

The Campaign to End Fistula



2005 Annual Report



Campaign 
to End Fistula

LIST OF ACRONYMS

DHS	Demographic and Health Surveys
FIGO	International Federation of Gynaecology and Obstetrics
ICPD	International Conference on Population and Development
ICM	International Confederation of Midwives
IEC	Information, Education and Communication
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Surveys
NGO	Non-Governmental Organization
OFWG	International Obstetric Fistula Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
VVF	Vesicovaginal Fistula
VSO	Voluntary Service Overseas
WHO	World Health Organization

EXECUTIVE SUMMARY

Obstetric fistula – one of the most devastating pregnancy-related disabilities – affects more than two million girls and women in developing countries. These women, who have suffered a near-death experience and often the loss of their baby, are living testimony to the challenges and gaps that persist in maternal health. An entirely preventable and treatable condition, fistula was virtually eliminated in industrialized nations more than 100 years ago through improved obstetric care. Its continued existence in resource-poor areas represents a visible violation of a woman's right to health and a life of dignity.

In 2003, UNFPA and partners launched the global Campaign to End Fistula, which includes interventions to prevent fistula from occurring, treat women who are affected and help women who have undergone treatment return to full and productive lives. The Campaign's ultimate goal is to make fistula as rare in developing countries as it is in the industrialized world today. The target for achieving fistula elimination is 2015, in line with ICPD and MDG targets.

In just a few short years, the Campaign – presently active in more than 35 countries in sub-Saharan Africa, Asia and the Arab region – has achieved remarkable success. At least 25 countries have already carried out assessments to document the extent of the problem and their existing capacity to address fistula, and 15 countries have reached full implementation of their national elimination programmes. Countries have made headway in reducing the silence and stigma that surrounds the condition and have begun to strengthen maternal health systems to ensure that fistula becomes part of the past in every community throughout the world.

Significant gains also have been made at global and regional levels. UNFPA's leadership and advocacy have been instrumental in raising awareness of fistula and drawing recognition among public health professionals, the media, policymakers, and the general public that fistula is a widespread problem in countries with high maternal mortality rates, but through joint efforts, it can be eliminated. Most importantly, consensus among UNFPA and its partners has been built in key areas to guarantee a united and coordinated front in the fight against fistula.

The Campaign is at a vital point requiring substantial investments to build on the current momentum in order to meet countries' technical and financial needs as they advance their national fistula elimination programmes. Additional resources are also required to adequately provide global and regional support for the Campaign. UNFPA's funding requirements for the Campaign's next five-year period (2006-2010) are \$78.3 million. Actions taken to end fistula will directly contribute to achieving our common international development goals, recently reaffirmed at the 2005 World Summit. Together, we can make safe and healthy childbirth a reality for all women.

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I. INTRODUCTION

Obstetric fistula is a devastating childbirth injury that leaves women incontinent, ashamed and often isolated from their communities. Preventable and treatable, it is a condition no woman should have to endure. UNFPA and partners launched the Campaign to End Fistula in 2003, focusing on three key interventions: prevention, treatment, and support to women after surgery. The Campaign's ultimate goal is to make fistula as rare in developing countries as it is in the industrialized world today as part of global efforts to improve maternal health. The target for achieving fistula elimination¹ is 2015, in line with ICPD and MDG targets.

Obstetric fistula provides a unique entry point to focus efforts on tackling maternal mortality and morbidity. Women with fistula are living testimony to the challenges and gaps faced in maternal and newborn health. Obstetric fistula can serve as a tracer condition to identify places where access to and utilization of maternal health care continue to be poor or nonexistent. Therefore, actions taken to eliminate fistula by 2015 will strongly contribute to reaching maternal and newborn health targets of MDG 4 & 5 and the ICPD target of universal access to reproductive health by 2015.

By the end of 2005, more than 35 countries in sub-Saharan Africa, Asia and the Arab region had begun the fight against fistula, with new countries continuing to join. Gains had also been made at the global and regional level by building consensus among medical and public health experts on several technical areas pertaining to fistula and by raising awareness of and mobilizing resources for this long-neglected issue among policymakers, donors, journalists and the general public.

The six sections of this report provide an overview of the demonstrable results achieved by the Campaign through country, regional and global activities in 2005. Section II focuses on country-level progress, including findings from needs assessments; national advocacy and policy activities; and prevention, treatment and reintegration efforts. Global and regional achievements, highlighted in Section III, focus on key technical forums and their outcomes, South-South networking and major media coverage and advocacy initiatives. Sections IV and V document lessons learned and the strategic direction of the Campaign over the next five year period (2006-2010). Lastly, provisional financial data and the *Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula* are included in the Annex.

ABOUT OBSTETRIC FISTULA

An entirely preventable and treatable condition, obstetric fistula was virtually eliminated in industrialized nations more than 100 years ago through improved obstetric care. Yet fistula continues to affect the most marginalized members of the population in developing countries – poor, young, illiterate girls and women in remote regions. Obstetric fistula persists in resource-poor areas because health care systems fail to provide accessible quality maternal health care – including family planning, skilled birth attendance and emergency obstetric care – and affordable treatment and rehabilitation for those suffering from the condition. It also reflects underlying poverty and gender-based inequities that hinder women from accessing services, even when they are available. Malnutrition, early marriage followed by early pregnancy, lack of opportunities for women and girls and certain harmful traditional practices (e.g. preference for delivery without skilled personnel) also are underlying factors. Consequently, fistula represents a visible violation of a woman's right to health and a life of dignity.

Obstetric fistula is typically the result of prolonged and obstructed labour, without timely and appropriate medical attention, usually a Caesarean section. The pressure of the baby's head against the mother's pelvis causes extensive tissue damage, leaving a hole between her vagina and bladder or vagina and rectum, making her incontinent of urine and/or faeces. In most cases, the baby does not survive. Women with fistula experience medical problems such as frequent bladder infections, painful genital ulcerations, kidney failure and infertility. The social consequences of the condition are life shattering: the humiliating smell combined with misperceptions about the condition often cause women to be stigmatized within their communities and abandoned by their husbands. This physical and emotional isolation is frequently accompanied by a loss of financial support and inability to work, further deepening their poverty.

At least two million girls and women² around the world live with fistula and at least 73,000 more are affected each year.³ Some health providers have estimated that incidence may be as high as 2 to 5 fistula cases per 1,000 deliveries in areas that lack access to

emergency obstetric care.⁴ Accurate population-based data, however, are scarce, reflecting the long neglect of the condition and the difficulty in locating these "hidden" women. Prevalence is believed to be highest in impoverished communities in sub-Saharan Africa and parts of Asia, as maternal and reproductive health is known to be poor in these regions.

