REPORT

MAKING MOTHERHOOD SAFER BY ADDRESSING OBSTETRIC FISTULA (OF)

JOHANNESBURG, SOUTH AFRICA

23 – 26 OCTOBER, 2005

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Acronyms

AIDS	Acute Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
AU	African Union
CAR	Central African Republic
DHS	Demographic Health Survey
DOCS	Doctors on Call for Service (in DRC)
DOH	Department of Health
DRC	Democratic Republic of Congo
DSA	Daily Subsistence Allowance
EmOC	Emergency Obstetric Care
FP	Family Planning
HIV	Human Immuno-Deficiency Virus
ICPD	International Conference on Population and Development
IGA	
MDGs	Millennium Development Goals
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NEPAD	New Partnership for African Development
NGO	Non-Governmental Organization
OF	Obstetric Fistula
RC	Resident Coordinator
RH	Reproductive Health
SA	South Africa
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Aid for International Development
WG	Working Group
WHO	World Health Organization

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Acknowledgement:

UNFPA would like to thank all individuals and organizations that contributed to the success of the South Africa Conference on Making Motherhood Safer by addressing Obstetric Fistula. Special appreciation goes to the Government of the Republic of South Africa. In particular, the Ministry of Health for hosting and organizing this important gathering, which marks a historic turning point in international efforts to come to grips with one of the most devastating maternal morbidities known as Fistula. We wish to express our heartfelt thanks to UNFPA/CO staff under the leadership of Mr. George Nsiah, the Department of Health and members of the Steering Committee for their guidance; the high level representatives of 34 African Governments; the Conference facilitators, the NGOs Dimol, Iamaneh Suisse, Delta Survie, Aumonerie des Hôpitaux, Monze Hospital, Americans for UNFPA, USAID/WARP, Women's Dignity Project (WDP), Nelson R. Mandela School of Medicine, Centre for SA Health Policy University of Wits, University of Limpopo (Medunsa), Point G Hospital (Mali), Nelson Mandela Academic Hospital Transkei, Addis Ababa Fistula Hospital, DOCS, AMREF, University of Zimbabwe, WHO, University of Pretoria and Engender Health as well as the significant financial and technical assistance provided by UNFPA/HQ and the Field.

Finally, special thanks to Mr. Yahya Kane, Dr G. Ogbaselassie and Ms. Bunie Matlanyane Sexwale Bunie for writing this report.

Foreword

Obstetric fistula (OF) is a living but painful reminder/indicator of our glaring failure to provide access and quality of care to our mothers and sisters during pregnancy and childbirth. The condition is particularly common in sub-Saharan Africa, where populations face poverty, gender inequality, illiteracy and challenges to access family planning and maternal health services. When faced with obstructed labor, very few of these poor rural women are fortunate enough to access Caesarean sections. If they do manage to avoid death, a constant leakage of urine and/or faeces through the vagina (fistula) is often a major complication.

OF is essentially a burden of the girl child. Deprived of her right to basic education and proper nutrition, the innocent girl child is plunged into an arranged marriage for which she is neither physically nor mentally prepared. A-fifteen years' old Tanzanian woman, who experienced the agony of painful and protracted labor that resulted in the death of her newborn baby and the development of fistula, said: ***"I just had to sit in a room by myself, never going out. People didn't want me near them because of the smell of the urine. I couldn't help in the fields. I just stayed at home for those 10 years."***

Dr. Manto Tshabala-Msimang, the South African Hon. Minister of Health, in her forceful Key Note address to the Conference participants remarked ***"Pregnancy constitutes God's plan for sustainability of creation itself; and through the ability to get pregnant and to bare children, women are nature's instrument for continued evolution of the human race. If this is the case, then why should an act so divine and a process which is meant to celebrate new beginnings of life, be nothing else but a death nail to many women?"***

Developed countries have demonstrated that OF can be eliminated. However, the prevalence of fistula is on the rise in many African countries. About two million women worldwide are living with OF, socially isolated and depressed – hoping, praying and searching for a miracle-cure! The number of new cases is conservatively estimated at 50,000 to 100,000 every year.

Indeed, the community needs accurate information and knowledge on the causes of OF; how it can be prevented; and where to go for treatment if fistula occurs. Prevention is the corner stone for eliminating OF and all efforts should be made to put in place effective measures aimed at prevention. Furthermore, strategies should be designed and implemented to clear the huge backlog of women silently suffering and waiting for the day that treatment in the hands of experienced surgeons and nurses would result in a miracle cure.

In this context, the Department of Health of the Government of South Africa, UNFPA and WHO organized the regional conference titled "*Making Motherhood Safer by addressing Obstetric Fistula* in Johannesburg from 23 to 26 October 2005. The conference brought together over 100 participants from 34 African countries and partner organizations, including senior officials of ministries of health, international

agencies, and Civil Society Organizations. All participating organizations and countries were represented at a high level, mostly Directors of Health Services or their Deputies.

The Campaign to End fistula is structured in three programmatic phases: i) Needs assessment, ii) Planning phase and iii) Implementation phase. There are three major intervention points namely Prevention, Treatment/Care and Social Reintegration. At the needs assessment phase countries map existing services and determine needs, and then in the subsequent phase bring together stakeholders to form a national network and develop a national strategy to eliminate fistula. The third phase consists of a development of a fully fledged project and implementation of the national strategy.

Ms. Thoraya Obaid, UNFPA Executive Director stressed on the need for greater political and financial commitment to accelerate action. She added ***"We must increase national spending and ensure that some of the additional resources being devoted to Africa through official development assistance are targeted at fistula. In particular, there is the possibility of significant technical and financial support by the Government of South Africa through the spirit of African Renaissance."***

Against a backdrop of rapidly growing worldwide interest in the management of OF, the Conference allowed for cross-fertilization of ideas, longitudinal comparison of progress and sharing of experiences and lessons learned across countries. The meeting was a resounding success and culminated with the following outcomes:

- Experiences and lessons learned from fistula programs in the region shared
- Consensus achieved on obstetric fistula as an entry point for improving maternal health and the need for it to be mainstreamed into national maternal health road maps
- Johannesburg Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula drafted and adopted by participants
- Preliminary draft of the Africa Regional Strategy for Fistula Elimination developed

The time for action is now. Increased support is of vital importance, especially in the areas of community awareness of the causes and appropriate responses to obstetric fistula; expansion of strategically located and fully functional treatment and emergency obstetric care services; investing in human resource capacity building; and initiating livelihood programmes to reintegrate survivors of obstetric fistula back into society.

