the **Democratic Republic of Congo (DRC)**, **Liberia**, **Somalia** and **Sudan** are shedding light on the occurrence of fistula and how best to assist survivors living in conflict and post-conflict situations.

² Millennium Development Goal 5 (MDG5) addresses maternal health and includes two targets: 1) Reduce by three quarters the maternal mortality ratio; 2) Achieve universal access to reproductive health.

FROM TRAUMA TO TRIUMPH: ONE WOMAN'S STORY

Like most of the young girls who grew up in her mountainous, rural village in Baluchistan, Gul Bano was married at the age of 12.

Much to the delight of her family, she became pregnant almost immediately. Because she appeared so healthy and strong, her in-laws anticipated no difficulties when the 13-year-old finally went into labour. After three days of agony Gul gave birth. The baby, however, was dead.

Eight days later, Gul realized she was passing urine and faeces uncontrollably from her vagina. Neither she nor her family nor the traditional birth attendant understood that the pressure from the baby's head had damaged so much tissue that the girl had developed multiple fistulae—from her rectum and bladder into her vagina.

The leakage left her constantly wet and smelling bad. The young girl stopped venturing out of her mud house because no one in the village would approach her or, worse, fled at the sight of her.

Despite the support of her husband, she saw no future and contemplated suicide. Still barely an adolescent, Gul felt her life was over.

Worldwide, at least two million women live as Gul once did—sequestered by the shame and stigma of obstetric fistula. An estimated 50,000 to 100,000 new cases occur each year,^{2,3} testimony to the failure of health systems to respond to the most basic reproductive needs of the world's poorest women. Most survivors are unaware that surgery can usually treat the damage.

Long consigned to the medical history books in most industrialized countries, fistula continues to rob millions of women and girls of their families, communities, livelihoods and dignity. It is perhaps one of the most telling examples of inequitable access to health care and, until recently, one of the most hidden.

What is Obstetric Fistula?

Obstetric fistula is a severe morbidity caused by prolonged obstructed labour unrelieved by timely medical intervention. It exposes the challenges that persist in reducing maternal mortality and morbidity. With timely access to skilled assisted delivery and emergency obstetric care, these injuries could have been avoided. Unfortunately, the condition affects more than 2 million women and girls in developing countries, with as many as 100,000 new cases each year.

A year of consolidation and progress

2008 was a year when the hard work of laying programme foundations—formulating, developing, establishing strategic plans, strengthening and developing capacity and programmes—began to pay off. It was also the fifth anniversary of the Campaign. As of this printing, the majority of Campaign countries are now treating and rehabilitating fistula survivors, while, at the same time, working to ensure that fistula will become a thing of the past.

The Campaign has garnered awards and won accolades as an example of innovative programming. The courage of girls such as Gul continues to inspire policymakers, celebrities, politicians and health-care personnel.

Despite this unprecedented show of support and good will, the Campaign is facing challenges. The financial crisis is taking its toll. Development aid has become ever scarcer even as need continues to outstrip the capacity of countries to counter the effect of the economic downturn and serve the millions of women whose lives still remain on hold.

No longer an infant, the Campaign is on the threshold of childhood. Like most children, it is confronting its fair share of growing pains. Chief among these is the need

²Wall, L. 2006. "Obstetric Vesicovaginal fistula as an international public-health problem." *The Lancet* 368 (9542): 1201-1209.
³Abou Zahr, C. (2003). "Global Burden of Maternal Death and Disability," *British Medical Bulletin* 67 (1).

to maintain a steady funding flow in order to support sustainable prevention and treatment programmes.

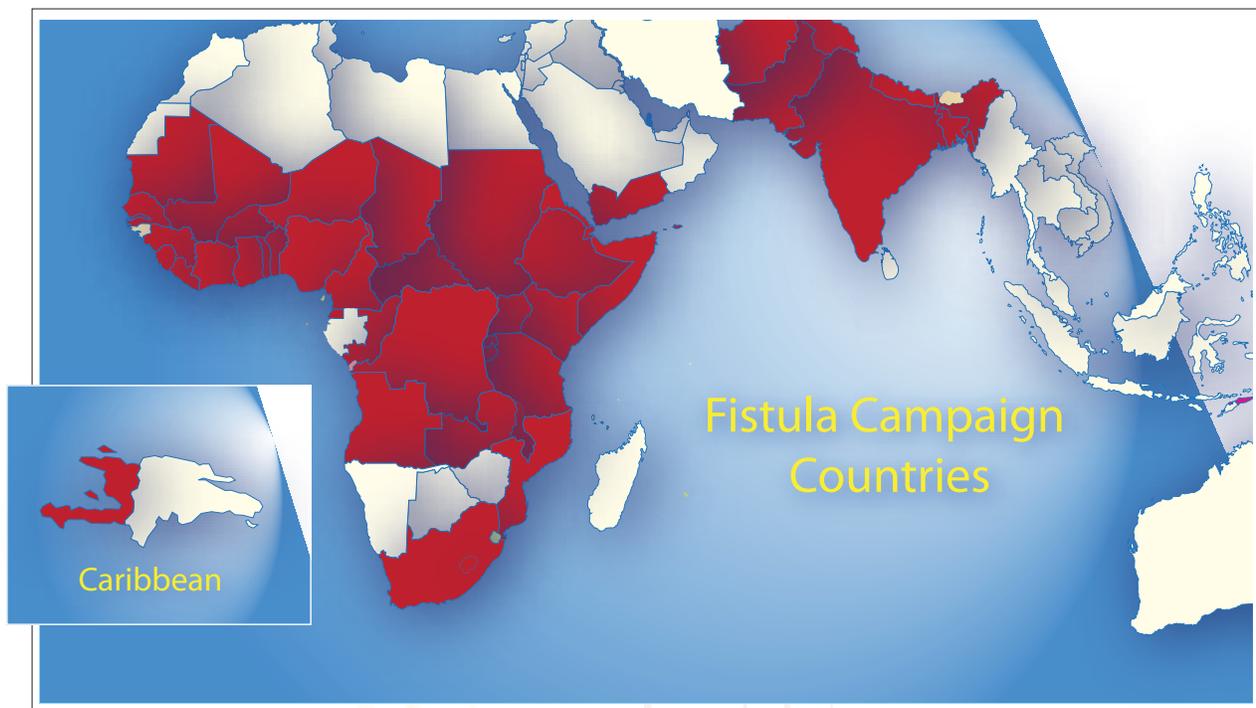
While challenges are many, so too are the women who have benefited. For Gul, the Campaign has not helped restore her health, but has also brought a renewed sense of purpose. Two long years following the birth of her stillborn child, Gul arrived at the Regional Treatment Centre at the Koochi Goth Women's Hospital in Karachi. Seven months later she released with fistulae treated and dignity intact.

Since then, her community has welcomed her back into the fold. Today, Gul is a good-will ambassador and works with other women suffering under the terrible burden of obstetric fistula. She has personally escorted several to the Karachi hospital where she herself was treated and has offered hundreds more the courage and determination to heal.

Her life, she says, has meaning once more.



Pakistan: Fistula survivor Gul Bano smiles for the camera following treatment for obstetric fistula. Ms. Bano is now working as an advocate for other women and has personally escorted them to the same clinic where she was treated.



2008 WHERE WE ARE

The Campaign to End Fistula works with some of the most marginalized women living in some of the poorest countries in the world. The economic, social and health indicators for these countries illustrate to what extent extreme poverty, gender inequity and poor health affects the reproductive health of women and girls.

Most women receiving services come from rural communities with low literacy and high rates of maternal and child mortality. In recognition of both the direct and underlying root causes of obstetric fistula, the Campaign approach focuses on three strategies: prevention, treatment and reintegration.

To this end, the Campaign works to address the comprehensive needs of women living with fistula and is fully aligned and imbedded in the UNFPA mandate and commitment to serve the most vulnerable. Indeed, because obstetric fistula constitutes one of the most serious and tragic forms of maternal morbidity, addressing it offers an opportunity to improve maternal health overall.

What is required to prevent fistula is the same as what is needed to prevent maternal death and other related disabilities: family planning, skilled attendance at birth and access to emergency obstetric care when needed. Moreover, access to fistula prevention,

treatment and rehabilitation services also opens the door to broader access to sexual and reproductive health services and information.

The majority of the more than 45 countries involved in the Campaign are located in Africa and South East Asia—regions characterized by the highest annual incidence of obstructed labour worldwide and only halting progress with regards to MDG5.¹ Almost half of all maternal deaths occur in Africa, while 35 per cent take place in South East Asia. Child marriage is also highly prevalent on both continents with between 44 and 49 per cent of women and girls married off before they reach the age of 18.

All of the countries that the Campaign supports have a maternal mortality ratio (MMR) greater than 300 per 100,000 live births, while more than half have an MMR of over 700 per 100,000.²

In the majority of countries, less than half of women and girls giving birth do so with the assistance of a skilled birth attendant.

In those Campaign countries where data are available, unmet need for family planning runs as high as 40 per cent.³ These numbers are considered underestimates owing to the fact that reproductive health and family planning are still considered highly sensitive topics in many countries.

¹ WHO. Global burden of obstructed labour in the year 2000. Carmen Doleal and Carla Abou Zahr. Evidence and Information for Policy (EIP), Geneva, July 2003

² WHO, UNICEF, UNFPA, and The World Bank. Maternal Mortality in 2005. World Health Organization, Geneva, 2007.

³ Millennium Development Goal Indicators. Accessible at <http://unstats.un.org/unsd/mdg/Default.aspx>



Lucian Read/WorldPictureNews for UNFPA

Osun State, Nigeria: Hajia Nafisat Ade Ajagu, Head Nurse in Charge of the Fistula Ward, passes through a hallway at the Babbar Ruga Fistula Hospital in Katsina State. The hospital is one of the largest centres in the world providing fistula treatment services and training in fistula management to approximately 1,500 patients annually.