UNFPA: LEADING PARTNERSHIPS FOR COORDINATED ACTION

UNFPA is leveraging the power of partnerships to make motherhood safer, especially for the poorest and most vulnerable women, to achieve MDG 5. Launched by UNFPA and partners in 2003, the Campaign to End Fistula is an integral component of UNFPA's overall strategy to improve maternal health, and includes interventions to prevent fistula from occurring, treat women who are affected and help women who have undergone treatment return to full and productive lives. The Campaign's ultimate goal is to make fistula as rare in developing countries as it is in the industrialized world today. The target for achieving fistula elimination is 2015, in line with ICPD and MDG targets.

National ownership and leadership of fistula elimination efforts are the foundation of the Campaign. Currently active in more than 35 countries in sub-Saharan Africa, South Asia and the Arab region, the Campaign has been an effective entry point for drawing national attention to the broader issues of maternal health and the solutions necessary for reaching MDG 5. It is also highlighting the relationship between poverty and equitable access to reproductive health.

To ensure a clear course of action at the national level, each Campaign country undergoes three programmatic phases: 1) rapid needs assessment; 2) collaborative planning of a national fistula elimination strategy/action plan; and 3) implementation of the national fistula elimination programme. In addition, the Campaign's three strategic intervention points – prevention, treatment and reintegration – are flexible to allow for country context and designed to situate fistula within ongoing UNFPA Country Programmes and national maternal health programmes and policies.

At global and regional levels, the Campaign aims to increase awareness of fistula; enhance the social

and political environment for maternal health; develop international and regional partnerships for coordinated action; build the evidence base for fistula-related interventions; and stimulate action for access to services.

The Campaign includes myriad partners, working together to ensure a coordinated response to effectively eliminate fistula. The most important partners in the effort to end fistula are the governments of Campaign countries. At the national level, partnerships between UNFPA, the government, civil society organizations and public health professionals are being formed while local coalitions are also being developed to enlist the commitment of communities and religious and traditional leaders to prevent maternal death and disability.

At the international level, the Obstetric Fistula Working Group (OFWG) comprised of UN agencies including WHO and UNFPA; professional societies including FIGO and ICM; and international and regional NGOs including EngenderHealth, Women's Dignity Project and Columbia University's Averting Maternal Death and Disability (AMDD) Programme helps to ensure greater coordination and collaboration in global and regional aspects of the Cam-

paigned to End Fistula. UNFPA also is building partnerships with the private sector.

Within UNFPA, an interdivisional working group manages the Campaign in regular consultation with country offices and Country Technical Services Teams, with each member bringing the specific expertise of their divisions to ensure that all necessary components – programmatic, technical, funding, media, advocacy – are in place.

RESOURCE MOBILIZATION

UNFPA is grateful to all donors who have contributed to the Campaign, enabling the Fund to successfully support more than 35 countries in their fight against fistula. In 2005, the Campaign received US\$ 4.8 million⁵ from donors, including the governments of Australia; Finland; Iceland; Kingdom of Spain, Autonomous Community of Catalunya; Luxembourg; Poland; and Sweden; The Bill & Melinda Gates Foundation (through EngenderHealth); Johnson & Johnson (through Americans for UNFPA); Virgin Unite; and individuals, primarily through Americans for UNFPA.

II. PROGRESS IN CAMPAIGN COUNTRIES

The Campaign is currently active in more than 35 countries in sub-Saharan Africa, Asia and the Arab region. As of December 2005, 25 countries had completed needs assessments to determine the extent of the problem, and 15 of those countries had begun to implement their national fistula elimination programmes within the broader context of maternal health programmes and policies.

NEEDS ASSESSMENT: BUILDING THE KNOWLEDGE BASE

Through needs assessments, qualitative studies and other research, understanding and awareness of the condition have increased significantly since the launch of the Campaign. During the last year, in-depth studies about the social and cultural determinants and consequences of fistula have deepened our knowledge of the factors underlying maternal death and disability. In addition, rapid needs assessments of capacity to

provide prevention and treatment have been carried out in a number of new countries. The findings from this research are assisting countries to build commitment and to plan their responses. Some countries have also begun to explore methods for obtaining better estimates on the prevalence of the condition.

During the reporting period, initial needs assessments were carried out in Central African Republic, Democratic Republic of Congo, Equatorial Guinea, Sierra Leone, Somalia, and South Africa, and Benin conducted further in-depth research on fistula. The studies varied in length, scope and methodology, as these were defined at the national level and were typically carried out in collaboration with the government and other key stakeholders. Nearly all countries in sub-Saharan Africa and the Arab region with suspected high prevalence have now embarked on or completed assessments. In the Asia and Pacific Region, several new studies began near the end of 2005.

Status of the Campaign to End Fistula at Country Level (April 2006)

Campaign Phase	Campaign Country		
	Africa	Asia	Arab States
Phase I: Needs Assessment	Angola, Central African Republic, Congo, Democratic Republic of Congo, Equatorial Guinea, Guinea, Liberia, Senegal, South Africa, Togo	East Timor India Nepal	Somalia, Yemen
Phase II: Planning Phase	Cameroon, Ghana, Mozambique, Rwanda, Sierra Leone	Pakistan	Djibouti, Sudan
Phase III: Implementation of National Programme	Benin, Burkina Faso, Chad, Eritrea, Ethiopia, Kenya, Malawi, Mali, Mauritania, Niger, Nigeria, Tanzania, Uganda, Zambia	Bangladesh	

Ongoing conflict in the **Democratic Republic of Congo** has resulted in increasing poverty and degradation of the health system, creating conditions that often lead to maternal death and disability, including obstetric fistula. The situation analysis on fistula in the country, conducted by the Ministry of Health and UNFPA, was the first assessment to incorporate aspects of traumatic gynaecologic fistula due to sexual violence. Through the study, 432 cases of fistula were identified, of which approximately 86 per cent were due to obstetric causes and 14 per cent attributed to sexual violence. Women with fistula of obstetric origin endured an average of three days of obstructed labour, travelling more than 12 kilometres to seek care by foot, vehicle, bicycle and canoe. Eighty per cent of the women with fistula due to traumatic causes reported having experienced three or more acts of sexual violence. These findings illustrate the complexity of the situation, requiring efforts to rebuild health system capacity to provide prevention and treatment care, to ensure appropriate care for the survivors of sexual violence and to put an end to sexual violence.

The civil war in **Somalia** has similarly led to a near collapse of the health system, leaving women with few to no options when they encounter complications during delivery. A rapid assessment of emergency obstetric care and obstetric fistula was conducted in early 2005 in Puntland and Somaliland, which revealed the limited number of health personnel, the poor state of health facilities and the dearth of supplies and essential drugs at these facilities. Awareness exists at all levels within the health sector and among women of childbearing age that obstetric fistula is a complication of childbirth, but currently no national plan or programme for organized prevention, treatment or rehabilitation care exists. Political instability as well as lack of human resources and basic health services make it difficult at this time to establish a centre for treatment although the need appears to be immense. The assessment's recommendations, therefore, call for robust investment to improve access to skilled care at delivery, including emergency obstetric care, and to provide treatment through outreach programmes.