OVERVIEW

Co-organized by the Department of Health of the Government of South Africa (SA), UNFPA and WHO, the regional conference titled "*Making Motherhood Safer by addressing Obstetric Fistula*" was held in Johannesburg from 23 to 26 October 2005. The conference brought together over 100 participants from 34 African countries and partner organizations, including senior officials of ministries of health, international agencies, and Civil Society Organizations. All participating organizations were represented at a high level. The UNFPA Executive Director; the Director of Africa Division; the Chief of RH Branch TSD; the AD, RH Senior Advisor were among the senior staff from UNFPA HQ. WHO dispatched a Senior Officer from its Regional Office who delivered a statement on behalf of the Director of WHO's Africa Regional Office as well as the Senior Maternal Health Advisor based in Geneva. The Minister of health of the Republic of South Africa took part in the opening and closing ceremonies. Special thanks go to the UNFPA Country Office in SA for its support and leadership in ensuring a well planned and coordinated event.

Against a backdrop of rapidly growing worldwide interest in the management of Obstetric Fistula (OF), the conference allowed for cross-fertilization of ideas, longitudinal comparison of progress and sharing of experiences and lessons learned across countries. The meeting was a resounding success and culminated with the following outcomes:

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Other critical issues were extensively covered notable among which are, the restoration of functions after surgical repair as an indicator to measure success rate and the increasingly central role of Civil Society Organizations in the promotion of sustainable development paradigm. Also the linkages between fistula and HIV/AIDS were extensively discussed though not introduced as a formal presentation but permeated most of the constructive debates that ensued. The meeting revealed however varying levels of understanding among participants of the concept of Capacity Development which is at the heart of technical assistance. The need to promote a demand-oriented technical assistance paradigm where the national counterpart is in the driver's seat came across very strongly. In this line of thinking it is of utmost importance in our interventions to strive to **"scan globally and reinvent locally"** to ensure sustainability and national ownership. As the Fistula Campaign moves toward a higher level of consolidation of its achievements, the need to pursue efforts in the promotion of an integrated approach can not be overemphasized. As a matter of fact, there is a growing consensus that Fistula should be addressed within the broader context of Reproductive Health and Safe Motherhood. In this regard, the WHO Road Map is a golden opportunity to mainstream fistula while at the same time providing the evidence that its strategic linkage to Safe Motherhood initiatives is critical if developing countries are to bring about a lasting response to the problem of fistula.

Fistula Campaign progress in Africa:

The Campaign to End fistula is structured in three programmatic phases: Needs assessment (1), Planning phase (2) and Implementation phase (3) and has three major intervention points namely prevention, Treatment and Social Reintegration. At the needs assessment phase countries map existing services and determine needs, and then in the subsequent phase bring together stakeholders to form a national network and develop a national strategy to eliminate fistula. The third phase consists of a development of a fully fledged project and implementation of the national strategy. So far 22 countries have completed their needs assessment, six in-depth assessments are underway, more than nine countries are at an advanced stage of their planning phase and seven countries are currently implementing fully fledged programs.

Call to Action and Draft Regional Strategy *(See Annex for details)*

Much participation was devoted to drafting, negotiating, developing and agreeing on the conference output in the form of A Johannesburg Call to Action (two pages) and a draft Regional Strategy for Obstetric Fistula Elimination in Africa *(see Annex)*. Together with the Road Map, these two documents will be the main guide towards mainstreaming fistula into national health systems and particularly the national reproductive health and safe motherhood strategies and programs. It was recommended that the Johannesburg Call to Action must, in addition to Ministers of Health, be delivered to AU and AU Social Affairs Cluster (both Technical and Ministerial). The NEPAD focal point for SA who has potential to work regionally also volunteered to add fistula and the outcomes of this conference to her undertakings.

In her closing remarks, the representative of the SA Minister of Health recommended that national strategies and advocacy must engage simple language and pursue simple but effective solutions that may not be too costly, and that they must emphasize a multi-sectoral approach that includes all disciplines and all Ministries, not only Health, Finance and Education. For instance Roads and Transport become important in facilitating access to health facilities. She advocated for improvement of tertiary facilities as well as district hospitals, clinics and primary health centers that are closer to communities, and the establishment of a register or audit of fistula prevalence and its posting on the fistula website as baseline against which to monitor trend and campaign impact at country level, sub-regional level (e.g. SADC, ECOWAS, Eastern Central Africa and so on), and regional level through AU. She informed conference that its outcomes and proceedings were to be reported to SA Parliament and urged other countries to do the same.

II. CONFERENCE PROCEEDINGS

1. Road Map for accelerated attainment of the MDGs related to Maternal and Newborn Health in Africa

Developed in Harare in 2004, the Road Map emanated from the need to meet MDGs 4 and 5 which call for 75% reduction of maternal mortality ratio and two thirds reduction of child mortality rate by 2015.

The fragmented nature of maternal health initiatives in the region and in different countries was identified as contributing to the lack of progress in attaining safe motherhood. In response, the Road Map is geared towards a coordinated and harmonized approach that prioritizes the use of the primary health care system to engage community resources and strengthen the referral system. It takes into account the magnitude, causes and consequences of newborn and maternal morbidity and mortality, fistula being but one of the problems. The specific objective to provide skilled attendance during pregnancy, childbirth and postnatal period at all levels of the health care delivery system; and to strengthen the capacity of individuals, families and communities to improve MNH, have clearly worked out strategies.

The Road Map is anchored on the guiding principles of a health systems approach; promotion of broad and inclusive partnerships with clearly defined roles and responsibilities; appropriateness and relevance to specific country situations; transparency and accountability; and promoting equitable access to quality health services with attention to the poor and vulnerable groups and to spatial distribution. It emphasizes and outlines the need for monitoring and evaluation with clear indicators and time frames for implementation and for reporting to REC, RC and AU. Challenges identified relate to consensus building at country level; lack of capacity; integrating MNH into national development plans; costing the country Road Map; and resource mobilization.