KEY ACHIEVEMENTS

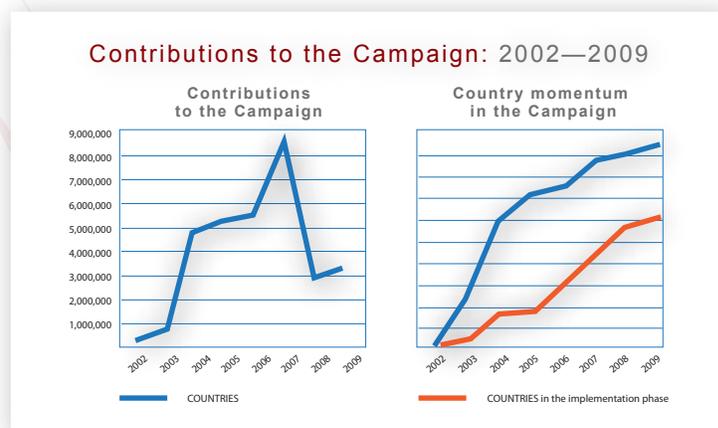
For years obstetric fistula remained largely unnoticed and the women living with it unseen. Engaging policymakers and national governments is a key component of raising awareness and providing the services required to eliminate fistula once and for all. To that end, the Campaign promotes an overarching strategy: to integrate maternal health interventions—including those related to fistula—into national development and health care plans.

The Campaign also strives to support countries to fight maternal mortality and morbidity by adhering to the Paris Declaration on Harmonization and Alignment, an international agreement with more than 100 signatories including ministers, heads of agencies and other senior officials. The aim is to increase efforts towards harmonization, alignment and managing aid for results.

Promoting national leadership

Only a few countries accounted for obstetric fistula in national policies at the beginning of the Campaign and those that did exist were largely unimplemented. During the last five years, as national plans and strategies have been revised or adopted, countries involved in the Campaign have increasingly integrated maternal morbidity and specifically obstetric fistula interventions into a variety

Figure 3



of national health sector, reproductive and maternal and newborn health policies, plans and strategies.

To date, 28 Campaign countries explicitly mention fistula in one or more national health-related plans or strategies.⁴ Additionally, nine countries have integrated fistula into more than one national document.

Although national leadership for fistula interventions typically resides with the Ministry for Health, others—most notably those dealing with gender/women’s affairs—are becoming increasingly involved. In **Ghana**, for example, the Ministry of Women and Children’s Affairs has been mobilized to assist with social reintegration efforts, while in **Liberia** the Minister of Gender is a major supporter.

Table 1

National Policy, Strategy or Plan	Countries
National Health Sector Plans	Bangladesh, Cameroon, Côte d’Ivoire, Ethiopia, Guinea-Bissau, Mali, Niger
National Reproductive Health Policy/Strategy/Plan	Afghanistan, Côte d’Ivoire, DR Congo, Equatorial Guinea, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Malawi, Mali, Niger, Pakistan, Sudan
National Roadmaps to Accelerate the Reduction of Maternal and Newborn Mortality and Morbidity (Africa)	Benin, Burundi, Cameroon, Chad, Congo, Côte d’Ivoire, DR Congo, Equatorial Guinea, Eritrea, Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Uganda, Zambia

⁴ Based on reporting from UNFPA country offices and review of publicly available documents. Note that some documents are expected to be finalized in early 2009.

Civil society organizations have also stepped forward with their own initiatives to address the social and economic determinants of fistula within the community. This combination of national and grassroots support is strengthening overall in-country capacity to prevent and treat the condition.

Table 1 (page 11) shows an overview of countries that have integrated fistula into a variety of plans. Based on

the data available, at least seven countries have included fistula into health sector plans and 13 into reproductive health plans/strategies. In Africa, 40-plus countries have completed National Roadmaps to Accelerate the Attainment of the Maternal and Newborn Health goals of the MDGs, which are now driving national efforts. Just over 50 per cent (21 countries) are addressing the issue, while still others are revising or developing new policies/



Lucien Read/World Picture News for UNFPA

Kano, Nigeria: A patient at the Gyadi-Gyadi Women's Training Centre holds her crying daughters. Centre staff work to help fistula sufferers recover from repair surgery and facilitate the reintegration of patients back into their communities and families.

Saving mothers and babies: The Maternal Health Thematic Fund

In 2008, as part of the commitment to support countries, UNFPA established a Maternal Health Thematic Fund (MHTF). Its raison d'être is to support countries in health-system strengthening in order to provide a broad range of quality maternal health services, minimize health inequities and empower women to exercise their right to maternal health—including the right to avoid the devastating consequences of maternal disability such as fistula. The aim is to assist high-priority countries to reduce maternal death and disability and thereby leverage more resources in a bid to achieve MDG5.

This can only be accomplished by working with civil society, the United Nations and other key partners to implement and scale up effective interventions as part of an overall reproductive health national strategy.

The Maternal Health Thematic Fund is also part of a larger joint effort with UNICEF, The World Health Organization (WHO) and the World Bank to increase support to 25 high maternal mortality countries before the end of 2009. Although it initially targets only 11 countries—**Benin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi and Sudan**—the ultimate objective is to expand support to include all 60 countries with high maternal mortality by 2015.

Funds are disbursed in response to country requests for priority activities that focus on the three interventions proven to be most effective in improving maternal health—family, skilled attendance at the time of birth and Emergency Obstetric and Newborn Care (EmONC).

plans that integrate obstetric fistula. At least eight countries have also developed national obstetric fistula strategies.

To build momentum in support of national policies, UNFPA has engaged with a variety of stakeholders. In 2008, UNFPA assisted with the organization of a workshop focusing on maternal mortality reduction with the First Lady of Nigeria and other wives of the state governors to assist them in developing a number of state-specific action plans. This was followed by a regional conference involving participants from 22 African countries that focused on the role traditional and religious leaders can play in the reduction of maternal mortality. In **Liberia** UNFPA—alongside the Minister of Gender and 500 participants from the Ministry of Health, NGOs, nursing and midwifery associations, the Federation of Liberia Youth, and health facility staff—sponsored a massive fistula awareness march that highlighted the need to strengthen health service delivery. In **Niger**, the 60th anniversary of the Declaration of Human Rights provided an opportunity to raise awareness of obstetric fistula as a consequence of child marriage, in addition to the overall lack of access to health services.

The Campaign is also striving to ensure that fistula is increasingly incorporated into regular country programmes—the official agreements of cooperation between the Fund and national counterparts. This contributes to sustainability and confirms that both recipient governments and UNFPA are committed to the issue. While almost no country programmes included fistula-specific interventions at the beginning of the Campaign, at the close of 2008, 31 Campaign countries had incorporated specific actions to address fistula in UNFPA country programmes.

In accordance with the 1989 *Convention on the Rights of the Child*, UNFPA is working with governments to stop child marriage. Although age at first marriage is rising, during the next decade more than 100 million girls will be married before the age of 18.⁵ This represents fully one-third of adolescent girls living in developing countries.

Although obstetric fistula may occur throughout reproductive life, it is important to note that, owing to both

⁵ UNFPA. 2007. "Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy." UNFPA. New York.

⁶ Tsui, A.O., A. A. Creanga and S. Ahmed. 2007. "The Role of Delayed Childbearing in the Prevention of Obstetric Fistulas." *International Journal of Gynecology and Obstetrics*, 99:598-5107.

The Midwives Programme

Jointly implemented by UNFPA and the International Confederation of Midwives (ICM), the Midwives Programme was officially launched in April 2008. UNFPA originally conceived of the programme as a response to the growing need for human resources for health in many countries. Not only are midwives in short supply, but their skills are also necessary to reduce maternal and newborn deaths in high maternal mortality countries.¹

The programme calls for a global effort to promote the work and role of midwives with a view towards achieving MDG5. It is aligned with the ICPD agenda and the 1994 international call to invest in sexual and reproductive health and rights. Its aim is to develop national capacity in high maternal mortality countries, to ensure skilled attendance at all births and to contribute to the other health MDGs: Reducing neonatal mortality (MDG4); promoting gender equality and empowering women (MDG3) and combating HIV/AIDS, malaria and other diseases (MDG6).

The Midwives Programme aims at building a "critical mass" of midwife advisers in all regions who will lead country level capacity building. The three-year programme ultimately aims to support between 20 and 25 priority countries and is fully integrated within the Maternal Health Thematic Fund to ensure a coherent response.

¹ WHO. Critical Role of Skilled Attendants. A Joint Statement by WHO ICM FIGO. Geneva, 2004
WHO. World Health Report 2005: Make every mother and child count. Geneva, 2005
WHO. World Health Report 2006: Working together for Health, Geneva 2006

biological and socio-economic reasons, adolescent girls face particular risks that increase their vulnerability. The pelvis of a girl or a young woman may not be fully developed, which may increase her susceptibility to prolonged obstructed labour. Delaying pregnancy until after adolescence may reduce the risk of obstructed labour, and therefore of fistula.⁶ Married girls may have less access to sexual and reproductive health (SRH) services and information. To redress this lack, several campaign countries are working to promote the implementation of laws and/or policies that set a minimum age of marriage.

In **Chad**, the new Obstetric Fistula National Strategy process works with parliamentarians to accelerate the adoption



G.M.B. Akash/Panos Pictures / UNFPA

Dhaka, Bangladesh: A woman weeps with relief following fistula surgery at Dhaka Medical College. Like so many fistula survivors, she had been abandoned by her family and community.

of the family code and to raise the legal age of marriage to 18. In **Nigeria**, the Federal Ministry of Women Affairs and Social Development acknowledges the importance of preventing early marriage as an important component in the fight against obstetric fistula. The Federal Government passed a law postponing the legal age to 18 years. Despite these promising developments, implementation continues to remain a challenge and requires continued effort.

Preventing Harm

All aspects of the UNFPA mandate contribute to the prevention of fistula—from ensuring access to quality reproductive health-care to promoting gender equality and the empowerment of women. When it comes to preventing maternal mortality and morbidity, UNFPA focuses on supporting countries to address immediate health system constraints as well as longer-term social change.

All 45-plus Campaign countries are now undertaking prevention efforts. These include interventions at the policy, service delivery and community levels that range from providing policy advice to training health providers,

improving quality of care, working with communities to end child marriage and promoting the rights of women. These efforts are financed through UNFPA core resources, Campaign funds, and increasingly, through the closer alignment of the Campaign with the Maternal Health Thematic Fund.