While the discovery of oil has helped the economy flourish, access to quality maternal health care remains weak in **Equatorial Guinea**, particularly in remote regions on the mainland and in the island regions. A nationwide survey on obstetric fistula by the government, UNFPA and the European Union revealed

that the majority of deliveries occur at home (51%) or at health posts or centres (16%) attended by traditional birth attendants or health agents. Causes of obstetric fistula were well understood among doctors, nurses and midwives, yet very low knowledge was found among health agents and traditional birth attendants. The absence of treatment for those women living with obstetric fistula is evidenced by the fact that nearly half of the women identified had lived with the condition for more than 10 years, some as long as 30 years. The regional hospitals in Malabo and Bata were identified as facilities that could provide fistula treatment and care while provincial hospitals require strengthening to provide quality emergency obstetric care to prevent fistula. The midwifery training initiated by the National Programme for Reproductive Health is a positive step towards increased access to skilled care.

Building on the rapid assessment performed in 2002, **Benin** conducted a qualitative assessment to better understand the social and cultural perspectives of the condition. The study found that communities, spouses and close family members' reactions to fistula are mostly positive, either providing assistance to (41%) or accepting (23.1%) women living with fistula. However, one in five women had still been abandoned by their husband and/or family. Conversely, health personnel were found to be less accepting or reluctant to provide care because of the odour of urine or faeces or for fear of contamination. The causes of fistula are still widely misunderstood in the community and among the women themselves, with respondents citing bad fate, sorcery, punishment for adultery, prostitution and lack of respect for sociocultural norms and taboos. High costs, shame, ignorance about the possibility of a cure and where to seek it, geographical barriers and the low number of qualified specialists are the principal obstacles to treatment. Women often seek traditional medicine when they lack the financial means for modern medical care or in cases of unsuccessful surgical repair.

In 2005, a number of countries began exploring methods to gain more accurate measures of the prevalence of obstetric fistula. **Nepal** embarked on a cross-sectional study, to be completed in 2006, which is exploring a range of reproductive morbidities. In **India**, a community-based cross-sectional study in one district in the state of Maharashtra is focusing on five chronic obstetric morbidities, including fistula, and

will be finalized in 2007. In addition, a number of countries have introduced obstetric fistula into ongoing national household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).

CREATING A FAVOURABLE POLITICAL ENVIRONMENT

Both globally and in the regions where the Campaign is active, particularly Africa, there is growing political commitment and understanding of obstetric fistula as an indication of the persistent gaps in reproductive health care, especially maternity care. In November 2005, UN member states adopted the Resolution on the Girl Child (A/C.3/60/L.18/Rev.1) during the 60th Session of the UN General Assembly (UNGA). For the first time, the resolution included an element on fistula, specifically that early childbearing and limited access to sexual and reproductive health care causes high levels of fistula and maternal mortality and morbidity. The resolution requests that the Secretary-General provides a report on the present resolution, including on fistula, during UNGA's 62nd session. The Call to Action developed for the African region in October 2005 urged governments to take up the fight against fistula as part of the global effort to attain MDG 5 and will help to drive national policy (see Annex).

Campaign needs assessments continue to serve as the key tools to build commitment and guide development of national plans. These plans are nationally led and owned, and many are being integrated into national reproductive health strategies and UNFPA Country Programmes. A number of countries finalized or commenced the development of national plans:

- In **Mauritania**, the first three-year plan of action was developed (2005-2007) and validated by the Ministry of Health and key partners. The strategy focuses on building capacity to treat the condition at two sites, sensitizing the public and health care providers on its prevention and treatment and scaling up efforts to improve emergency obstetric care. During the national reproductive health week, the strategy was disseminated widely to key stakeholders, and implementation began shortly thereafter.
- A draft national strategy for fistula elimination has been developed in **Niger**. The draft document will be finalized by the national Network for the Eradication of Fistula (REF)⁶, to complement the National Health Development Plan (2005-2009) and the National Reproductive Health Programme, which have integrated fistula as a national priority.
- The Nigerian National Committee on VVF continued to meet during 2005 and ensured the finalization of the National Strategic Framework for the Eradication of VVF in **Nigeria**, which will guide all fistula-related interventions in the country. The document has been adopted by the National Council on Health and is in publication.
- A comprehensive framework to address fistula is in development in **Sudan** based on the findings of the needs assessment conducted in 2004. The process was initiated through a workshop of stakeholders held in February 2005 to disseminate the assessment findings and develop the initial outline of the national framework. The workshop was attended by key officials in the government, including the State Minister of Health at the Federal Level and the Reproductive Health and Primary Health Care Directors of the Federal Ministry of Health.
- In **Pakistan**, advocacy and awareness raising seminars were held at two regional fistula centres for government officials, local political leaders, clergy and journalists in order to build commitment for the issue of fistula prior to the formal launch of the fistula elimination initiative in January 2006.
- The Campaign to End Fistula was officially launched by the Minister of Health in **Burkina Faso** in March 2005. National efforts will be guided by the country's integrated plan for safe motherhood and the fight against fistula. The Family Health Department of the Ministry of Health has begun building commitment for the plan by conducting two advocacy visits with administrative and medical officials at the two involved facilities, the mayors in both localities and the governor of the eastern region. Current low awareness and understanding of the condition are a challenge, but the growing interest of health officials and the possibility of inter-sectoral collaboration, par-

ticularly with the Ministry of Social Action and National Solidarity and NGOs, are important opportunities.

Both **Chad** and **Uganda** have begun to integrate fistula elimination into the UNFPA Country Programme. Sensitization on obstetric fistula, as part of reproductive health services as well as IEC for adolescents and rural radio broadcasts, is included in Chad's current Country Programme activities (2001-2005). Chad's new Common Country Programme Action Plan drafted in October 2005 has also incorporated fistula elimination activities within the reproductive health and gender components. During the formulation of the Government of Uganda/UNFPA 6th Country Programme, obstetric fistula was included under the reproductive health component, thereby enabling a comprehensive response to address preventive activities as well as management of patients.

PREVENTING HARM

Richard Stanley photo



Prevention is central to the long-term elimination of fistula as well as to efforts to achieve the targets set by ICPD and the MDGs. Far from being a vertical intervention, the Campaign

is intended to complement and strengthen national safe motherhood efforts. Hence, capacity building to ensure robust, functioning health systems that provide access to a full continuum of maternal health care is at the core of preventing fistula and improving maternal health. UNFPA's overall maternal health strategy, including the Campaign, focuses on three critical components of maternal health care – family planning to ensure that every pregnancy is wanted, skilled birth attendance and emergency obstetric care to ensure that every birth is safe. The Campaign also supports behaviour change interventions and community mobilization through national civil society organizations to address the social and cultural determinants that lead to maternal ill-health.