It was noted that Africa was leading the way in this strategic approach and discussions highlighted linkages between the Road Map and the fistula campaign; the need for an enabling environment; descent salaries and incentives for health personnel; Non-existence of health programs and or women's health programs in some countries, particularly but not exclusively those emerging from conflict; importance of motivated personnel in addition to technical medical capacity; dangers of relying on foreign personnel which poses a problem of sustainability.

2. Fistula Manual

The fistula manual was developed under the leadership of the WHO in close collaboration with UNFPA and the key partners of the Campaign to end Fistula. The objective of the book is to collect and present the available evidence and experience based knowledge on fistula prevention and management to help a large range of actors, policymakers, community leaders, health planners and professionals, design and implement some strategies and programs aimed at eliminating obstetric fistula and at evaluating this program. The manual is not a guideline to help surgeons and other health providers to treat fistula. In this endeavor, WHO has worked together with a steering committee established in Addis Ababa in 2003 and drawn on the knowledge of experts working in this field around the world as surgeons, civil society organizations, NGOs etcetera.

The manual is divided into two sections, the first dealing with understanding the problem and developing a national approach with an introduction that describes the situation, the burden, the suffering, the abuses, and the underlying causes. The section elaborates principles for developing national, sub-national strategies for prevention and treatment which in a sense is the core of the manual.

It defines long term goals to help countries to have the vision about OF elimination. In order to help countries develop concrete OF prevention and treatment strategies, it is recommended that each country establish an OF prevention and treatment committee which could be embedded in the national committee for maternal health or national committee for maternal mortality reduction. Data collection is an important part of the process as are developing realistic policies with short- medium- and long-term objectives, planning, programming, community involvement, service provision, training and monitoring and evaluation.

The second section tables the basic principles for caring for women undergoing OF repair. It gives clinical and surgical principles for OF management with an annexure A: containing classification of obstetric fistula. It gives principles of nursing care with annexure B: of patient card used by Addis Ababa Fistula Hospital and C: recipes for tinctures and emulsions. It also gives principles for pre- and post-operative physiotherapy. Lastly, it outlines principles for the social integration and rehabilitation of women who have had an obstetric fistula repair – successfully and where treatment has been unsuccessful.

The introduction of the manual by WHO triggered constructive discussions on all aspects of fistula programming and management.

3. Needs Assessment exercises

Research on fistula from four countries, Central African Republic (CAR), Congo Brazzaville (CB), Burkina Faso (BF) and South Africa (SA), was shared and discussed. These studies varied in length, breadth, depth, degree of completion, and though exhibiting commonalties, each highlighted some instructive specifics. With the country recently emerging from conflict, the rationale of the CAR study was to obtain much needed information on the extent and socio-cultural characteristics, and to craft strategies for the effective management of OF. Both Congo and Burkina were interested in exploring the socio-anthropological dynamics, evaluate knowledge, perceptions and understanding, context and contribution of communities in connection with OF. Departing from deep skepticism about the existence of fistula in the country, SA on the other hand, set off to investigate the prevalence of VVF, availability of treatment, and rehabilitation, and advocacy needs.

All engaged quantitative and qualitative methods and tools to varying degrees. While South Africa relied heavily on tele-communications to administer the questionnaire, Congo and Burkina ventured into multi-disciplinary teams and multi-method approaches including Oral/Life History, document analysis, (separate and mixed) focus groups with women and men of varying age groups (thirteen to seventy nine). Placing women living with OF, their significant others and communities, at the centre of the investigation, no less than fourteen ethnic groups were selected, local languages prioritized and eleven translators incorporated into the Congolese research teams.

The findings highlighted issues related to varying causes of fistula, social and medical characteristics and effects on women living with fistula, lack of skilled personnel, skewed

distribution of material and human resources, cultural and religious beliefs, traditional treatments, support systems and lack thereof, and fistula's linkages with poverty. Recommendations related to training of staff, proper hospital equipment, and integration of fistula in health systems in general and reproductive health programs in particular.

Discussions drew attention to the need to take into account the multiple dimensions of fistula, gender issues, particularly sexual violence; the need to address fistula in general and not only OF; the need to define criteria for 'successful repair' as part of the monitoring mechanisms; necessity to set up research studies about women who have healed from fistula; the importance of re-emphasizing Family Planning and men's responsibility; the need for logistically and financially accessible maternal health facility and service including free maternal healthcare; and the need for a health systems approach.

4. Prevention

Prevention measures undertaken in various African countries were shared as formal presentations and under general discussion. While there were differences in the type, coverage and intensity of preventative measures implemented by various countries, there was general consensus that prevention strategies are central to bringing about significant impact towards the elimination of fistula.

- **Community mobilization and education**

It is essential to increase awareness and understanding of fistula, its causes, how it can be prevented or treated, and to strive to change attitudes towards victims and survivors of fistula. Increasingly, research is being undertaken to investigate whether and how communities, families and individuals, understand fistula and their attitudes towards women living with fistula, in order to develop effective strategies including community mobilization strategies. Studies such as the one carried out in Eritrea illustrated a clear correlation between poor knowledge and low awareness with the occurrence of obstetric fistula. In Congo Brazzaville preliminary findings indicated a significant lack of knowledge of fistula by the population. This lack of knowledge, the tendency to treat Fistula as taboo, combined with cultural and religious beliefs in the supernatural – witchcraft, divine curse – were also observed in Burkina Faso, CAR and other places. In the context of the integrated reproductive health program, a study is in process in six (out of 34) regions and 94 facilities covering the North and South of Benin with results expected in 2008.

In addition to training and engaging 3500 health extension workers, community based reproductive health workers, TBAs, supplying delivery kits donated by financial institutions, Ethiopia MOH works together with NGOs in its community awareness, care provision and prevention of fistula and maternal mortality.

As stressed in the Road Map and the UNFPA campaign strategies, partnerships with all relevant stakeholders are essential. The involvement of, and partnerships with media professionals and institutions is important in creating and disseminating information about fistula to the public. The media is essential in mobilizing communities, public opinion and support at all stages of the campaign and at both international and national levels.