Human resources for health

Lack of health-care personnel continues to slow efforts to prevent fistula and maternal mortality. Midwives provide skilled care throughout pregnancy and delivery and are essential when it comes to basic emergency obstetric and newborn care, as well as other vital reproductive health services (including family planning).

Nearly half of Campaign countries (23) supported efforts to strengthen midwifery in 2008 by revising midwifery training institution curricula in **Lesotho**, **Madagascar** and **Rwanda**, and rehabilitating or establishing midwifery schools in **Sudan** and **Timor Leste**. UNFPA also supported young women attending midwifery school in **Afghanistan**, **Haiti**, **Somalia** and **Uganda**. In the

meantime, **Bangladesh, Kenya, Mauritania and Senegal** are establishing community midwifery services, training providers in remote regions and advocating for trained midwives to be deployed to rural posts. In **Sudan**, UNFPA has worked with the Ministry of Health to strengthen the supervisory system for village midwives.

Emergency obstetric and newborn care (EmONC) includes essential interventions to prevent maternal death and disability—including obstetric fistula—and can only be provided by skilled professional health workers. In order to do so, health workers need an enabling environment, with proper space, equipment and medications. In 85 per cent of the Campaign countries, UNFPA and partners are improving access to EmONC by training health providers and upgrading health facilities.

The Fund also supported continuing medical education for professors and instructors at medical, midwifery and nursing training institutions in Benin and Equatorial Guinea. Innovative solutions to the human resource crisis have been undertaken in Ethiopia where the Ministry of Health, with support from UNFPA, is initiating a programme to train mid-level providers to perform caesarean sections—a strategy which several countries in the region have implemented with considerable success. In **Pakistan**, medical officers are receiving anaesthesia and caesarean section training in order to provide 24-hour EmONC access.

Supporting maternal health care also includes ensuring quality of care. This involves training personnel, developing and establishing clinical protocols and continuous quality assurance. In **Mozambique and Nepal**, UNFPA and

Champions in the Fight Against Fistula

Individuals and organizations bring fistula prevention and treatment to some of the world's most marginalized women and girls. These champions in the fight against fistula are often under-acknowledged despite their significant contribution. Seventeen countries nominated a total of 21 champions in 2008. Their stories and commitment should motivate others to join the effort to deliver hope to hundreds of thousands of women and girls who live with a condition that has been all but eliminated in the developed world. The following pages will feature the top 'champions' for 2008.

Ms. Constanca Mangue Nsue Okomo is the First Lady of **Equatorial Guinea** and has worked hard to build bilateral and multilateral partnerships as part of the Fight Against Maternal and Infant mortality and HIV/AIDS. Since 2005, she has worked with UNFPA to launch two national campaigns to end fistula. Mrs. Okomo believes that fistula management, treatment and care should be integrated as a permanent feature of health professional training. She encourages communities to end all forms of discrimination against women living with fistula and believes that prevention and treatment should be included as a national priority to ensure that the Government allocates necessary resources. Through the recommendation of the First Lady, fistula was prioritized in the 2020 Economic and Social Development Plan and will be included in the national public investment programme.



Ms. Okomo says, "The exclusion of women living with obstetric fistula by husbands, friends or the community constitutes a serious violation of the rights of women in Equatorial Guinea society. All women living with fistula have a right to psychological support by their family, friends and society."



G.M.B Akash: Panos Pictures / UNFPA

Dhaka, Bangladesh: 18-year-old fistula patient 'Fatima' weeps as she recalls the gang rape that left her pregnant. Her family took her to a local hospital for an abortion but the procedure left her with a fistula. It took three operations to repair the damage. Her assailants were never brought to justice.

partners are working with health-care providers to improve quality of care and to hone their communications skills.

Lowering costs and saving lives

Numerous assessments have also noted that the high cost of care dissuades women from accessing prevention services. In 16 Campaign countries, UNFPA is working with government and other partners to reduce costs through a variety of financing schemes. These vary depending on context—from national and community-based health insurance programmes to reducing fees or providing services free-of-charge.

UNFPA has supported the governments of **Côte d'Ivoire**, **Guinea** and **Niger** to implement national policies that offer free caesarean sections, and in **Burundi** and **Ghana**, free delivery care. In **Djibouti** and **Guinea-Bissau**, UNFPA supported community based health insurance schemes (mutuelles) in regions with the highest maternal death and disability rates.

In **India**, UNFPA has helped establish the conditional cash transfer programme in which women receive cash for delivering in a facility, while in **Bangladesh**, the Government and UNFPA are piloting a voucher scheme that is encouraging more women to take advantage of early antenatal care and delivery services. Countries such as **Eritrea** and **Lesotho** have established maternity waiting homes. These are designed to house women who live in remote regions so that they can access quality care both before and following delivery.

Communication is key

Ensuring connections between the health system and the community is necessary if the system is to be more responsive to patient needs. At the same time, communities need information in order to understand that childbirth can be dangerous and that individuals have a right to quality reproductive health.

Many countries have been training community health workers to disseminate messages regarding maternal health and consequences of childbirth complications, including obstetric fistula. In **Zambia**, Safe Motherhood Action Groups are also spreading the word.

Fistula Champion



Ms. Esther Dodoo is the Principal Nursing Officer at Tamale Teaching Hospital in the Northern Region of **Ghana**. She began to work on fistula in 1994. Ms. Dodoo believes that husbands in particular require more information concerning prevention and treatment to better to support their wives. All categories of health workers also require more information to assist in education and management.

Healing Wounds

Although prevention is the key to eliminate fistula, treatment is a necessary step to restoring a woman to her livelihood, family and community. The Campaign to End Fistula emphasizes a comprehensive approach—from surgical interventions to post operative care. This also involves capacity development such as upgrading of health facilities, providing equipment and supplies and emphasizing the team-based training of health-care providers with a particular focus on quality of care.

In 2008, more than 4,000 women received treatment services through UNFPA-supported interventions. Over 100 health facilities were fully equipped and upgraded, enabling countries to increase access to treatment services. More than 750 health-care professionals (surgeons, nurses, midwives and anaesthetists) received formal training in fistula management while more than 1,200 others—including social workers, paramedical staff and community health workers—were trained in fistula care.

Steady treatment progress was evident in countries such as the **Democratic Republic of Congo (DRC)**, **Mauritania** and **Niger**, and in 2008, largely attributable to increased human resources, upgraded facilities and the provision of equipment and supplies. In **DRC**, 13 doctors, 35 nurses, 14 paramedics and seven social assistants were trained in fistula management. As a result, there has been a sudden and visible surge in the numbers of women obtaining treatment in health care facilities.

The Campaign supported 472 women in receiving treatment and provided occupational training to ease their reintegration back into society. In **Niger**, treatment capacity increased from 220 in 2007 to 387 in 2008. And in **Mauritania**, as part of its efforts to build sustainable capacities, the Campaign established and fully equipped an operating theater at the Sebkhah Hospital where the numbers of women being treated have increased. Since the centre opened and began providing EmONC services, maternal deaths within the facility have decreased by 20 per cent.

The strengthening of regional centres in 2008 has had far-reaching effects both in West Africa and South Asia. The regional hospital in Upper East **Ghana**, where 137 women accessed treatment services in 2008, has been certified as a referral centre for fistula management. Four outreach campaigns were organized there with a substantial capacity building component marked by an effective transfer of knowledge and expertise.

During the campaigns, two obstetricians, four anaesthetists and three nurses were trained in fistula management. And in **Pakistan**, where seven regional centres were renovated and fully equipped, a solid patient identification and referral system was established to link district hospitals with the private sector, NGOs and regional centres. Eighteen outreach camps were held there in 2008, resulting in the treatment of more than 200 women, and the training of 31 doctors and 28 nurses and midwives.

Fistula in Complex Humanitarian Settings

Conflicts cause destruction of communities, health infrastructure and social systems, leaving women and girls especially vulnerable. Fistula highlights the increased

Fistula Champion



Dr. Adam Salih Mohamadein is an associate professor in OB/GYN at Elfasher University, Darfur, **Sudan** and a fistula surgeon at Elfasher Hospital, where he also serves as the Director of the Fistula Center. Dr. Mohamadein believes that Campaign to End Fistula programmes should continue to treat all fistula cases in greater Darfur and beyond. He also advocates that local staff be trained in surgical techniques, to manage stress incontinence following surgery, and that programmes be expanded to include the rehabilitation and social reintegration of fistula patients. He also believes that community mobilization and awareness-raising be mainstreamed into reproductive health projects. "The campaign to end fistula is a collective effort, that needs collaboration and coordination between all actors, United Nations agencies, NGOs and local authorities to succeed," he says.

vulnerability in conflict and post-conflict settings and is symptomatic of conflict's affect on societies. Obstetric fistula is a dramatic consequence of the vulnerability that arises from restricted access to reproductive health-care.

Therefore, in complex humanitarian settings, with extremely limited resources, facilitating access to fistula prevention and treatment services involves addressing the overall health services system with attention not only to medical needs, but also to issues including security and long-term psychosocial impact.

In **Sudan**, surgical outreach campaigns resulted in the treatment of more than 120 women. More specifically, a fistula campaign in Zalingei Civil Hospital, **West Darfur**,

resulted in extensive advocacy and awareness raising, policy dialogue and the treatment of 63 women.

Continuing fistula work in **Somalia** illustrates the possibility of delivering these services during full-blown humanitarian crises: security Phase IV, emergency operations only and Phase V, full-scale evacuation.

Building upon the experience of the first ever fistula campaign in 2007, two outreach treatment campaigns were conducted in 2008, providing fistula surgical services for 85 women, several of whom were transported to Puntland from Mogadishu, where active conflict persists.

In order to continue building provider capacity, seven doctors and 11 nurses received training during outreach missions. In **Afghanistan**, a total of 221 women were successfully treated at two treatment centres, and the skills of three doctors upgraded.

French Funds in Mali

The French funding allocated to the UNFPA Dakar Sub-regional office in 2007, “Appui à l’amélioration de la santé des femmes dans les pays de la ZSP”, is dedicated to the development and the implementation of national maternal and newborn road maps and obstetric fistula strategies in Francophone West African countries.