In **Eritrea**, a baseline survey was conducted in

two rural communities, Kamchuwa and Habero, for a community mobilization/education project promoting safe motherhood and prevention of fistula. The findings showed that more than 96 per cent of women deliver at home. Additionally, 11.8 per cent of women in Kamchuwa and 1.6 per cent in Habero reported having suffered from fistula. The study findings were disseminated during a meeting of more than 30 community members and leaders in Kamchuwa and used to inform the design of an initiative, beginning in 2006, to train and support local maternal health volunteers to teach community members about utilization of antenatal care, recognition of danger signs during delivery and evacuation plans for emergency care when complications arise. At the same time, the referral system for accessing comprehensive emergency obstetric care services at Afabet hospital will be strengthened.

In **Mauritania**, sensitization workshops were carried out to inform all midwives, regional directors of health, general practitioners, and some nurses about fistula prevention and referral. At the national midwifery school, a component on fistula prevention has been included in the curriculum. At least 80 per cent of Mauritanian health personnel have now been informed about the issue of fistula compared to 25 per cent in 2004.

In **Niger**, support groups were formed to help with community-level sensitization. As a result, 2,953 households (3,233 persons) were sensitized, and 50 members of the Muslim Women's Association were trained to raise awareness of fistula prevention.

In **Senegal**, as a result of intensive advocacy and sensitization campaigns, fistula and safe motherhood have been prominently highlighted in the media. Training was provided to journalists, namely members of the network of journalists for population and development and those who have a particular interest in reproductive health issues. In addition, a press trip was arranged to the region of Tambacounda. As a result of these efforts, fistula and safe motherhood programmes were covered in major national newspapers and on television and radio stations. UNFPA, together with the trained journalists, developed an advocacy video, featuring the First Lady of Senegal, Mrs. Viviane Wade, an ardent advocate for greater national commitment to the elimination of fistula.



Although prevention is the cornerstone of the Campaign, there is also a strong commitment to provide immediate help to women suffering from fistula. When the

condition occurs, treatment, including catheterization or surgery followed by a period of post-operative care, can be successful in up to 90 per cent of cases. Needs assessment reports have revealed that fistula treatment services are provided to some extent by individuals and organizations in almost every Campaign country, but are often under-funded and under-supplied. The Campaign focuses on strengthening the capacity of these efforts to provide high quality fistula treatment services and establishing services where none currently exist.

Bangladesh continued to make great strides in the area of fistula treatment and training of human resources. The country was the first to develop a national comprehensive training manual for fistula management intended for both trainers and trainees. In 2005, 45 doctors and 30 nurses were trained in fistula repair. To decentralize services and build capacity in remote regions, "Fistula Camps" were conducted at six regional medical college hospitals throughout the year. As a result, 67 patients were treated, and 659 doctors and nurses were oriented on the causes of fistula and its prevention. In addition, 151 complicated cases of fistula were treated at the Dhaka Medical College Hospital during the reporting period.

Kenya field-tested and finalized a national obstetric fistula training curriculum in 2005, and four training centres have been designated. Two workshops were held in December during which 25 service providers (e.g. 10 doctors and 15 other health professionals including nurses, anaesthetists, physiotherapists and counsellors) from 10 medical centres received training in fistula management and repair. Through the workshops, 41 patients with fistula were repaired.

UNFPA also provided support to four hospitals – namely Machakos, Coast and Nyanza Provincial General Hospitals and Moi Referral/ Teaching Hospital – building their capacity for fistula treatment.

In 2005, UNFPA supported further renovations of Point G Hospital in Bamako, **Mali**. A new 17-bed ward was established for fistula patients, and two operating theatres are now fully equipped and functional for fistula repair. Quality of, and access and utilization to the fistula services has increased: 190 women with fistula were treated during 2005.

In **Niger**, a total of 214 women were treated at the hospitals in Niamey, Zinder and Lamordé. Two Nigerian doctors, one from Zinder and one from Niamey, trained for three months in repair and management of complex cases at Babbar Ruga Hospital in Nigeria under Dr. Kees Waaldijk, an expert fistula surgeon. In addition, six surgeon's assistants and eight nurses from the national hospitals in Niamey and Lamordé were trained in pre- and post-operative fistula treatment. To ensure a continuum of care at all levels of the health system, 600 community health agents were trained in the management of obstetric fistula that can be undertaken at the health post level, including catheter insertion, antibiotic administration and timely referral.

During the Fistula Fortnight – a two-week treatment, training and advocacy initiative that took place in four northern Nigerian states in February/March 2005 – 564 women were repaired and more than 100 medical professionals were trained in fistula management (see supplemental box). Furthermore, UNFPA **Nigeria** provided a full range of fistula surgical equipment and consumables to seven other fistula treatment centres during the year, including Maiduguri Fistula Centre, Borno State; Family Life Centre, Annona State; Ebonyi State Teaching Hospital Fistula Centre; Evangel Hospital Fistula Centre, Plateau State; Fistula Hospital, Zamfara State; Jahun Fistula Centre, Jigawa State; and Karu General Hospital, Nasarawa State. These supplies have resulted in increased access to surgical treatment for fistula clients, and the centres in Borno, Ebonyi and Zamfara states, which were previously non-functional for fistula repair, have resumed surgical treatment for the condition. Through support from the United Nations Trust Fund for Human Security, plans are underway to create a freestanding fistula

treatment centre in Abuja to serve as a regional centre of excellence for treatment, training and research.

In **Uganda**, six regional and national referral hospitals were equipped with specialized fistula equipment and supplies. At Mulago hospital, the operating theatre was rehabilitated, and a six-bed ward was created for post-operative fistula patients. Nine medical doctors and nine nurses/midwives have been trained in fistula management. At least 220 patients were repaired in 2005 during training workshops in Kitgum, Lacor, Arua, Nebbi, Kitovu and Mulago Hospitals.

RENEWING HOPE

Obstetric fistula has been recognized as more than a medical issue. Both the determinants and consequences of fistula are deeply rooted in social and cultural factors. Prevailing abject poverty and sociocultural norms predispose women from resource-poor settings to fistula. The condition compounds their situation, resulting in social, economic and psychological consequences that require care in addition to medical treatment. The Campaign therefore supports concrete interventions to ensure women receive the comprehensive care needed to facilitate their reinte-



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gration into society. UNFPA is partnering with civil society organizations to ensure effective community mobilization and support and to identify the support needed for women to ease their reintegration into society.

On 30 October 2005, **Bangladesh's** first Training and Rehabilitation Centre for fistula patients was inaugurated at Dhaka Medical College Hospital. Within two months, 20 women received literacy education, skills training in home gardening, embroidery, tailoring, knitting and animal husbandry as well as health and hygiene classes. Patients with the greatest need are provided with a sewing machine or a small grant for income generation activities upon discharge from the hospital.

In **Niger**, financial assistance was provided to facilitate the social and economic reintegration of 121 treated women. The women were accompanied for their return home, which allowed for sensitization sessions on maternal health in 120 villages, covering a population of 72,000. Successful reintegration can also lead to prevention of future recurrences of fistula – seven previously treated women returned in 2005 for a Caesarean section as instructed.