- **Access to Family Planning**

Access to FP and improved uptake was acknowledged as vital to successful prevention of fistula through the role of family planning in delaying pregnancy and reducing probability of obstruction in delivery. A recent regional effort at adopting a framework for repositioning FP was for this purpose. The impact of family planning could best be illustrated by a contribution that stated that delaying pregnancy by 2 years could reduce maternal mortality by up to 60%. At 67% and much higher than the common African averages, the South African contraceptive prevalence rate was acknowledged as one that other countries could learn from. However, this hopeful situation had to be understood in the context of great spatial variations, and according to the Nelson R Mandela School of Medicine presenter, it appeared to be slowly retrogressing and needed to be safeguarded in SA as well. He underlined that strategies must emphasize men's responsibility and their participation in FP.

- **Access to skilled maternal healthcare**

The point of departure for the Women's Dignity Project (Tanzania) presentation was that a system that provides quality care from competent and committed providers is absolutely and fundamentally essential to preventing fistula. While acknowledging the importance of the broader socio-cultural causes of fistula, and of addressing fistula from community and family levels, the Women's Dignity Project presentation elected to highlight specifically the continent-wide human resources crisis in health as an important factor that hinders the attainment of health rights, and maternal health, for the poor. Availability of EMOC and Skilled Attendance could only be achieved with sufficient supply of healthcare providers that are well trained and supervised, well and timely paid, equitably distributed particularly to remote rural areas, and working under enabling environments.

Yet the reality is that the enabling environment is weak, training and supervision of health workers not optimum, and, as well as being infrequently paid, their wages are unacceptably lower than a living wage in most countries and in particular Tanzania. This manifestation of disrespect by the system results, understandably, in low motivation and morale. Related to these is the uneven distribution of trained and specialist healthcare providers, internationally between rich and poor countries that continues with unabated migration out of Africa; nationally between urban and rural areas, also evinced and exacerbated by the increasing shift of trained professional health workers away from basic healthcare services (including MNH) towards "verticalized" and well funded programs.

Information from various other countries such as Eritrea, Congo, Burkina Faso and Chad revealed this general critical and skewed shortage of skilled health care providers facing the Africa Region.

Health care givers trained and sensitized to Obstetric Fistula prevention

These health care givers were considered absolutely essential to prevention. The presentation from South Africa gave an excellent illustration of the work of two missionaries working in one of the districts, who started training doctors and nurses to recognize the problems in early labor and referring these patients for assisted delivery, such as Caesarean section and vacuum extraction. They also started building clinics and mother's waiting homes for easy access to a functional referral facility. Later, a tool for monitoring progress of labor, known as the partograph, was developed and widely disseminated at national level, which made a significant contribution to the drastic reduction of OF in SA.

In many African countries, health care givers were still not adequately trained to be able to handle obstructed labor. Mainly because of the war, countries such as Congo Brazzaville had still not implemented preventative care of Obstetric Fistula. There was only one competent surgeon based at the university.

A training program of the Point G Hospital in Mali for surgeons and traditional midwives and the involvement with communities offered many valuable lessons.

South Africa has abundant surgeons but ill-distributed with a heavy bias towards the rich, private sector and cities. Many competent surgeons have left the public health system and joined the private sector, a problem that had left Eastern Cape acutely short of qualified personnel. Others had left the country for greener pastures abroad, thus posing a challenge of staff retention after training and exacerbating what Women's Dignity Project, dubbed “global health apartheid”.

- **Preliminary consensus on training: Outcomes of an expert meeting**

Discussions centered on the presentation of the outcomes of an expert meeting held in Niamey in April 2005 (English, French). It was clearly acknowledged that, no matter how well or expensively equipped a maternal health facility may be, healthcare providers and associates need relevant skills, hence training, in order to achieve the MDGs and the ICDP Program of Action. Consensus on a number of key areas of training in the management of fistula was achieved. (For more details, see training meeting report, Niamey April 2005).

5. Treatment and Care

Various experiences and treatment models/approaches were presented by very experienced surgeons and other health care practitioners who have been involved for the past couple of years in the work of the Fistula Campaign.

The Fistula Fortnight Campaign in Nigeria was a treatment, training and advocacy campaign which included counseling and health education before and after treatment operations. The initiative was a resounding success and allowed 12 doctors, 40 nurses, 40 social workers and 20 Red Cross volunteers to be trained in the management of Fistula. This campaign led to 545 women receiving surgical treatment. The initiative led to a raised national awareness and commitment to the elimination of Fistula among community leaders and the state at both the federal, state and local levels. Challenges related to facility capacity, post-operative care, and

monitoring of patients were noted including the deaths of four patients which appeared to be relatively high for an elective surgery.

The satellite centers approach for Fistula treatment was carried out in Ethiopia. This outreach effort involved five satellite centers distributed throughout the country to cover the different regions of Ethiopia. Key objectives were to provide treatment, train staff and prevent OF. Each centre was set up to meet given standards of bed capacity for fistula patients and high risk maternity patients, obstetrician and gynecologist, nursing and nurse aid levels and medicine stock levels.

The mobile unit is a treatment outreach program carried out in Chad that provides 20 operating days and 30 postoperative days. During the mission functional theatres in local hospitals are used. This approach has brought about improvements in patient numbers coming for treatment, incremental capacity of doctors from simple repairs to the more complicated cases. Road infrastructure is a challenge and air transport is being considered for the future. The method however shows promise as a solution for large countries with limited resources.

Other outreach services that have been tried include the outreach to general hospitals such as that used in Mali and that adopted by AMREF which visits over 70 hospitals in East Africa.

For long, Fistula repairs have been dominated by the approach consisting of closing the hole only. However, the SA presentation came up with an innovative approach which focuses on patient's functional restoration of affected organs.

The key challenges to treatment efforts include availability of adequate numbers of well trained health personnel, including doctors, surgeons, clinical officers and nurses with a comprehensive understanding of Fistula, its treatment and the necessary post operative care required to ensure a successful outcome. Training will have to be an integral part of any treatment until the numbers of health professionals are adequate. Training strategies need to be developed. Pre and post treatment counseling and support is necessary to eliminate recurrence and ensure early treatment.