Initially, the funds were earmarked for the establishment of a sub-regional obstetric fistula treatment, training and research centre at the Point G University hospital, Bamako, **Mali**. An evaluation mission conducted in September 2007 assessed the current situation to study the feasibility of establishing an obstetric fistula training and research centre and to propose a strategy.

The mission concluded that efforts were needed first to improve management and surgical care as well the management of the Oasis centre.

The Mali UNFPA country office managed to equip the centre along with two others: Segou and Mopti, and to support the development of the country’s fistula strategy.

A second mission was conducted one year later, in January 2009, by an Ethiopian team who provided surgical and management support with a clear set of recommendations. As follow-up, regular missions are being planned and

international staff recruited with an eye towards boosting management capacity and quality of care.

Renewing Hope

Experience in countries continues to show that healing fistula requires more than just a surgical intervention—survivors also require psychosocial and economic support to heal the damage. Nonetheless, there remains a lack of clarity about exactly what reintegration means and the types of interventions and stakeholders that can best facilitate it. Full healing requires four inter-related components: physical health, mental health, social and economic well being. Survivors themselves will need to contribute to the full definition of exactly what constitutes reintegration and speak to those services best suited to their particular needs.

This understanding has grown from country experiences, which have expanded in the wake of the Campaign’s inception. About one-quarter of the Campaign countries established reintegration programmes in 2008 with many more slated to begin in 2009. A number of countries, such as **Niger** and **Senegal**, have substantially increased access to reintegration services—increasing from one to four sites in the former and, in the latter, from one to five sites.

In most countries, the standard components of reintegration services are evolving to include counseling, reproductive health

Fistula Champion

Dr. Nadira Hayat Burhani is the Deputy Minister (Health Service Provision) within the **Afghanistan** Ministry of Public Health. Dr. Burhani believes her country must address the shortage of skilled birth attendants through education, training, and deployment to underserved areas in order to end obstetric fistula and improve maternal health. Developing community health worker capacity and strengthening basic and comprehensive obstetric care services is also essential. “The Ministry of Public Health should take this opportunity to call upon every citizen, every donor agency and the United Nations agencies to help in achieving the goals of eliminating maternal mortality, reducing maternal morbidity including obstetric fistula and improving the status of women in this country.”



Dhaka, Bangladesh: Recovering from surgery at the Dhaka Medical College Hospital.

G.M. B Akash: Panos Pictures / UNFPA

education, and income generation activities combined with community sensitization to reduce stigma. Countries such as the **DRC, Liberia, Mauritania** and **Nigeria** offer survivors an array of options that match their interest and skills—from professional to small business training. Following programme implementation, the **DRC** undertook a rapid evaluation and found improvements in survivor health, self-confidence and the ability to participate in community events.

Countries are employing a mix of community and centre-based reintegration approaches to assist women in their smooth transition into society.

Nigeria discovered through a pilot programme that it may be more effective to shift from institutional and centre-based approaches to community-based programmes—including those that provide women with microcredit to start up their own businesses. The shift has allowed more needs-based specific support. While only a small number of women were involved, results show that 80 per cent of those participating multiplied the initial investment.

Bangladesh has established a rehabilitation centre in Dhaka, but is also working with fistula advocates to expand to the community level. **Liberia** and **Pakistan** have also established services through their national treatment centres

of excellence, while, at the same time, establishing partnerships in outlying areas through county health teams, community health workers and organizations. The aim here is to reduce stigma. **Burkina Faso** and **Sudan** have likewise established and inaugurated hostels or reintegration centres. **Côte d'Ivoire** focused its efforts on reducing stigma and training traditional birth attendants and community health agents to assist women in reintegrating into their communities.

Broadening the Knowledge Base

As the Campaign continues to move forward, more countries are transitioning into the implementation phase with fewer conducting fistula-specific needs assessments. This transition marks a significant step forward in the progress of the Campaign. Many countries, such as **Ethiopia**, are also conducting EmONC needs assessments that include a subset of fistula-specific questions. These allow certain countries to collect follow-up data from previous fistula assessments and/or gather new information. This type of intelligence is vital as the Campaign continues to integrate fistula into sexual and reproductive health initiatives.

Experts from around the world are working tirelessly to structure and harmonize treatment protocols and training

standards to facilitate the integration of fistula into existing reproductive health standards. To that end, the first annual meeting of the International Society of Fistula Surgeons (ISOFS) was held in **Ethiopia** to discuss issues such as fistula management training, international standardization for the classification of fistula and data collection. Fifty country-level participants from **Bangladesh, Belgium, Burkina-Faso, Ethiopia, Sudan, Nigeria, Mali, Tanzania, Uganda, the UK and the USA** attended.

National Data and Research

As fistula becomes more visible, countries are taking the initiative, often with support from the Campaign, to conduct national research and analyze national level data. In 2008, seven countries made data on fistula available through national Demographic and Health Survey (DHS) reports. The **DRC, Ethiopia, Malawi, Mali, Niger, Pakistan and Uganda** all included fistula questions within their DHS to identify—among other things—prevalence and awareness. A standard module has now been developed and is currently being piloted in **Burkina Faso, Kenya and Nigeria**.

As more data become available, countries are better able to focus on fistula elimination, especially through improving access to services. The **Côte d’Ivoire** UNFPA country office values data that maps where fistula patients come from—particularly if they cross borders. This information assists in making services more accessible by improving transport and the geographic distribution of services.

Maternal death and near-miss⁷ reviews are an increasingly recognized and utilized means to improve quality assurance.

Fistula Champion

Mr. Edwin Gondwe is a Clinical Officer working with the Ministry of Health-Zomba Central Hospital, located in the southern part of **Malawi**. Mr. Gondwe received on-the-job and formal training in fistula surgery and has first-hand experience of what it does to women. “Fistula is such a devastating social condition,” he says. “Women with fistula are stigmatized, hence they lose out on participation in community activities. We need more clinicians and nurses to be trained in fistula repair.”

By reviewing how cases of maternal death and severe complications (near-misses) are handled, it is possible to understand where quality of care needs to be strengthened. In ten of the Campaign countries, UNFPA has supported the government and health providers to establish standards and tools for conducting maternal death reviews.

In **Benin**, UNFPA is specifically supporting the review of fistula cases as a near-miss. Ten audits were organized in 2008, with six completed from the maternity wards at Bembèrèkè and Tanguiéta Hospitals. UNFPA and partners are recommending that “near-miss” audits be replicated elsewhere in **Benin** and indeed, in other Campaign countries.

In **Kenya**, an assessment was undertaken in 2008 to help better understand the experiences of women with obstetric fistula and the effectiveness of community midwives in preventing the condition in rural areas. The assessment covered four UNFPA-supported districts with data collected via questionnaires targeting women living with fistula, those who had received fistula treatment, and those who had experienced obstructed labour.

Community midwives were also interviewed and focus groups held with both men and women to determine their perceptions around maternal health and community midwifery. Findings confirmed that women who develop fistula were less likely to have attended school, and more likely to live in poverty. Their husbands were also less likely to have received an education. Affordability was also a major deterrent to seeking timely care—despite increased community awareness that obstetric fistula can be successfully repaired.

The Community Midwives initiative assessment determined that 100 per cent of women with obstructed labour who were treated by community midwives were promptly referred and none developed fistula. While a few midwives are not knowledgeable or as well-trained as they could have been, the assessment found the initiative feasible, acceptable and effective.

Findings from Evaluations

In **Niger**, Réseau Pour l’Élimination de la Fistule Obstétricale (REF) organized an evaluation of social and economic reintegration activities aimed at women who

⁷ A “near-miss” has a number of definitions, but typically is understood as a severe life-threatening obstetric complication necessitating an urgent medical intervention in order to prevent the likely death of the mother. (WHO, Beyond the Numbers, 2004) Women who have survived an obstructed labour, but are left with an obstetric fistula, would be considered as having experienced a near-miss by some interpretations.

have been treated for fistula. The overall purpose of the evaluation was to determine activity effectiveness and to strengthen the relationship between UNFPA and the two implementing local NGOs. The study covered the regions of Zinder, Tillabéri and Niamey.

Key findings include:

- The necessity of providing ongoing, safe pregnancy education. Despite receiving post-fistula treatment, many women continued to deliver at home;
- The bulk of financial support provided to women post-treatment was used for small business ventures, such as animal husbandry, whereas the majority of women returned home to resume traditional family roles;
- Although costly, accompanying women back to their communities following treatment facilitates reintegration and provides an opportunity for community education.

Campaign to End Fistula Mid-Term Review

The year 2008 marked the mid-point of the Obstetric Fistula Thematic Fund's current phase (2006-2011) and the fifth year since the Campaign launched. In an effort to assess progress thus far, a mid-term review evaluation is planned for early 2009. This evaluation will contribute to evidence-based fistula elimination programming and answer critical questions regarding the effectiveness of approaches used to date and their role in supporting maternal health programmes more broadly. It will also determine how effective the Campaign approach—which emphasizes multiple strategies undertaken simultaneously at national, regional and global levels—has been.

In 2008, the preparatory work was completed, including the selection of countries and the bidding process for those organizations interested in conducting the evaluation. The final review of bids was completed and the external evaluation firm selected.

Johns Hopkins University Study

Capturing the magnitude of obstetric fistula is an important step in addressing its elimination. Unfortunately, data on existing prevalence and incidence are limited and often of poor quality. Previous studies are mostly characterized

by short-term, follow-up periods without adequate information regarding the long-term clinical prognosis and quality of life of those women trying to reintegrate into society following treatment.

In response to these data limitations, Johns Hopkins University, UNFPA and the World Health Organization (WHO), in collaboration with medical and national institutions in seven countries, are conducting a prospective, multi-centre study to examine links between surgical prognosis and treatment to long-term health, psychosocial status, and reintegration outcomes following surgery. The results of the study will help guide advocacy and devise appropriate, cost effective, feasible programmes and national strategies. A secondary objective is to utilize study data to validate a standardized, prognostic-based classification system for obstetric fistula. Data collection is expected to begin in the spring of 2009 and will be completed by the close of 2010.