In **Chad**, the NGO COTIMAF, managed by nine volunteers, collaborates with hospitals to visit women with fistula, providing them with food and psychological counseling on a weekly basis. In addition, 65 social workers in **Burkina Faso** were trained during a three-day sensitization workshop to assist treated women with social reintegration.



Richard Stanley photo

Zainab Abdu

"I went through a very hard labour; it lasted more than two days. I suffered a lot. I was in agony all over my body. I couldn't even lift my hand. When I was in that agony, I was thinking, 'Is this the way that other women suffer?' I asked for help but nobody was ready to assist me. I asked them to please call my relations, as my relatives are far away from where I am married. I even asked them to take me to the hospital to get help. Nobody was willing to assist me.

After the fistula happened, I would spend all my time crying. I felt that there was no hope. My relatives have been able to reassure me that this can be fixed and I have been sent to Babbar Ruga Hospital. I hope that my fistula can be repaired and that I will be able to live a normal life."

After two years of living with fistula, Zainab was treated during the Fistula Fortnight, a UNFPA-supported initiative in Nigeria.

FISTULA FORTNIGHT



Richard Stanley photo

On 21 February 2005, UNFPA and partners launched the Fistula Fortnight, a two-week advocacy, treatment and training project to address the problem of obstetric fistula in Nigeria – a country believed to have upwards of 400,000 women living with fistula and 20,000 new cases added each year. In preparation for the event, four fistula centres in Kano, Katsina, Kebbi and Sokoto states were renovated and equipped with new surgical supplies. During the two weeks, 564 women with fistula were treated, with an 87 per cent closure success rate. Dozens of Nigerian providers were trained in fistula surgery, post-operative care and counselling, including 12 doctors and 40 nurses. Additionally, four volunteer doctors from the US and UK participated in the Fortnight and will now join the growing roster of mobile surgeons committed to fistula repair.

While providing treatment for hundreds of women, the Fortnight was also a critical tool for fistula prevention. By bringing national attention and support to the issue, the Fortnight, as a first step in Nigeria's national strategy to eliminate fistula, served as an important advocacy tool, highlighting the critical gaps in women's access to quality maternal health services and reducing the stigma surrounding fistula.

The success of the Fistula Fortnight was the result of a unique partnership between the Federal and State Governments of Nigeria, UNFPA, Virgin Unite, the Nigerian Red Cross Society, VSO, health professionals and local NGOs.

III. GLOBAL AND REGIONAL ACHIEVEMENTS

In 2005, UNFPA's leadership and advocacy at all levels were effective in increasing recognition among public health professionals, the media, policymakers and the general public that fistula is a widespread problem in countries with high maternal mortality rates, but through joint efforts, it can be eliminated.

BUILDING PARTNERSHIPS

UNFPA continued to serve as the secretariat of the OFWG. During the reporting period, several meetings of this international coordinating body were held to exchange information among major stakeholders in the Campaign and to build consensus on key issues. New partners, including the Centers for Disease Control and Prevention (CDC) and the Gates Institute at Johns Hopkins University, joined the OFWG in 2005, expanding global efforts to eliminate obstetric fistula through increased availability of resources and expertise.

Additionally, UNFPA is building partnerships with the private sector. Virgin Unite, the independent charitable arm of the Virgin Group, was one of several partners providing support for the February 2005 Fistula Fortnight in northern Nigeria. Throughout 2005, Virgin Unite, together with Campaign Spokesperson Natalie Imbruglia, assisted with awareness raising activities for the Campaign, bringing greater attention to this issue. Rainey Kelly Campbell Roalfe/Y&R, a London-based advertising agency, has also partnered with UNFPA to raise public awareness of obstetric fistula (see Global Media & Advocacy Activities). Johnson & Johnson, through Americans for UNFPA, provided funds for an assessment in three Campaign countries to take place in 2006, which will inform the design of an innovative fistula prevention and treatment programme in selected communities. In March 2005, One by One – a volunteer-led initiative

that raises funds from individuals in support of the Campaign – was launched in Seattle. With the UN Foundation as a partner and fiduciary, One by One raised more than US\$ 100,000 during the reporting period, which will be received by UNFPA and directed to Campaign activities in 2006.

HIGHLIGHTING FISTULA IN TECHNICAL FORUMS AND PUBLICATIONS

During the reporting period, a number of key workshops and international and regional meetings took place to increase consensus on several technical issues and to promote knowledge sharing and networking. These forums have played a significant role in addressing fistula within the context of broader efforts to improve maternal health and to ensure universal access to reproductive health. In April 2005, UNFPA hosted two workshops in Niamey, Niger bringing together the OFWG and other experts to develop preliminary training standards and a monitoring and evaluation framework for fistula elimination programmes. UNFPA, with WHO and FIGO, co-sponsored the meeting *Prevention and Treatment of Obstetric Fistula: Identifying Research Needs and Public Health Priorities* hosted by the Bill & Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins Bloomberg School of Public Health. The meeting resulted in a call for greater research in a number of areas related to the prevention and treatment of obstetric fistula, including effective community-level prevention measures; a standard classification system and an international databank for fistula cases; and evidence-based practices for fistula management. A strategic analysis of the Campaign was undertaken by key experts in reproductive health and disease eradication from Africa, Asia, Europe and North America at the meeting *Obstetric Fistula as a Catalyst: Exploring Approaches for Safe Motherhood* convened by UNFPA,

Health and Development International and the CDC. Actions to be taken as a result of the meeting include strengthening the international partnership, improving data collection (particularly prevalence data) and building consensus on indicators for prevention and treatment.

In 2005, WHO finalized the manual *Obstetric Fistula: Guiding principles for clinical management and programme development*. The manual was supported technically by UNFPA through representation on the steering committee, review and comments and surveys distributed through UNFPA's Country Offices. Recommendations from the aforementioned Niamey meetings were incorporated into the manual. In addition, an article authored by UNFPA staff on obstetric fistula was accepted and presented at the Global Forum for Health Research and a supplement to *Obstetric & Gynecological Survey* entitled "Obstetric Vesicovaginal Fistula in the Developing World" was published in July 2005 with support from UNFPA.

SUPPORTING REGIONAL NETWORKING AND KNOWLEDGE SHARING

The 2005 global technical forums described in the previous section were primarily attended by public health professionals from developing countries, thus contributing to strengthened South-South networking and knowledge sharing. In addition, UNFPA, WHO and the Government of South Africa co-sponsored a meeting in Johannesburg bringing together representatives from 34 African countries and other fistula experts. The outcome of this meeting was a *Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula* (see Annex), urging governments to ensure the rapid implementation of national programmes to address maternal health and obstetric fistula. The Call to Action has been transmitted to the African Union for adoption. Participants at the meeting also drafted a Regional Strategy for the Elimination of Fistula in Africa, which is expected to be finalized in 2006.

GLOBAL MEDIA AND ADVOCACY ACTIVITIES

In May 2005, the UN listed obstetric fistula as one of the world's top 10 underreported stories, calling it "a tragic blind spot in health care for women." However, during the past year, increased media coverage of obstetric fistula and the global Campaign has helped to raise visibility of this long-neglected issue.