6. Social Reintegration

The tendency for many facilities involved with fistula has been to focus on the technical aspects related to treatment and repair. Often repairs are done to varying levels of success and the woman returns to face poverty, rejection, exclusion, marginalization and other social realities that may drive them to sex work or other risk behavior which may, for instance, result in another pregnancy before the expiry of the six months recommended abstention from sexual intercourse. The conference noted a growing consensus that a holistic approach was needed to effectively respond to challenges posed by the scourge of fistula and to work towards its elimination. This approach encourages that a woman should be treated as a whole (not fragmented) person, with equal attention paid to her physical, psychological, social and spiritual well being; to her as an individual and as a family and community member, in relationships with others. Recently health service providers have acknowledged the need to place emphasis as well on reintegration as a third and integral leg of a three-pronged strategy in order to prepare women to resume as close to normal life as possible following treatment and to overcome adverse factors related to causes of fistula.

- **Counseling services**

It was noted that thinking about counseling services for women with fistula was relatively new for most participants. In their vulnerable situation, women afflicted with fistula needed information on their situation, its causes, physical and mental rehabilitation – possible treatment and likely consequences, healing, maintaining health and self care, and reintegrating family, religious institutions and other organs of community. Where they exist, counseling services at some health care facilities (post op or exit) have mostly concentrated on the woman as an individual, a patient, and as a potential carrier of another pregnancy. They have seldom if ever, included follow up services after discharge from the facility. Some civil society groups also offer counseling services as part of a more community involved effort.

Engender Health noted the results of the needs assessments carried out in twelve countries in 2002/3 which identified the general lack of appropriate standards of quality counseling afforded fistula clients and, therefore, the need for guidelines for counseling this specific group. Hence Engender Health facilitated a meeting in Uganda March 2005 with twelve participants from Africa and Asia with the objective to learn about critical issues that fistula clients faced in order to better understand their needs, identify barriers and ways to overcome them, and locate points of counseling intervention and appropriate messages related thereto. The meeting culminated with the following key points:

- ✓ Understand the clients reality (e.g. illiteracy);
- ✓ Build confidence and rapport, and dispel misconceptions;
- ✓ Work with former fistula clients as translators or counselors to overcome language and other barriers;
- ✓ Counsel client at all stages to prepare them for treatment and reintegration;
- ✓ Train all staff of facilities involved with fistula;
- ✓ Support groups and share success stories;
- ✓ Centre women with fistula as key players in the healing process; and
- ✓ Counseling to incorporate partners and family members.

Discussion noted that staff in general and particularly the nurses were often too overstretched to offer quality counseling if at al. Further noted were the need to include social workers and to include health workers from Northern Uganda where AMREF had run outreach fistula clinics since 1992, even if Engender Health did not operate in that area.

- **Community entrenched strategies and solidarity:**

DIMOL's (an NGO working in Niger) process of social rehabilitation is a cycle beginning where the woman is found (often places near health facilities but not their 'home' where they take refuge away from stigmatization and marginalization) and ending in the community. The first phase comprises interviews with fistula victims/survivors to establish origin, where fistula was contracted, history of the condition etc. After physical examination patients are referred to a health care facility if they have not yet been repaired. The women receive counseling to prepare them for return to their communities. DIMOL facilitates meetings with husband, family, village leaders, community health care personnel, and any significant others. Learning from experience, realizing that women do not want it known where they have been, DIMOL uses a low entry technique widely accepted in Niger. To foster reintegration they use various methods of communication such as videos with interviews with survivors, community sensitization campaigns, fundraising, setting-up women's groups to fight for their rights. Groups in the community such as fistula survivors, youth, women, spouses, neighbors, and so on, are actively involved in these reintegration activities.

Similarly Delta Survie in Mali provides a continuum of services ranging from IGA, to education while also focusing on the protection of the environment. The NGO is promoting a socio-cultural approach to development and is currently doing extensive work at the community level. Delta Survie is also actively involved in research to determine the critical factors that hinder or facilitate access to services.

- **Networking and advocacy**

As reiterated in various presentations, the Roadmap, UNFPA campaign documents, partnerships are key to the success of the Campaign to End Fistula. DIMOL in Niger spearheaded the creation of a network by lobbying all organizations engaged in any way with fistula and those dealing with women's and children's rights. Awareness-raising among this group led to coordination of efforts and of the group. A constitution was adopted in June 2004 . Other Civil Society Organizations in the region also engage networking as a conscious strategy (e.g. "Delta Survie" in Mali)

- **Economic empowerment Poverty and Reproductive health**

A recurring theme of the conference was the stress on the interface between poverty and fistula. It was acknowledged that the sustained success of repairs, counseling and other support may be threatened by survivors returning to situations of dire poverty. In that situation the pecking order of hierarchies defined by economic, gender and other social relations situates them in the relatively most powerless and most vulnerable positions which expose them to risk and abuse. Realizing this, DIMOL's program in Niger includes financial assistance of CFA 25,000 to each survivor to ease the reintegration back into society. Communities have set up a funding pool to enable women with transport difficulties to access health facilities and medical supplies and other needs. Income generating activities such as sewing, weaving and preparation of beauty products are helpful in the social reintegration of women affected by fistula.

In Chad COTIMAF with nine volunteers work together in collaboration with hospitals to visit different places to find sufferers and, in their own words, enable them to live in dignity. During weekly visits they bring them food and psychological counseling. Sensitive to the need for sustainability, with the help of UNFPA, COTIMAF training centre ran from 1995. Ten of the poorest women received training in weaving and related skills that afforded them self sufficiency and ability to reintegrate successfully with five proceeding into remarriage. Sustainability of the project is now threatened by lack of funding, equipment and the far distances women have to travel.

The relationship between RH and Poverty was extensively debated. For long, poverty alleviation paradigms were dominated by the income and economic approach. Over time, development specialists came to realize that the non-income dimensions of poverty namely health and education are critical if developing countries don't want the ICPD and MDGs to be elusive goals. This is particularly important at a time when the UN system is undergoing drastic reforms that are likely to have far-reaching consequences on both the structure and mandates of UN Funds and Programs. UNFPA has all the cards in its hands because without health and education development will always remain a distant goal. It is the right time to strategically position UNFPA within the broader context of the UN reform and work out functional synergies with key partners and agencies.