Partnership Building

As obstetric fistula becomes more widely recognized, the number and variety of partners continues to grow. This increasing engagement means that it will be possible for more women to avoid fistula in the first place or have their hopes renewed following treatment.

Increasing collaboration among the UN agencies on maternal and newborn health—particularly between UNICEF, UNFPA, WHO and the World Bank—will greatly strengthen support to countries for MDG5. Joint programmes and integrated technical support for planning and assessments are underway in countries across all regions—including **Afghanistan, Angola, Bangladesh, Burkina Faso, Central African Republic, Congo, Eritrea, Haiti, Pakistan, Senegal, Sudan, Tanzania and Timor Leste**. This collaboration will continue to grow and has been reinforced by the Joint Statement on Maternal and Newborn Health released by UNICEF, UNFPA, WHO and the World Bank in September 2008.

National partnerships continue to drive country level efforts. Coordination mechanisms take various forms based on the country context and needs—such as special, maternal health or sub-committees, task forces or working

groups. These provide an important mechanism for planning and for technical discussions regarding fistula-specific interventions. Ministries of Health often take the leadership, although many countries have begun to involve those specifically related to gender and women's affairs.

The **Bangladesh** National Fistula Committee was established in 2009 and brings together Government, UNFPA, EngenderHealth and 14 medical college hospitals. Similarly, UN agencies and NGOs have established a fistula task force in Darfur, **Sudan**. In **Pakistan**, the national working group provides a forum for fistula surgeons to exchange technical expertise.

The national coordination is reflected at the global level in the international Obstetric Fistula Working Group. Led by UNFPA, the group has grown from 7 organizations in 2003 to 25 organizations in 2008—with more planning to join in 2009. The group is structured to stimulate dialogue, improve coordination and take action in areas of key concern.

Working with Civil Society Organizations

As part of the Campaign efforts to adopt an exit strategy and promote sustainability and ownership, civil society organizations (CSOs) are increasingly assuming a prominent role in the management of fistula. Their work consists mainly of identifying survivors, referring them to health facilities—thereby contributing to demand. Civil Society Organizations help raise community awareness and work for social change, while, at the same time, promoting family planning, skilled birth attendance and emergency obstetric care.

Civil Society Organizations also engage in dialogue with governments and can influence policy development and national budget allocations for maternal health. On the social reintegration front, they promote income-generating activities as part of a broader poverty reduction strategy. This can include accompanying women to their respective communities to facilitate their reintegration back into society. The Campaign works with more than 20 African CSOs—of which approximately 10 received funding to fight fistula.

In 2008, in **Côte d'Ivoire**, **Mali**, **Mauritania**, **Niger** and **Tanzania**, the Campaign worked closely with CSOs and

Figure 4



adopted a comprehensive approach from prevention to social reintegration. The CSOs helped reintegrate more than 1,000 women into their communities and coordinated efforts that culminated in the establishment of the Africa Regional Network for Fistula Elimination in Africa (RAEFO).

The Network was established at the recent Abidjan conference and adopted an action plan, a statute, an internal regulatory framework, and elected its office members. It will focus on coordination, advocacy for resource mobilization (both technical and financial) and political support, capacity development of individual countries in fistula programming, management, and monitoring and evaluation. It is expected to

Fistula Champion

Following her participation as a delegate and speaker at the Women Deliver Conference (2007), **Ms. Halima Gouroukoye**, fistula survivor and advocate from **Niger**, went on to contribute to the Commission on the Status of Women in 2008. As Ambassador for Fistula Elimination, she advocates on behalf of women seeking to obtain information regarding their reproductive health, access to maternal health services and fistula treatment. In her village she raises awareness about reproductive health and the importance of girls' education. She has also initiated a community health mutuelle (financing mechanism) to assist with the transport of women suffering birth complications to the nearest facility. Her community now recognizes her as a decision-maker and village leaders, including the chief, frequently solicit her opinions. She has assisted at least four women to access fistula treatment in Niamey.

Ms. Gouroukoye has also worked to raise awareness in more than 20 villages. She speaks to communities about fistula prevention, its causes and consequences, and where to go for



treatment. She also follows her own advice. During her most recent pregnancy, Ms. Gouroukoye obtained prenatal care and made plans to deliver by caesarean section so as to avoid potential obstetric complications. Ms. Gouroukoye and her husband welcomed a baby boy on 16 February 2009.

play a critical role in supporting community-based efforts in the future. The network will also work jointly with the Campaign towards the development of a Compact Guidance Note on the effective engagement of civil society organizations (NGOs, fistula advocates and media) in the management of fistula and the promotion of maternal health.

The Campaign also has established a variety of partnerships to increase resources and build capacity. South-South collaboration is a key aspect of the Campaign. However, North-South collaborations with organizations and academia are also strengthening capacity—for example: the collaboration between **Benin** and the Geneva Foundation for Medical Education and Research (GFMER), the **DRC** and Medecins Sans Vacances and the long-standing collaboration between **Eritrea** and Stanford University. Partnerships with the private sector are also ongoing. While relationships with Virgin Unite and Johnson & Johnson continue at the global level, both **Côte d'Ivoire** and **Pakistan** have linked up with mobile telephone companies to support their programmes.

South-South Collaboration

South-south collaboration is a highlight of the Campaign's innovative approach. With the help of UNFPA, health providers and civil society organizations have travelled from **Nigeria** to **Sudan**, from **Ethiopia** to **Niger**, from **Mali** to **Cameroon**, and many more countries, to exchange experiences and promote innovative programming. Health ministries from different countries have worked towards common solutions, and fistula survivors have become influential advocates—raising awareness and offering hope.

In 2008, a regional fistula treatment and management capacity building workshop was organized in Sylhet, **Bangladesh**, with support from the Government, Dhaka Medical College Hospital and UNFPA. Teams of surgeons, anaesthesiologists and nurses from three countries (**Nepal**, **Pakistan** and **Timor-Leste**) traveled to Sylhet and performed 29 complex fistula surgeries during the three-day workshop. A film was also produced to be used in future training programmes. The National Fistula Centre at Dhaka Medical College is being established as a regional

Centre of Excellence and it is hoped that the centre will continue to organize similar south-south capacity building exercises, including with professionals in the Africa Region.

A recent fistula training session in **Mali** highlights country level efforts to develop the capacity of fistula service providers through south-south collaboration. **Liberia** uses nurse instrumentists, operating theatre nurses who specifically assist with surgical instruments, for surgery. To effectively transfer these skills, a Liberian nurse instrumentist trained three Malian nurses during a team-based training at Point G Hospital.

Raising Awareness

Two thousand and eight (2008) proved to be a landmark year for the Campaign when the first-ever **United Nations Secretary-General's Report** (A/63/222) examining the causes and consequences of obstetric fistula was presented to Member States in October. After the Third Committee of the General Assembly adopted a resolution in 2007 in support of efforts to end obstetric fistula, it

requested that the Secretary-General submit a report at its sixty-third session.

The report, which outlines efforts to end obstetric fistula at the international, regional and national levels, concluded with recommendations to intensify efforts and to support the achievement of MDG5. Recommendations included strengthening health systems, ensuring funding levels and maintaining predictability. Although it emphasized that considerable progress had been achieved during the past two

Fistula Champion

Brigitte Mopane is a journalist from the **DRC** who works with the Journalist and Communication Network for Population and Development and for National Congolese Radio & Television. Ms. Mopane is trained to write about fistula and has become an advocate for prevention and treatment—particularly in rural communities. “Good information contributes to the prevention of fistula and the protection of a mother’s health,” she says.



Washington, DC, USA: Fistula advocates Sarah Omega and Caroline Ditina

Fistula Champion



Dr. Alyona F. Lewis currently works for the Ministry of Health and Sanitation, which is attached to the Aberdeen West Africa Fistula Centre in **Sierra Leone**. Dr. Lewis notes that prolonged obstructed labour is not only the leading cause of maternal mortality and morbidity in Sierra Leone and many other developing countries, but also of obstetric fistula. “Obstetric fistula is a complication which exposes how crippled our health-care systems are,” she says. “It is therefore my belief that access to free maternity services must be paramount in the fight against obstetric fistula in Sierra Leone. The issue of poverty, fear and illiteracy cannot be ignored.”

decades, report authors acknowledged that serious challenges remain. They estimate that US\$ 750 million is required to treat existing and new cases of obstetric fistula between now and 2015—and that is only based on the assumption that the numbers of new cases will decline each year.

A Walk to Beautiful

In early 2008, a film capturing the agony and endurance of five fistula survivors was screened at theatres in New York, Los Angeles and San Francisco. The documentary, **A Walk to Beautiful**, attracted audiences across America, and won the prestigious International Documentary Association’s 2007 Feature Documentary Award. The film follows five

Ethiopian women to Addis Ababa as they seek treatment for the devastating childbirth injury that has left each of them incontinent. From their remote villages, over miles of dusty steppes and sprawling lowlands, the women travel to the capital city to reclaim their dignity after years of social ostracism. Produced by Engel Entertainment and partially funded by UNFPA, the film was also shown on the PBS NOVA series and screened at a packed theater at the United Nations headquarters in New York.

Working with Fistula Advocates

Spreading the word and raising awareness is imperative if the lives of millions of women are to improve. The best advocates in the fight to prevent maternal deaths and disabilities are the survivors themselves. It is rare to hear the voices of women who have experienced maternal health complications first-hand because so many die before they have a chance to speak out. Survivors testify to the reality of obstetric complications and the importance of equitable access to maternal health care. By doing so they also contribute to more effective safe motherhood programming. These powerful women can persuade communities and policymakers to take action. In 2008, their voices were heard around the world.

Thirteen Campaign-supported countries are now working with fistula advocates, each of whom is working in her own way to sensitize communities, providing peer support to women living with fistula, and advocating for improved maternal health. Several countries are just beginning to plan fistula advocacy activities in which survivors can participate actively. Still others have been involved in this work for a few years and are sharing their experiences with other countries.

In **Côte d’Ivoire**, 20 fistula survivors received training in educational communication techniques and now speak at community gatherings to encourage behaviour change. They also work with the media and discuss fistula prevention and treatment on radio and television programmes. A pilot effort in **Eritrea** provided training to 21 fistula survivors to work as maternal health volunteers—focusing in particular on counseling, safe motherhood, and the prevention and treatment of obstetric fistula. Trainees are now conducting

community mobilization and educational sessions with pregnant women to educate them regarding the importance of antenatal care and giving birth in hospitals.