The February 2005 Fistula Fortnight in Nigeria was covered extensively by local press and international media, including the *Associated Press* and *Voice of America*. Additionally, the two-week pilot project was the subject of a feature story in the *Pittsburgh Post-Gazette*. "Like the public-private partnership that has worked to eradicate polio, the United Nations Population Fund has put together a similar group for a global program called the Campaign to End Fistula," said Virginia Linn of the *Post-Gazette*.

In August, Australian singer/songwriter Natalie Imbruglia – Spokesperson for the global Campaign – travelled to northern Nigeria with UNFPA and Virgin Unite to raise awareness of the cause. The visit was covered by *CNN International*, *Reuters* and *Australian Women's Weekly*, the leading women's magazine in the country with more than 3.2 million readers.

On 28 September, an article highlighting obstetric fistula and the leadership role that UNFPA has assumed in the elimination efforts was featured on the cover of *The New York Times*. "Two years of global fundraising by the United Nations Population Fund has netted only \$11 million for the problem," said *Times* reporter Sharon LaFraniere. The article ran the following day in the *International Herald Tribune*.

Over the past year, award-winning advertising agency RKCR/Y&R has developed, on a pro bono basis, a series of broadcast, print and web materials to raise visibility of fistula among the British public. UNFPA will launch the advertising campaign at a London press conference with Spokesperson Natalie Imbruglia in June 2006.

IV. LESSONS LEARNED

- The Campaign has achieved notable success in a short time, stimulating interest and renewed energy on the part of governments and other stakeholders in the reduction of maternal mortality and morbidity. Increased investment in the Campaign is needed to maintain this momentum and to meet countries' needs and expectations.
- As countries strive to reach the targets laid out in MDG 5, obstetric fistula can help draw the attention of the public and policymakers to the consequences of poor maternal health – contributing to efforts to ensure adequate funding and implementation of national plans to reduce maternal mortality and morbidity.
- The issue of fistula, particularly the testimonials of women living with the condition, is compelling for national as well as international media. Treatment, due to its hopeful nature and concrete outcome, helps to raise this interest and draw visibility to the broader messages that fistula is a preventable condition linked to extreme poverty and gender inequity.
- Data collection is a necessary first step to launching activities for fistula elimination. Situation analyses continue to provide vital preliminary information to begin advocating and implementing strategies for the elimination of fistula, including treating women with fistula who have been identified through the assessments. However, in the long term, more data are needed on the burden of the condition and its impact on women's social and economic situation.
- To ensure sustainability and integration of the Campaign, opportunities to include fistula in national plans and development frameworks need to be seized (e.g. the National Road Maps for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Africa).
- In countries with large geographic area and long distances between health centres, more than one facility capable of fistula repair will be needed. The social and economic circumstances of fistula patients compound the difficulty of travelling long distances. Therefore, services need to be decentralized where possible, with simple cases treated at selected hospitals at the peripheral level and more complex cases referred to the national centre or unit.
- Women living with fistula often require assistance with transport money to return home after treatment and in some cases for support while undergoing rehabilitation in the facility. Where possible, it is best if food can be provided free of charge to the women, in addition to subsidized treatment.
- Door-to-door communication strategies and the involvement of the community (e.g. religious and opinion leaders) can help to ensure rapid identification and treatment of women living with fistula.
- Quality pre- and post-operative care is vital for the success of fistula treatment; however, in many cases this care remains weak. Often, facilities within countries and between countries use different clinical protocols for treatment of fistula patients. Harmonized clinical protocols based on further research on quality of care will help to improve outcomes.
- Reintegration for treated fistula patients continues to be an area that requires strengthening. In

many places, the lack of fistula-specific counselling skills among both nurses and social workers makes rehabilitation less effective. To ensure comprehensive care, training programmes should focus not only on clinical aspects of care, but also on the psychosocial component.

- There is a need for regular and harmonized data collection on fistula. This includes mechanisms for collecting standardized data at global levels as well as regular data collection through health management information systems at the national level.

- Implementing institutions' capacity should be assessed during the design of programmes to ensure that appropriate support for capacity development is included in the intervention.
- Partnerships, both at national and global levels, have increased coordination of activities and attracted new technical and financial partners. As more partners become involved, there is a need for the structure and functioning of the partnerships to adapt.

V. WAY FORWARD: 2006-2010

Governments around the world have committed to achieving the MDG target of a 75 per cent reduction in maternal mortality and the ICPD target of universal access to reproductive health by 2015, both of which were reaffirmed at the 2005 World Summit. To ensure these targets are met, rapid scale-up of programmes to improve maternal health is imperative, ensuring equity in access and fulfillment of the right to maternal health.

During the first phase of the Campaign to End Fistula (2003-2005), there was an overwhelming response from countries recognizing fistula as an effective entry point to strengthen maternal health and achieve MDG 5. With more than 35 active countries and still growing, the Campaign is at a vital point requiring substantial resources to meet countries' technical and financial needs and to increase global and regional support for the elimination of fistula. To ensure full implementation of national, regional and global activities, UNFPA's funding requirements for the Campaign's next five-year period (2006-2010) are US\$ 78.3 million.

In the years ahead, UNFPA and its partners intend to place more emphasis on fistula prevention, requiring strategies to effectively build national capacity to address maternal health. The next five-year period of the Campaign programme will enable UNFPA

to make longer-term collaborative arrangements with country-level partners to implement sustainable systems for improving reproductive health within the context of national efforts to reduce maternal mortality and morbidity. UNFPA will focus its support on capacity building to ensure effective design, implementation, coordination and management of wide-scale advocacy, prevention, care and support efforts.

At the global and regional levels, UNFPA will continue to support and promote research, documentation of good practices and expert consensus building as well as create mechanisms for South-South cooperation and networking to ensure that experiences and good practices are shared for replication. As the Campaign moves forward, there is a need for reliable data on the incidence and prevalence of the condition. UNFPA and partners will work together to better estimate prevalence and ensure there is adequate data to track the impact of the Campaign over the long term.

Ending fistula is a long-term goal that demands financial resources, political will, strong collaboration and concerted efforts. UNFPA will continue to work with current partners and explore new partnerships for greater complementarity and coordination of fistula elimination programmes as well as improved advocacy and resource mobilization.

¹ Elimination is defined as "eliminated as a public health problem", which entails reducing the incidence of obstetric fistula to levels below public health significance. Unlike some infectious diseases, obstetric fistula cannot be eradicated because continued interventions are required to prevent new cases (e.g. obstetric services).

² Murray C and Lopez A (1998) *Health Dimensions of Sex and Reproduction*. Geneva: WHO.

³ Abou Zahr, C (2003). 'Global Burden of Maternal Death and Disability', *British Medical Bulletin* 67 (1).

⁴ UNFPA and EngenderHealth (2003). *Needs Assessment Report: Findings from Nine African Countries*. New York: UNFPA.