V. Mainstreaming Obstetric Fistula into Country Health Systems and National/Regional Policies and Programs

Much work was devoted to drafting, negotiating developing and agreeing on the conference output in the form of a Call to Action and a draft Regional Strategy for Obstetric Fistula Elimination in Africa. Together with the Road Map, these two documents will be the main guide towards mainstreaming OF into national health systems and programs.

The methodology adopted for the development of the regional strategy consisted of group work structured along the Fistula Campaign major intervention points namely Prevention, Treatment/Care and Social Reintegration. The different groups worked alongside the preliminary elements of the strategy provided by the working group established early this year to reflect on and produce a working document that would serve as a basis for the development of a regional strategy for the elimination of Fistula in the Africa region. The consultations culminated with a preliminary draft of the regional strategy which is going to be shared with the Country offices and partners for review and comments before it is finalized and adopted.

The group set up to develop the Call to Action adopted a strategy similar to the one applied by the regional strategy group. The working group was comprised of UNFPA staff, international partners as well as Government representatives. The process was truly participatory. The Call to Action was discussed and adopted in plenary and inputs from all participants were reflected in the document which has been submitted to WHO for endorsement.

- **National Strategy Development**

The experience of ***Mauritania*** in developing a national strategy was useful and instructive. A study was conducted in 2004 to determine the scope of fistula and available expertise as well as identify needs in three of the thirteen regions of the country. A draft strategy was developed in February 2005, and adopted in April of the same year. The aim of the national strategy is to integrate the fight against fistula into national reproductive health and safe motherhood policies and programs, health facilities, advocacy and sensitization of communities about OF. The first mission of fistula repairing was planned in Nouakchott in 2005, which will be followed by decentralized missions.

The strategic framework focuses on the development of partnerships between all stakeholders; strengthening of prevention strategies, strengthening capacities, health services, upgrade and rehabilitate hospitals; psycho-social treatment and counseling with support of NGOs. Long term actions are education of young women, fight against poverty, delay marriages and first pregnancies. Achieved during 2004 were building of partnerships, national committee, upgrading of hospitals, integrating OF into training of doctors and surgeons, training health professionals on OF, promotion of research in collaboration with associations. Lessons learned related to the complexity and multi-causal nature of OF, the need to create enabling environment, importance of advocacy tools in order to rid women of the scourge of fistula, the need to get politicians on board, need to improve living conditions and the need to build sustainable capacities to effectively manage fistula.

- **Ongoing advocacy for Obstetric Fistula**

Incorporation of OF into maternal health strategies and programs and allocation of adequate resources remained central to all efforts to eliminate fistula, irrespective of the components,

prevention, treatment and re-integration. Some progress was recorded and acknowledged, indicating that the current advocacy was beginning to show results. In Benin 39 women counselors had already been identified to be advocates of OF. Other countries needed to follow the example of appointing advocates.

The protection of health and reproductive rights was acknowledged by a few presenters during discussions but there was a glaring silence on experiences in these. Many speakers did however highlight the importance of these rights as one of the key preventative strategies.

VI. Media strategies for the campaign to end fistula

1. UNFPA

From a communications standpoint fistula has been approach as a window of opportunity to engage the media and other new partners including the private sector, in support of health, gender equity, maternal health and adolescent reproductive rights in the context of poverty and inadequate EmOC in Africa. The media strategy is structured in four main components as follows.

Global Communication Strategy comprises a logo with orange rings symbolizing wellness and partnerships, to be used consistently by all partners; Three signature themes reflecting the three pillars of the campaign – Preventing harm (prevention), healing wounds (treatment), renewing hope (reintegration); A comprehensive website in English and French for multiple audiences; A campaign brochure in English, French, Spanish and Arabic; Documented stories of fistula patients and their doctors in various countries that are pasted on the website.

Raising visibility: media outreach with articles already having appeared in major international media (e.g. New York Times, International Herald Tribune, The Wall Street Journal, Reuters, Drum Magazine, Marie Claire, and Australian Women's Weekly). Private sector support of the London based advertising agency, Young and Rubican, which is developing an ad campaign to be launched in the UK in 2006 has been secured while Virgin Unite (Virgin Group of companies) supported the Nigeria Fistula Fortnight in February 2005 that was covered extensively by local and international press. Natalie Umbruglia, an Australian singer/actress who is the face of L'Oreal, signed on as a spokesperson for the Fistula Campaign in January 2005.

Increasing donor agency support through keeping the press interested in Natalie's fistula activities, distributing campaign materials, continuous updates on progress and results in different countries, strengthening monitoring and evaluation, and continued outreach to partners and country offices.

Building national and regional communication strategies: with the purpose of providing guidance to country media workers ensure that the Fistula Campaign media work is strategically focused with most effective use of resources, with the same aim and approach as the international strategy. Challenging, motivating and empowering messages will be made relevant to varying national contexts.

Challenges for the media so far are that fistula as a condition is hard to explain to both public and media. Lack of data on fistula prevalence rates in various countries and reliance on WHO 1989 data, hence the urgency for needs assessment studies to determine prevalence. Need for

short and long term targets to be developed in order to monitor and demonstrate progress to partners, media and donors. Need to build national and regional communication strategies and advocacy materials.

2. Campaign involving the media in Benin

The experience of Benin in engaging the media was an instructive case study. The two-pronged (prevention and treatment) strategy was driven by the Public Health Ministry with the support of UNFPA and in partnership with various stakeholders. To fulfill the first objective to propagate information on reproductive health including OF, partnership with the media was developed. A documentary on OF and ten relevant messages were developed and used in the campaign by 19 radio stations, TV and electronic media. 40 healthcare practitioners and radio announcers and 39 municipal representatives were trained. With regard to the provision of emergency obstetric care, needs assessment were carried out, partnership with e.g. UNICEF and USAID and a network established. The referral system was strengthened, supply of medicines drugs ensured, 80 service providers at maternity clinics trained on OF treatment, and actual screening and referrals done. A big challenge was imposed by poor roads and transport to ferry patients to clinics and treatment centre in Cotonou. Among lessons learned were, the importance of systematically integrating OF within the health (and RH) program as against being a vertical strategy, hence the equipping of all facilities and training and improving efficiency of various personnel during the campaign left lasting benefits for the whole system. Second is the importance of collaboration and clear messages.