The Campaign partnered with the United Nations Foundation to send two fistula advocates, Caroline Ditina of the **DRC** and Sarah Omega of **Kenya**, to Washington D.C. Both women shared their experiences at a series of events with donors, media, governments and policymakers. A press conference on Capitol Hill in support of a Congressional maternal mortality resolution was introduced by Congresswoman Lois Capps and hosted by Congresswoman Carolyn Maloney with six more Congresswomen attending in an unprecedented show of support. Ms. Omega delivered a strong call to action, urging Congress and the U.S. Government to make maternal health a priority. Congresswoman Capps described Omega's pleas as the "tipping point" that would transform words into action.

UNFPA Goodwill Ambassador, Geri Halliwell, spoke of her support for UNFPA's work and supermodel Christy Turlington Burns (CARE Goodwill Ambassador) called for safe motherhood. The following day, the U.S. House of Representatives passed a resolution on maternal mortality.

Reproductive Health in Emergencies Conference 2008—panel

Bringing examples of effective fistula programmes in conflict and post-conflict settings to the global stage allows for knowledge exchange and increased awareness of the particular barriers to reproductive health care that women face in these contexts.

To this end, national fistula experts from the **DRC**, **Liberia**, **Somalia** and **Sudan** participated in a panel entitled *Fistula: A Symptom of Women's Vulnerability in Conflict and Post-Conflict Settings* at the Reproductive Health in Emergencies Conference 2008 in Kampala, Uganda. This international conference was organized by the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and brought together more than 500 service providers, managers, advocates, researchers and policy makers.



Chris de Bode/Panos Pictures / UNFPA

Nigeria: Natalie Imbruglia cradles a child in a fistula treatment centre while the mother looks on. The singer and actress is a spokesperson for the Campaign to End Fistula and lends both her voice and her face to raise awareness of the devastating condition.

Fistula Champion

Dr. Justus Barageine works at the Mulago Teaching and Referral Hospital in Kampala, **Uganda** and is currently the Head of the Uro-gynaecology Division where he started fistula work in 2003. In 2005, he opened the fistula unit and runs a regular weekly fistula clinic in the hospital. Dr. Barageine has also established Mulago Fistula outreach surgical/training camps in the country's Buganda and Bunyoro regions and continues to teach and offer safe motherhood services. Today, Dr. Barageine is serving on the executive committee for ISOFS and is also member of the committee that authored the fistula curriculum for East and Central Africa.

"Prevention is better than cure," he says. "There is need to step up institutional deliveries and empower women through education and other community-based interventions. The health centre concept in Uganda must be fully functional and reproductive health should be the government's first priority if MDGs 4 and 5 are to be attained."

Panelists discussed the severe morbidity associated with fistula in conflict and post-conflict contexts, called for increased access to prevention and treatment services, and highlighted innovative programming.

The panelist from **Sudan**, Ms. Awatif Eltayib Mohammed Hussein, is a fistula survivor who trained as a midwife to help other women avoid the suffering she endured. During her presentation, she said, “The reason I work to inform people about these issues, is that I want people and women to have better lives.”

Raising Awareness Through Film

In 2008, UNFPA supported the production of two films set in **Afghanistan** and **Burundi**. A special video news report followed Fatima, an Afghani woman, who suffered two miscarriages in her early 20s but cannot afford medical care during a third pregnancy.

Like most of her compatriots, she laboured at home with no skilled assistance. The video also documents the work being done at the UNFPA-supported surgery unit at Kabul’s Malalai Maternity Hospital. UN in Action distributed the video report to over 50 broadcasters worldwide. A shorter version was broadcast in February 2009 on CNN International.

In 2007, fistula was an unknown condition in **Burundi**. Thanks to a country-wide campaign launched by UNFPA, women now know about treatment options. This was the subject of a 2008 UNTV-produced investigative video report produced with the assistance of the UNFPA country office. The video was broadcast on March 2009—also on CNN International—and distributed globally by UN in Action to over 50 broadcasters.

National Level

Various approaches are utilized to increase awareness at the community level. Using media that are acceptable and accessible to communities is an essential component of effective awareness-raising.

In 2008, countries continued to develop and deploy unique ways to increase community awareness. In **Liberia**, a series of successful community forums featured elderly women with the aim of informing participants about what causes fistula, how to prevent it and how to treat it.

Engaging health-care providers is also an important element in communicating messages about fistula to communities. In **Ghana**, 400 medical students conducted advocacy/awareness-raising outreach activities targeting all ten regions during the annual health week celebration—using fistula prevention and treatment information gained during previous training to educate communities in 80 districts.

In **Senegal**, a network of social workers, community health workers, fistula survivors and women’s organizations in the Kolda region initiated a team approach designed to identify, screen, treat and prevent fistula within the community. The network works with treatment facilities and plays an important role in educating and reintegrating women post-fistula treatment.

Radio continues to be a major source of communication in many Campaign countries. These can reach a broad audience through an accessible and popular medium. For example, **Côte d’Ivoire** collaborates with both international and local media partners to disseminate fistula information. Through a partnership with IRIN, radio programmes have been translated into 15 languages and broadcast on 66 local stations, such as Man FM, Danane Radio and Radio Tonkpi.

In **Benin** and **Niger**, UNFPA and partners are training radio hosts to strengthen their capacity to deliver appropriate and accessible fistula messages to communities.

National television is also a useful communication medium in some countries. During a treatment campaign in **Eritrea**, media coverage included interviews with the fistula surgeon, as well as the women themselves. The piece was aired as part of the Ministry of Information Tigrigna health programme. In August, an Ending Fistula Advocacy Campaign was launched in Garowe, **Somalia**, with funding and technical assistance provided by UNFPA.

Hosted by the Puntland Ministry of Health, the workshop brought together Government ministers, members of Parliament, sheikhs, local elders, doctors and activists from the Nugul, Mudug and Bari regions to discuss both medical and psychosocial impact of the condition.

Fistula survivors also spoke to the audience about the consequences of childbearing complications—potential

Saving mothers and babies: What will it cost?

At the Millennium Summit in September 2000, the largest gathering of world leaders in history adopted the UN Millennium Declaration and committed their nations to a new global partnership to reduce extreme poverty by 2015. The Declaration was a first, given that it outlined eight goals bound by a 2015 deadline. These are now known as the Millennium Development Goals or MDGs.

Two of those goals—MDG 4 and 5—are most relevant to the fight to end fistula. MDG 4 aims to reduce the under-five mortality rate by two thirds. MDG5, improving maternal health, seeks to reduce maternal death by three quarters and to achieve universal access to reproductive health.

Although countries such as **Brazil, China** and **India** are accelerating action to meet these goals, many resource-strapped nations are lagging behind. Fragile health care systems and poor governance characterize the world's 51 poorest countries, many of which are conflict prone or politically unstable.

Economists estimate that the cost of expanding care to these 50 aid-dependent countries is US\$ 7.2 billion in 2009 rising to \$18.4 billion in 2015. Country-specific costing conducted by individual countries in Africa and Asia corroborate this estimate. In order to meet both MDGs, health expenditures will have to increase markedly—well beyond the reach of domestic budgets.

These costs, however, need to be balanced against the extraordinary impact that investing in MDGs 4 and 5 will have. Experts estimate that investing in both MDGs will save an estimated 20 million lives: 3 million mothers, 15 million



children and an estimated 3 million infants who would otherwise have been stillborn.

Forty per cent of these costs will be needed to strengthen health systems. This means funding the building of hospitals and clinics, purchasing equipment, maintenance, electricity, running water, vehicles, paying salaries, providing training, stockpiling drugs and offering incentives for new and existing staff. However, these types of expenditure will not only benefit mothers, their babies and children, but will also improve the health of the entire population. More direct costs include family planning (9%), antenatal care (7%), hospital or clinic births (18%) postnatal care (3%) and child health care (23%).

Source: Global Campaign for the Health Millennium Development Goals: Progress Report. NORAD, Norway (2008).

loss of life, death of a newborn, isolation, spousal abandonment, stigma and discrimination.

New Media Tools

FistulaNetwork.org: New media has become increasingly critical. An Internet portal, FistulaNetwork.org, was launched in 2008 to exchange and share information. UNFPA developed the site on behalf of the international Obstetric Fistula Working Group and it now serves as a tool to improve Campaign coordination and collaboration.

FistulaNetwork.org includes resources on prevention, treatment and reintegration as well as the latest news and updates on events and activities.

Facebook

A 'Campaign to End Fistula' group was launched on the Internet social site, Facebook. Numbering more than 500 members, it is an online community and forum targeting interested users and donors, and is designed to heighten awareness about the Campaign and its activities worldwide.



Chris de Bode/Panos Pictures / UNFPA
Kebbi State, Nigeria: The ulama of Kebbi, seated around one of the boxes in which they collect money to pay the medical expenses of pregnant women.

CHALLENGES

The Campaign to End Fistula has grown rapidly and made remarkable progress during the five years since it launched. Channeling successes into ongoing momentum while, at the same time, expanding services is necessary to its continued success. However, every initiative benefits from a sober assessment of lessons learned. This will help refine the Campaign and address gaps.

Because multiple partners are engaged at the national, regional and global levels, **coordination** is an essential element of effective fistula programming. Ongoing efforts, however, need to be sustained to engage and more fully develop communication channels between all partners—including national governments. This will ensure that fistula programmes are comprehensive and meet the needs of women. UNFPA is uniquely positioned to work on coordination strengthening at both global, regional and country levels.

At the global level, UNFPA serves as the Secretariat of the international Obstetric Fistula Working Group, and continues to bring to the forefront discussions around partnership and coordination. As part of this effort to build upon existing coordination mechanisms, the Campaign is working with partners to complete a functional and geographic mapping of fistula prevention, treatment and reintegration efforts at the global, regional and country levels. In 2010, this information will be disseminated through knowledge sharing. At the national level, UNFPA works with partners to improve communication and collaboration. UNFPA country offices facilitate the establishment of networks that include relevant ministries, international and national NGOs, CSOs, women's associations and fistula care providers.