⁵ Amount only includes payments received in 2005 and does not include unpaid pledges made in 2005.

⁶ The REF is a diverse partnership of 40 members established in 2004, which is responsible for advocacy and the development and monitoring of the national action plan for fistula. All fistula-related activities in Niger are coordinated through the REF.

VI. ANNEX

DONORS TO THE CAMPAIGN TO END FISTULA, 2005*

Donors (2005)	2005 Commitments		2005 Payments in US\$
	Donor Currency	US\$ Equivalent	
Americans for UNFPA		257,946 ¹	439,538 ²
Australia	AUD 300,000	234,375	234,375
EngenderHealth			238,000 ³
Finland			36,716 ⁴
Iceland**		47,026	47,026
Kingdom of Spain, Autonomous Community of Catalunya	EUR 350,000	411,764	411,764
Luxembourg	EUR 300,000	362,756	1,482,155 ⁵
Poland**		20,000	20,000
Private Contributions** ⁶		44,366	44,366 ⁷
Sweden	SEK 15,000,000	1,861,042	1,861,042
Virgin Unite	GBP 5,000	9,542	42,484 ⁸
Column Totals		3,248,817	4,857,466

* Provisional, subject to certified financial statements issued by UNFPA.

** Denotes contributions to the Pooled Fistula Thematic Trust Fund.

¹ Includes contributions from Johnson & Johnson in the amount of \$54,255.

² 2005 payments includes 2004 4th quarter funds in the amount of \$203,690 received on 4 February 2005. Does not include 2005 4th quarter funds in the amount of \$22,098 received on 3 April 2006.

³ Second tranche of 2004 grant totalling \$750,000.

⁴ The 2004 contribution from Finland (from trust fund interest) was received in February 2005. It was listed in error as being received in 2004 in the 2004 Campaign Annual Report.

⁵ Includes 2004 commitments, totalling \$1,119,399, that were paid in 2005.

⁶ All private contributions directed to the Pooled Fistula Thematic Trust Fund with the exception of Campaign Spokesperson Natalie Imbruglia's contributions in the amount of \$10,340 received prior to creation of the thematic trust fund.

⁷ Includes contribution from Japanese Organization for International Cooperation in Family Planning (JOICFP) from trust fund interest in the amount of \$2,656.

⁸ Includes 2004 commitment for the Fistula Fortnight, totalling \$32,942, that was paid in 2005. Payment total does not include value of in-kind contributions.

UNFPA CAMPAIGN TO END FISTULA APPROVED ALLOCATIONS, 2005*

Country/Global Activity	Amount Allocated (US\$)	Funding Source	Activity Timeframe
Country Level			
Burkina Faso	350,000	Luxembourg	2005-2006
Congo Brazzaville	15,000	Americans for UNFPA	2005
Central African Republic	16,050	Sweden ¹	2005
Cote d'Ivoire	15,000	Sweden	2005-2006
Democratic Republic of the Congo	15,000	Sweden	2005
East Timor	15,000	Sweden	2006
Eritrea	150,000	Sweden	2005-2006
Ethiopia	9,542	Virgin Unite	2005-2006
	1,845	Private Contributions	2005-2006
Ghana	149,800	Luxembourg	2005-2006
Kenya	400,000	Sweden	2005-2006
Malawi	181,900	Fistula Thematic Trust Fund	2006
Mali	177,500	UN Trust Fund for Human Security ²	2005
Mauritania	475,000	Luxembourg	2005-2006
Niger	83,115	EngenderHealth ³	2005-2006
Nigeria	36,716	Finland	2005
	350,000	Sweden	2005-2006
	1,005,000	UN Trust Fund for Human Security	2005
	8,505	Private Contributions	2005
	32,943	Virgin Unite	2005
Pakistan	283,200	UN Trust Fund for Human Security	2005
Somalia	17,500	Americans for UNFPA	2005
Sierra Leone	40,000	Sweden	2005
South Africa	15,000	Luxembourg	2005
Uganda	132,612	EngenderHealth	2005-2006
Zambia	207,552	New Zealand ⁴	2005-2006
Country Sub-total	4,183,780		
Global/Regional Level			
Africa Division Programme Mgmt. (Including Prog. Specialist)	170,000	Luxembourg	2005-2006
	50,000	Pooled Fistula Thematic Trust Fund	2005-2006
Africa Region Programme Support	85,600	Sweden	2005
Africa Regional Meeting (Johannesburg, South Africa)	125,000	Fistula Thematic Trust Fund	2005
Media Activities (incl. production of advocacy materials)	73,500	Americans for UNFPA	2005
Technical Publications	17,000	Americans for UNFPA	2005
Technical Support (Including Technical Specialist)	186,797	Luxembourg	2005-2006
Obstetric Fistula as a Catalyst Mtg.	50,000	Sweden	2005
Global Sub-total	757,897		
GRAND TOTAL	4,941,677		

Note: In 2005, UNFPA contributed approximately \$1 million from core resources, in both in-kind technical support services, staffing and contributions.

*Provisional, subject to certified financial statements issued by UNFPA.

¹ The source of Swedish funds noted in above matrix is from their 2004 contribution totalling \$1,190,476 received on 27 December 2004.

² The source of the UN Trust Fund for Human Security funds noted in above matrix is from the first tranche of their grant received on 30 December 2004.

³ EngenderHealth funds are for May 2005 through May 2006.

⁴ From New Zealand's 2004 contribution totalling \$621,700.

CAMPAIGN TO END FISTULA EXPENDITURES (US\$), 2005*

Region/Country	Donor	Authorized Allocation	2005 Budget	2005 Expenditure	Balance
Africa Region					
Benin	Australia	75,415	64,585	55,952	8,633
Benin	Americans for UNFPA	125,000**	75,415	63,099	12,316
Burkina Faso	Luxembourg	350,000**	350,000	122,004	227,996
Central African Republic	Sweden	16,050	16,050	15,789	261
Chad	UNF	137,461**	111,338	110,341	997
Congo	Americans for UNFPA	15,000	15,714.55	16,500	-785.45
Cote d'Ivoire	Sweden	15,000**	15,000	3,744	11,256
DRC	Sweden	15,000	15,000	13,212	1,788
Eritrea	New Zealand	300,000**	200,000	1,507	198,493
Eritrea	Sweden	150,000	150,000	84,644	65,356
Eritrea	Americans for UNFPA	150,000**	136,722	21,740	114,982
Ethiopia	Austria	63,613	58,601.30	44,086.45	14,514.85
Ethiopia	Virgin Unite	9,542**	9,542	3,430	6,112
Kenya	Sweden	400,000**	297,000	179,828	117,172
Mali	Americans for UNFPA	100,000	107,500	109,211.64	-1,711.64
Mauritania	Luxembourg	475,000**	401,250	377,704	23,546
Mozambique	Americans for UNFPA	40,000**	2,726	2,727	-1.00
Niger	EngenderHealth	83,115**	83,115	80,867	2,248
Nigeria	Finland	36,716	36,716	36,716	0
Nigeria	Sweden	350,000**	350,000	155,627.06	194,372.94
Nigeria	Virgin Unite	32,943	32,942.53	28,733.95	4,208.58
Nigeria	Private Contributions	8,505	8,505	8,505	0
Senegal	Canada	150,000**	137,000	28,445.66	108,554.34
South Africa	Luxembourg	15,000	15,000	8,062.50	6,937.50
Uganda	EngenderHealth	132,612**	130,000	124,597.81	5,402.19
Zambia	New Zealand	207,552**	69,661.50	798.54	68,862.96
Africa Total		3,453,524	2,889,383.40	1,697,872	1,191,511.10

* Provisional, subject to certified financial statements issued by UNFPA.