VII. Capacity Development: New Solutions to old problems?

For decades, Capacity Development has been a crucial component of Technical Cooperation. The prevailing visions and approaches have been dominated by a simplistic and optimistic view that focused only on the transfer of knowledge and know-how to the national counterpart. Over time, it was realized that this view ignored or underestimated other critical factors such as local knowledge, institutions, culture, social capital as well as the different layers of Capacity Development. The participants extensively discussed the concept and agreed that capacities (understood in the sense of ability to perform functions, solve problems set and achieve objectives) should not be reduced only to training of individuals. Instead, capacities should be developed at the institutional and organizational levels. In addition these capacities can only be effective if systems and mechanisms to operationalize them are put in place, hence the fourth dimension: the Strategic System level.

The dividing lines between Capacity Development and Capacity for Development tend to blur. The former being the process by which external partners strengthen the existing capacities in a given country. Capacity for Development however consists of identifying the critical capacities needed to achieve development in a particular country and is to be informed by a critical preliminary needs assessment phase to map existing capacities and identify gaps.

Another critical issue of Capacity Development is the functional linkage and relationship between capacity and performance. There are still unresolved questions regarding the elements of capacity that are critical to performance and the level of capacity necessary for adequate performance.

VIII. Summary of Conclusions and recommendations

The South Africa Conference was by all accounts a resounding success. While much has been achieved, tremendous challenges still lie ahead. The finalization and dissemination of both the Call to Action and the Regional Strategy are of critical importance if we do not want the SA Conference to be just another meeting. In addition, the effective integration and strategic linkages between Fistula and Safe Motherhood initiatives should go beyond public declaration of principles and be demonstrated at the policy and program delivery levels. There is also an urgent need to make sure that Fistula is integrated into National Roadmaps for accelerated attainment of the MDGs related to Maternal and Newborn Health in Africa.

Conference provided a good forum for sharing experience and lessons learned from various countries and various quarters in government, civil society, Non-Governmental Organizations and other people involved in the fight to end fistula in Africa. The sharing of experiences has demonstrated the steady and sustainable pace at which the campaign to end fistula has moved, so much so that by the end of 2005 more than 30 countries have been registered as active members of the worldwide fistula campaign. Of the 22 African countries that have completed the needs assessment, more than ten have completed national strategies to end fistula within the framework of national reproductive health policies and programs. This will be precisely one of the objectives of the new UNFPA initiative to tackle maternal mortality and morbidity using Obstetric Fistula as an entry point.

Many of the needs assessment that have been conducted in the region have shifted from the initial narrow focus to encompass the areas of socio-cultural and socio-anthropological issues, thus entailing a more qualitative component that would help expand the scope and reach of efforts to address fistula. Most countries have networks including a core group of well informed, dedicated, well meaning professionals, civil society leaders, community leaders, women and other activists who in pledging to combat this scourge have lent their support, minds and brains, their muscle and voices, to advocate and mobilize for the campaign in Africa.

The outcomes of the conference in the form of the Johannesburg Call to Action and the Draft Outline of the Africa Regional Strategy for Fistula Elimination were other main conference achievements. These were subjected to intense participation, contribution and consensus before adoption and should enable all to 'walk the talk'. The Call reflects the common denominator of all views expressed by the participants and is to be used as 'a call to arms' to lobby and nurture political commitment and support, to leverage more commitment and resources, to mobilize and to build networks and coalitions. The regional strategy, on the other hand, is a solid framework that would guide and inform the formulation of national as well as regional responses to effectively tackle fistula within a broader context of maternal health.

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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 theMDGs related to Maternal and Newborn Health in Africa.

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 labor 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, counseling, mental health services and health education; additionally, ensure access for all women to social reintegration support, including partnership with women's associations, organizations 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 programs, 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.

Making Motherhood Safer by addressing Obstetric Fistula (OF), South Africa, 23 – 26 October 2005

Objectives

- To share experiences from fistula programmes in the region and to draw lessons learned with a view to guide programming
- To explore how obstetric fistula can be an entry point for improving maternal health and how national maternal health road maps can mainstream the management of obstetric fistula
- To draft a Call to Action highlighting key policy and programming issues towards eliminating fistula in the context of improving maternal health
- To build consensus on preliminary elements towards the development of a draft Africa Regional Strategy for Fistula Elimination

Expected Results:

- Experiences and lessons learned in obstetric fistula programming shared and disseminated
- Consensus reached on how obstetric fistula can act as an entry point to improving maternal health and how it can be mainstreamed into safe motherhood national policies and programmes
- Call to Action adopted and disseminated
- Outline of a draft Regional Strategy for Obstetric Fistula Elimination in Africa developed

Opening Ceremony: Sunday, 23 October 2005		
Chair: Mr. T. Mseleku, Director General of Health, SA		
Time	**Topic**	**Presenter/Facilitator**
15.00 – 18.00	Registration	-
18.00 – 18.10	Chair person's remarks	Director General of Health, SA
18.10 – 18.20	Welcoming remarks	Mr. George Nsiah, UNFPA Representative, SA
18.20 – 18.30	Video Presentation	-
18.30 – 18.45	Objectives of the conference	Ms. Fama Ba, Director, Africa Division, UNFPA/HQ
18.45 – 19.05	Statement from UNFPA	Ms. Thoraya Obaid, Executive Director, UNFPA
19.05 – 19.25	Statement from WHO	WHO/AFRO
19.25 – 19.50	Key note address and opening of workshop by Government of South	Dr. Manto Tshabalala-Msimang, Minister of Health, SA