The ultimate goal of the Campaign and the solution to the problem is **to prevent fistula in the first place**. However, this continues to pose special challenges—including how

best to meet the increasing demand for skilled attendance that is generated by community mobilization and the offer of free maternal services in some countries. In order to do so, it will be necessary to continue to invest in the health system. Quality of care is also an issue, with several Campaign countries reporting that iatrogenic fistula, a fistula caused accidentally as a result of a medical intervention, is a major issue. Ongoing training of EmONC within the context of supportive supervision is needed to ensure that women receive the quality of care required.

Working within complex humanitarian settings, including post-conflict contexts, presents particular challenges to the delivery of fistula prevention and treatment. Conflicts destroy communities, health infrastructure and social systems, leaving women and girls especially vulnerable. Facilities providing prevention services—including family planning, prenatal care, assisted delivery and emergency obstetric care—are often ruined, inaccessible or unavailable. One of the dramatic consequences can be an increase in the occurrence of obstetric fistula. Volatile security situations, such as those in **Afghanistan, Darfur** and the **DRC**, can severely limit mobility and even further reduce access to fistula prevention and treatment.

Overcoming barriers to both prevention and treatment services is an ongoing challenge. These include penetrating isolated and remote zones where the majority of women living with fistula reside—areas already compromised by inadequate facilities and a dearth of health-care personnel. The costs associated with prevention, such as family planning and EmONC, as well as transportation to healthcare facilities, are high.

Cultural perceptions and beliefs that go against hospital-based delivery and caesarean section also prevent many women from accessing services. Long distances and the absence of waiting homes near facilities further constrain



Chris de Bode/Panos Pictures / UNFPA
Katsina State, Nigeria: Women await
consultation at a fistula treatment centre.

access to care. Furthermore, many families have no idea that these even exist. The low-status of women and girls in general can also prevent many from requesting a hospital-based delivery or treatment once fistula develops.

The majority of Campaign countries also report that there is a need for trained health-care personnel. Trained providers are often transferred to new positions, thereby creating a ‘care vacuum’. Additionally, countries face difficulties in maintaining staff trained to deal with fistula—many are either drawn away to undertake other tasks or leave for more lucrative pursuits. This is further complicated by the uneven distribution of trained staff between urban centres and isolated, rural areas. Staff engaged in fistula management and care can lose motivation—with fistula services perceived as additional work rather than part of regular service provision.

In many countries, the capacity to **monitor programme activities and evaluate programmatic efforts** (M&E) is limited. Many Campaign countries are working to build M&E capacity, but it is an ongoing process that requires government investment. Fistula treatment is usually not tracked at the national level, which limits the ability to gather and analyze data and thus to improve service provision and fill in the gaps.

Working with fistula survivors presents unique opportunities, but also challenges that need to be adequately addressed. These women are frequently among the most poor and marginalized, with little formal education and limited economic opportunity. As the work with fistula advocates develops, it will be necessary to identify and support additional economic empowerment opportunities. Fistula advocates deserve appropriate training—not only to improve their skills as advocates, but also to meet their own personal goals. Survivors can help identify solutions and contribute important insights that will enhance future programming. How to further develop their unique capacity and contributions is an important Campaign goal.

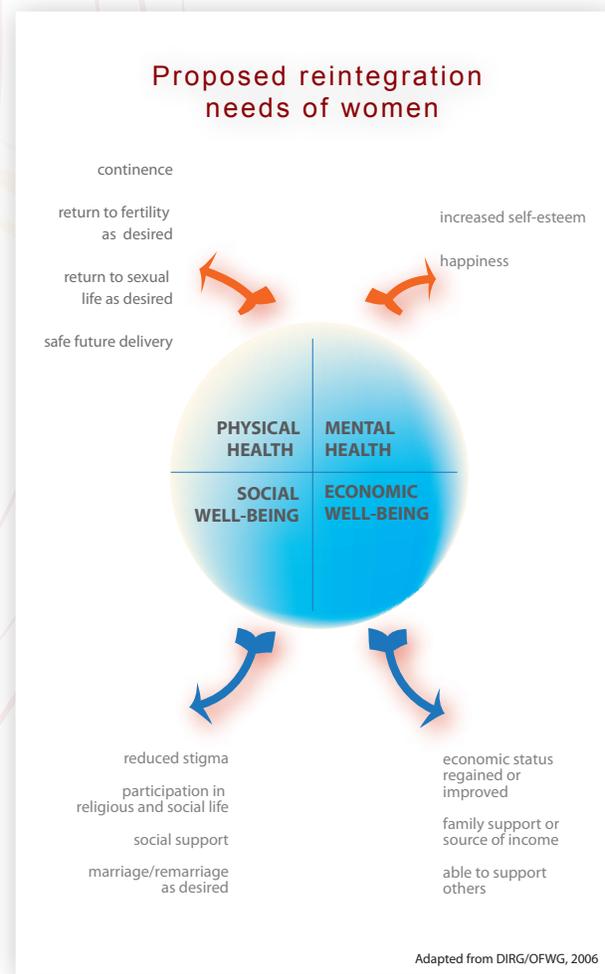
Reintegrating survivors into their communities also presents a special set of challenges. What this actually means in practice is still being defined and refined. What an individual requires in order to return to her community

depends on her own circumstances and context. These include how long she has lived with fistula, the extent of the stigma and discrimination experienced and to what degree surgery was—or was not—successful.

It is essential to continue research efforts to collect data regarding reintegration expectations and quality of life outcomes following treatment. This involves working closely with survivors to achieve a comprehensive definition of reintegration. Follow-up, however, can be expensive and difficult.

The absence of social workers is also a problem. How reintegration is undertaken requires further analysis—whether it should be done via the hospital system or through occupational training or women’s empowerment programmes. Improved documentation and evaluation programmes will help build the evidence base.

Figure 5





Chris de Bode, Panos Pictures / UNFPA

Katsina State, Nigeria: 14-year-old Gaje Ganuwa holding her new-born baby, Rkno. Both mother and baby would not have survived the delivery if it weren't for Gaje's friend who brought her to the nearest health centre when she realized Gaje was suffering complications.

Chapter three

LESSONS LEARNED

The Campaign is committed to reinforcing south-south collaboration efforts by identifying and facilitating linkages between countries. Opportunities include transferring knowledge and skills, treatment and training, the development and implementation of national media and communication approaches, and the integration of best practices. For example, the Campaign helps facilitate professional relationships between expert fistula surgical trainers and countries that need to develop human resources to provide fistula management and care. These enhance skills-transfer and, ultimately, the lives of thousands of women living in poorer countries.

In addition to knowledge-transfer between countries, the Campaign is exploring the option of ‘task-shifting’ from specialists to mid-level practitioner providers who, once trained, can be qualified to offer simple fistula treatment. This is one way to address the serious shortage of skilled personnel.

A team approach is also central to the Campaign and ranges from the provision of care to community mobilization. Team-based training develops the technical capacity of health personnel, including surgeons, anaesthesiologists and nurses—all of whom contribute to the comprehensive care of women living with fistula.

This is perhaps best illustrated by country examples characterized by a network of social workers, community educators and fistula survivors who work together to educate and mobilize the community. This in turn can solidify links between the community as a whole and the health centre that serves it. The team approach also helps strengthen linkages between communities and facilities – as specific members of clinical teams may have responsibility for elements of follow-up post-fistula treatment.

It is rare to hear the voices of women who have experienced maternal health complications first-hand, as

many of them do not live to speak out. The empowerment of fistula survivors advances development by respecting their rights to actively engage in dialogue about decisions affecting their lives.

Fistula survivors are highly effective in raising awareness at all levels—testifying to the impact of maternal morbidity on the quality of women’s lives and adding a new voice to maternal and reproductive health advocacy. They shed light on the reality of obstetric complications, contributing helpful information for more effective safe-motherhood programming.

Survivors are working to increase attention to maternal health issues within national and global policy dialogue. Additionally, fistula survivors provide important peer support to other women living with the condition—through community outreach and case finding, engagement with women’s groups, and through continued engagement at treatment facilities.

Countries engaged in the Campaign want to highlight those individuals and organizations working effectively to address fistula prevention and treatment. These champions are often under-acknowledged despite their significant contributions to the efforts. Seventeen countries nominated a total of 21 champions—highlighting the important contributions made by physicians, nurses, civil society organizations, fistula survivors, policy makers and others. Showcasing their dedication and commitment may help to increase the visibility of those who toil on behalf of women everywhere. These champions are an inspiration that will encourage others to either begin or continue to work to eliminate fistula.



Warrick Page, Panos Pictures / UNFPA

Islamabad, Pakistan: The mother of a 35-year-old fistula patient handles prayer beads at the Pakistan Institute for Medical Sciences (PIMS) Hospital. Her daughter, Zahra, has lived with fistula for two years following a failed hysterectomy. Zahra has three children and—a rarity among survivors—a supportive husband.

THE YEARS AHEAD: MOVING FORWARD

Obstetric fistula and the global Campaign to End Fistula lies at the heart of the UNFPA mandate to make every pregnancy wanted, every birth safe and ensure that every woman is treated with dignity and respect. The campaign to End Fistula has grown rapidly since it first launched in 2003. Today the majority of Campaign countries are implementing programmes, saving and restoring lives.

Now active in more than 45 countries, the Campaign does not plan to expand into many additional countries, but will instead, emphasize full and comprehensive implementation within existing countries. In 2009, the Campaign will continue to support fistula programmes—technically and financially—with an eye towards future sustainability.

In order to do so, more and better data are required. The Campaign to End Fistula is working globally, regionally and nationally to redress this gap. Data collected as part of a Johns Hopkins/UNFPA/WHO research study will inform fistula programming, both in terms of clinical outcomes and in the area of women's quality of life following treatment. Additionally, the research study emphasizes the need to strengthen the capacity of national research/academic institutions so that they can undertake similar research studies in the future. This will, in turn, contribute to the feasibility of collecting and analyzing fistula data during the coming years.