** Authorized allocation covers multiple years.

CAMPAIGN TO END FISTULA EXPENDITURES, 2005*

Region/Country	Donor	Authorized Allocation	2005 Budget	2005 Expenditure	Balance
Asia Region					
Bangladesh	Americans for UNFPA UN Trust Fund for Human Security	78,750**	78,750	76,222	2,528
Pakistan		283,200	119,102	11,319.74	107,782.26
Asia Total		361,950	197,852	87,541.74	110,310.26

Arab Region					
Somalia	Americans for UNFPA	17,500	17,470	17,084.87	385.13
Arab Total		17,500	17,470	17,084.87	385.13

Global/Regional					
Africa Division	Luxembourg	170,000**	11,500	11,280.67	219.33
Africa Division	Sweden	85,600	85,600	83,370.68	2,229.32
Africa Division	UNF	112,538**	110,768	99,969.30	10,798.70
Africa Division	Fistula Thematic Trust Fund	50,000	50,000	23,247.57	26,752.43
Africa Regional Meeting, South Africa	Fistula Thematic Trust Fund	125,000	125,000	120,597.62	4,403
IERD	Americans for UNFPA	73,500	73,333	72,313.56	1,019.44
TSD	EngenderHealth	22,272**	4,028	2,527.33	1,500.67
TSD	Luxembourg**	186,797**	73,065	73,064.16	0.84
TSD	Sweden	50,000	50,000	32,546.62	17,453.38
TSD	Americans for UNFPA	17,000	17,000	17,000	0
Global/Regional Total		892,707	600,294	535,918	64,377
GRAND TOTAL		4,725,681	3,704,999	2,338,416	1,336,583

* Provisional, subject to certified financial statements issued by UNFPA.

** Authorized allocation covers multiple years.



The Johannesburg Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula

Obstetric fistula is a major injury and disability to women who survive childbirth, altering the lives of more than 2 million women worldwide, the majority of whom are in Africa. Fistula causes constant leakage of urine and/or faeces through the vagina resulting in serious physical and mental ill health and often leading to social isolation. It is associated with stillbirths and poor maternal and infant health. The failure of state health systems to provide access to preventive care and treatment implicates women's internationally recognized human rights. Major contributing factors include poverty, illiteracy, low status of women and gender inequality, malnutrition, adolescent pregnancy, lack of awareness, and low geographic, financial and socio-cultural access to family planning and emergency obstetric care.

As women with fistula survive the death of their baby and the near-death experience of delivery, they are living testimony to the challenges faced in maternal and newborn health. Globally, more than half a million women die annually of maternal causes. There are approximately four million stillbirths and four million newborn deaths each year. Attention to obstetric fistula is also uncovering the very serious problem of traumatic fistula stemming from sexual violence against women.

Obstetric fistula is preventable and treatable. Yet, to date, limited efforts have been made to address this scourge. We know what needs to be done, have effective interventions, and can take action immediately in any setting. We also know that fistula can be eliminated, even in countries with limited resources. Local health care providers and advocates, together with international efforts, such as the global Campaign to End Fistula¹, have brought this hidden issue to international and national agendas. These efforts are aimed at increasing support to countries that have shown political commitment; consequently, remarkable progress has been achieved in a short time.

Actions taken to eliminate obstetric fistula will strongly contribute to the achievement of the international commitments on development – in particular, improving maternal and newborn health and addressing gender and economic inequity (International Conference on Population and Development, Millennium Development Goals (MDGs) 1, 2, 3, 4 and 5, World Summit Outcome Document).

Participants of the *Johannesburg Meeting to Make Motherhood Safer by Addressing Obstetric Fistula*, including over 100 senior officials of ministries of health, international agencies, and non-governmental organizations (NGOs), urge governments of Africa - in particular ministries of health, women's affairs, education and finance - to urgently address the issue of obstetric fistula and maternal health.

Governments should ensure the rapid implementation and scale-up of national programmes to address maternal health and obstetric fistula, including *National Road Maps for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa*.

¹ www.endfistula.org

Together with civil society and partners, governments should:

Strengthen health systems

- Ensure rapid scale up towards universal access to reproductive health, in particular family planning, including for young people
- Ensure the right of access to maternal health care, which includes attendance of all pregnancies and births by a skilled health professional, emergency obstetric and newborn care, and referral and transport for caesarean section for obstructed labour when required
- Specifically, ensure free or highly subsidized caesarean sections, delivery care and fistula treatment
- Urgently address the health human resource crisis due to lack of investment in human resource development and management and loss to AIDS and to brain drain, by addressing in particular the number of trainees and quality of training, recruitment and retention, geographic distribution, working conditions, remuneration levels, professional attitude and respect for clients
- Establish in each country at least one referral service / centre for fistula treatment to ensure high quality of care and training, so that all women with fistula have access to comprehensive treatment, including quality medical care, rehabilitation, counselling, mental health services and health education; additionally, ensure access for all women to social reintegration support, including partnership with women's associations, organisations involved in education, skills development and income generating activities, such as microfinance
- Countries should have strong data collection, monitoring and evaluation systems: community-based notification of fistula cases and maternal and newborn deaths, addressing determinants, monitoring successes of prevention, treatment, and reintegration programmes, documenting lessons learned, and conducting necessary research and publication of results

Adopt a broad approach across sectors and involve all key actors

- Promote girls' education, delay of the age of marriage and childbearing, gender equality and programming sensitive to culture and religion; address harmful practices
- Foster community awareness and mobilization, particularly the participation of men, to be more involved in fistula elimination and maternal health
- Foster strong partnerships, including with civil society, religious leaders, women's and professional associations, NGOs and donors
- Intensify advocacy for increased resource allocation to strengthen health systems in order to ensure a continuum of skilled maternal health care, including appropriate measures for the prevention and management of fistula
- Specifically, ensure that maternal health national road maps are costed and properly financed, and that African governments implement their pledge to allocate at least 15 per cent of their annual budgets to the health sector (Abuja Declaration, 27 April 2001)
- Empower women living with fistula through advocacy and peer-support

By addressing gender equality, girls' education and strengthening health systems – in particular, access to family planning and maternal health services - together, we can make obstetric fistula history in every community in Africa.

We call on the Government of South Africa to transmit this *Call to Action* to the African Union for adoption.