To ensure the integrated provision of technical support and more efficient reporting, UNFPA has begun a process of aligning its Reproductive Health Thematic Funds—the Maternal Health Thematic Fund (MHTF), the Obstetric Fistula Thematic Fund and the Global Programme on Reproductive Health Commodity Security (GPRHCS). Considering the synergy of the prevention efforts of the Campaign and the MHTF, the two thematic funds will be more closely integrated, thereby reducing overall transaction costs. However, the Campaign to End Fistula will remain an independent entity and a central focus of UNFPA's work.

The global Campaign mid-term evaluation will increase the understanding of why, where and how the Campaign has been successful, and evaluate whether the Campaign approach—with its multiple strategies undertaken simultaneously at national, regional and global levels—has assisted in ending fistula. In addition, it will contribute to the evidence-base and answer critical questions regarding fistula-related programme effectiveness and its relationship to other maternal health programmes. It is hoped that evaluation findings and recommendations (expected by late 2009) will result in improvements at the policy, service and community levels.

Work with fistula advocates—survivors who speak out on behalf of improved maternal health—will continue to grow. The Campaign is compiling lessons learned and specific recommendations regarding how best to utilize this unique resource. The aim is to promote a fully participatory approach with fistula survivors as recognized experts whose voices are part of the maternal health and broader sexual and reproductive health dialogue. In 2009, efforts will focus on continued engagement and capacity development opportunities, including how best to link fistula survivors to existing networks, such as youth associations—the better to facilitate the development of new peer communities and potential alliances.

Today, the Campaign is experiencing great momentum both globally and in those countries characterized by strong fistula programmes. In a bid to reach as many women and girls as possible, the Campaign is communicating successes, developing partnerships and disseminating programme information. The coming year will see even greater outreach efforts—both locally and internationally.

Fistula is not a disability of the past: It is very much of the present. Eliminating it will require sustainable financing, commitment and dedication.

Annex I: Donors to Campaign to End Fistula, 2008

Donors	US\$ [†]
Luxembourg	4.57
Spain*	1.90
Korea, Republic of	0.49
Zonta International Foundation	0.25
Americans for UNFPA**	0.22
European Voice	0.04
Poland	0.04
UNFIP	0.03
Private/Individual	0.02
Total	7.5

[†] amount in millions

*Includes contribution from Spain MDG Achievement Fund

**Includes contribution from Johnson and Johnson

Annex II: Campaign To End Fistula : Approved Allocations For 2008

Country/ Global Activity	2008 Allocations In US\$	Funding Source
Country Level		
Afghanistan	107,000.00	Fistula Thematic Trust Fund
Bangladesh	232,482.00	Fistula Thematic Trust Fund
Benin	300,000.00	Fistula Thematic Trust Fund
Cameroon	218,000.00	Catalonia
Central African Republic	125,000.00	Australia
Chad	100,000.00	Luxembourg
Côte d'Ivoire	100,000.00	Luxembourg
	321,627.00	Fistula Thematic Trust Fund
Democratic Republic of the Congo	282,964.00	Catalonia
	17,319.00	United Nations Foundation
	263,740.00	Fistula Thematic Trust Fund
Eritrea	276,228.00	Fistula Thematic Trust Fund
	160,000.00	Johnson & Johnson
Ghana	100,000.00	Luxembourg
Guinea	329.198	Fistula Thematic Trust Fund
Guinea Bissau	21,937.00	Fistula Thematic Trust Fund
Kenya	20,299.00	United Nations Foundation
	542,490.00	Fistula Thematic Trust Fund
Lesotho	48,640.00	Fistula Thematic Trust Fund

Liberia	620,763.00	Fistula Thematic Trust Fund
Malawi	203,300.00	Fistula Thematic Trust Fund
Mali	61,527.00	Human Security Fund
Mauritania	250,000.00	Fistula Thematic Trust Fund
	362,000.00	Luxembourg
Niger	238,610.00	Fistula Thematic Trust Fund
Nigeria	663,000.00	Human Security Fund
Pakistan	273,323.00	Fistula Thematic Trust Fund
Senegal	60,000.00	Luxembourg
	279,805.00	Fistula Thematic Trust Fund
Sudan	250,000.00	Fistula Thematic Trust Fund
Swaziland	16,050.00	Fistula Thematic Trust Fund
Timor Leste	97,370.00	Fistula Thematic Trust Fund
Togo	20,000.00	Americans for UNFPA
Uganda	60,000.00	Luxembourg
Country Sub-Total	7,022,672.00	
Global/Regional Level		
Africa Regional Office (ARO)	677,174.00	Fistula Thematic Trust Fund
Asia and Pacific Regional Office (APRO)	169,595.00	Fistula Thematic Trust Fund
Arab States Regional Office (ASRO)	58,561.00	Fistula Thematic Trust Fund
Media and Communications Branch	155,000.00	Americans for UNFPA
	130,585.00	Fistula Thematic Trust Fund
Technical Support Division	491,302.00	Fistula Thematic Trust Fund
Global/Regional Sub-total	1,682,217.00	
Grand Total	8,704,889.00	

*Figures are provisional, subject to certified financial statements issued by UNFPA.

Annex III: Campaign To End Fistula : Expenditures 2008

Country/ global activity	Funding source	Programme funds	Expenditures	Balance
COUNTRY LEVEL				
Afghanistan	Fistula Thematic Trust Fund	107,000.00	106,908.91	91.09
Bangladesh	Fistula Thematic Trust Fund	232,482.00	105,832.43	126,649.57
	Luxembourg	48,473.00	47,546.07	926.93
Benin	Fistula Thematic Trust Fund	300,000.00	229,352.92	70,647.08
Cameroon	Catalonia	233,509.00	129,945.00	103,564.00
Central African Rep	Australia	125,000.00	28,630.11	96,369.89
Chad	Luxembourg	100,000.00	-	100,000.00
Côte d'Ivoire	Luxembourg	150,000.00	104,007.52	45,992.48
	Fistula Thematic Trust Fund	382,730.64	343,248.43	39,482.21
Democratic Republic of the Congo	Australia	9,300.00	8,649.00	651.00
	Catalonia	282,964.00	181,310.00	101,654.00
	United Nations Foundation	17,319.00	11,011.00	6,308.00
	Fistula Thematic Trust Fund	441,430.00	209,211.70	232,218.30
Eritrea	Fistula Thematic Trust Fund	307,560.00	226,808.69	80,751.31
	Americans for UNFPA	-	46,154	(46,154.00)
	Johnson & Johnson	234,988.62	198,673.00	36,315.62
Ethiopia	Austria	104,873.00	87,211.22	17,661.78
Ghana	Luxembourg	262,543.08	92,808.48	169,734.60
Guinea	Fistula Thematic Trust Fund	95,376.00	62,562.35	32,813.65
Guinea Bissau	Fistula Thematic Trust Fund	21,937.00	15,816.00	6,121.00
Kenya	Americans for UNFPA	65,230.00	-	65,230.00
	United Nations Foundation	20,299.00	9,080.00	11,219.00
	Fistula Thematic Trust Fund	542,490.00	445,786.73	96,703.27
Lesotho	Fistula Thematic Trust Fund	48,640.00	44,266.81	4,373.19
Liberia	Fistula Thematic Trust Fund	708,484.97	655,893.19	52,591.78
Malawi	Fistula Thematic Trust Fund	203,300.00	160,239.69	43,060.31
Mali	Luxembourg	-	737.51	(737.51)
	Human Security Fund	73,300.00	67,064.73	6,235.27
Mauritania	Fistula Thematic Trust Fund	250,000.00	222,191.00	27,809.00
	Luxembourg	362,000.00	348,674.64	13,325.36
Niger	Fistula Thematic Trust Fund	238,610.00	220,296.16	18,313.84
Nigeria	Fistula Thematic Trust Fund	38,251.00	85,816.76	(47,565.76)
	Human Security Fund	920,292.00	4,299.26	915,992.74
	Americans for UNFPA	46,204.35	46,313.00	(108.65)
Pakistan	Fistula Thematic Trust Fund	279,343.00	171,286.34	108,056.66
	Human Security Fund	-	47,593.99	(47,593.99)
Senegal	Luxembourg	60,000.00	57,583.25	2,416.75
	Fistula Thematic Trust Fund	299,391.00	122,324.20	177,066.80

Somalia	Americans for UNFPA	15,000.00	15,408.70	(408.70)
Sudan	Fistula Thematic Trust Fund	250,000.00	181,783.00	68,217.00
Swaziland	Fistula Thematic Trust Fund	16,050.00	8,744.78	7,305.22
Timor Leste	Fistula Thematic Trust Fund	97,370.00	37,183.00	60,187.00
Togo	Americans for UNFPA	20,000.00	19,905.25	94.75
Uganda	Luxembourg	60,000.00	26,324.97	33,675.03
Zambia	New Zealand	234,291.00	176,021.00	58,270.00
GLOBAL/REGIONAL LEVEL				
Africa Regional Office (ARO)	Fistula Thematic Trust Fund	677,174.00	511,078.16	166,095.84
Asia & Pacific Regional Office (APRO)	Fistula Thematic Trust Fund	169,595.00	58,995.65	110,599.35
Arab States Regional Office (ASRO)	Fistula Thematic Trust Fund	84,259.00	47,423.71	36,835.29
Media and Communications Branch	Australia	15,868.00	7,243.90	8,624.10
	Fistula Thematic Trust Fund	254,116.50	217,106.70	37,009.80
Technical Support Division	Fistula Thematic Trust Fund	252,727.00	178,932.00	73,795.00
	Luxembourg	82,360.00	82,360.00	-
	Americans for UNFPA	58,798.00	58,798.00	-
	Australia	15,564.00	14,581.62	982.38
Grand Total		9,916,493.16	6,587,024.53	3,329,468.63
*Figures are provisional subject to certified financial statements issued by UNFPA.				



Chris de Bode: UNFPA/Panos Pictures
Osun State, Nigeria: a young mother waits
for care at a free maternal health clinic.





The UNFPA-led global Campaign to End Fistula is helping to prevent and treat fistula, and support women after surgery. The Campaign is working in more than 45 countries across Africa, Asia and the Arab region.

United Nations Population Fund
220 East 42nd St., New York, New York 10017 USA
www.endfistula.org

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.