	Africa	
20.00 – 22.00	Dinner	-
DAY 1: Monday, 24 October 2005		
Chair: Dr. Luc de Bernis, WHO, Geneva		
Morning Rapporteur: Dr. Gifty Addico, UNFPA Ghana		
08.00 – 08.15	Objectives and expected results	Mr. Yahya Kane, UNFPA/HQ
08.15 – 08.45	Africa Regional Roadmap for Maternal Health	Dr. Seipati Mothebesoane-Anoh, WHO AFRO
08.45 – 09.15	The Global Campaign to End Fistula	Overview and preliminary remarks: Dr. Arletty Pinel Presentation: Mr. Yahya Kane, UNFPA/HQ
09.15 – 09.30	Addressing fistula in the context of Poverty Alleviation	Ms. Maggie Bangser - Women's Dignity Project
09.30 – 10.00	**Discussion**	
10.00 - 10:30	**Coffee/Tea Break**	
Chair: Dr. Loyiso Mpuntsha, Department of Health (DOH), SA		
10.30 – 10.45	Needs assessment findings	Dr. Yvette Dologuele-Dessande, CAR
10.45 – 11.00	Needs assessment findings: Qualitative study	Dr. Jeannette Kouangha, Congo Brazzaville
11.00 – 11.15	Socio-cultural study on OF from Burkina Faso	Dr. Olga Sankara, Burkina Faso
11.15 – 11.45	**Discussion**	
11.45 – 12.00	Preliminary results of OF situation analysis in SA	Dr. Pulane Tlebere, DOH, SA
12.00 – 12.15	Strategies and experiences in prevention of OF	Prof. Eddie Mhlanga, Nelson Mandela SM, Durban, SA
12.15 – 12.30	Experience on prevention of OF from Benin	Mr. Theodore Soude, Benin
12.30 – 13.00	**Discussion**	
13.00 – 14.00	**Lunch Break**	
Chair: Mr. Yacine Diallo, UNFPA Representative, Chad		
Afternoon Rapporteur: Dr. Isabelle Moreira, UNFPA Senegal		
14.00 – 14.15	Community Mobilisation for OF to improve Maternal Health in Eritrea	Dr. Berhane Debru, MoH Eritrea

14.15 - 14.30	National Strategy Development	Dr. Savy Genereux and Dr. Sara Khan, Mauritania
14.30 – 14.50	**Discussion**	
14.50– 15.05	Fistula Fortnight	Preliminary remarks: Yahya Kane Presentation: Mrs. Beatrice Eluaka, MOH Nigeria
15.05 – 15.20	Preliminary consensus on training: Outcomes of an expert meeting	Dr. Peter Sikana, Sierra Leone
15.20 – 15.35	Fistula Treatment services and preliminary experiences with satellite centers	Dr.Solomon Abebe, Addis Ababa Fistula Hospital
15.35 – 16.00	**Discussion**	
16.00 – 16.20	**Coffee/Tea Break**	
Chair: Ms. Kristin Cooney, USAID/WARP Ghana		
16.20 – 16.35	Fistula Treatment through outreach services	Dr. Tom Raassen, AMREF
16.35 – 16.50	Fistula Treatment Services within a general hospital	Prof. Kalilou Ouattara, Point G Hospital, Mali
16.50 – 17.05	Management of OF patients with focus on functional restoration of affected organs	Prof. Bruno Cooreman, University of Free State, South Africa
17.05 – 17.20	Mobile treatment services	Dr. Mohammed Koyalta, Hopital de la Liberte, Chad
17.20 – 17.45	**Discussion**	

DAY 2: Tuesday, 25 October 2005		
Chair: Ms. Maggie Bangser, Women's Dignity Project		
Rapporteur: Dr. Sara Khan, UNFPA Mauritania		
08.00 – 08.15	Preliminary Elements of the Call to Action	Dr. Yves Bergevin, UNFPA/HQ
08.15 – 08.35	Obstetric Fistula: Guiding principles for clinical management and programme development	Dr. Luc de Bernis, Making Pregnancy Safer, WHO/Geneva
08.35 – 08.50	Counselling Services	Ms. Erika Sinclair, EngenderHealth
08.50 – 09.10	**Discussion**	
09.10 – 10.30 (Presentation & Discussion)	Panel on civil society experiences in prevention and management of OF	Mrs. Traoré Salamatou, DIMOL, Niger Mr. BenjaminToidibaye COTIMAF, Chad Mr. Ibrahim Sankaré, Delta Survie, Mali Dr. Kéïta Kadiatou, IAMANEH SUISSE, Mali DOCS, DR Congo (TBC)
10.30 – 10.50	**Coffee/Tea Break**	
Chair: Mr. Makane Kane, UNFPA Rep. Ghana		
10.50 – 11.05	Fistula as a catalyst :Outcomes of a strategy meeting	Ms. Kate Ramsey, UNFPA/HQ
11.05 – 11.20	Media Strategies for the Campaign to End Fistula	Mr. George Ngwa, UNFPA
11.20 – 11.40	**Discussion**	
11.40 – 12.20	Presentation of draft elements for an Africa Regional Strategy for Fistula Elimination	Mr. Theodore Soude, Prevention Dr. Charlotte Gardiner, Treatment Mr. Yahya Kane, Reintegration
12.20 – 13.00	**Discussion**	
13.00 – 14.00	**Lunch Break**	
Chair: Dr. Kéïta Kadiatou, IAMANEH SUISSE, Mali		
Afternoon Rapporteur: Dr. Florence Ebanyat, UNFPA CST Harare		
14.00 – 15.45	Group work on Prevention, Treatment and Reintegration	Facilitators: Prevention – Mr. Theodore Soude

		(French), Prof. Eddie Mhlanga (English) Treatment – Prof. Kalilou Ouattara (French), Dr. Charlotte Gardiner (English) Reintegration – Dr. Yelibi Sibili (French), Mr. Yahya Kane (English)
15.45 – 16.30	**Coffee/Tea Break**	
16.30 – 16.45	Group presentation - Prevention	Group rapporteur
16.45 – 17.00	Group presentation – Treatment	Group rapporteur
17.00 – 17.15	Group presentation - Reintegration	Group rapporteur
17.15 – 18.00	**Discussions and recommendations**	
DAY 3: Wednesday, 26 October 2005 - Plenary		
Chair: Dr Uche Azie, Director, UNFPA/CST, Harrare		
Rapporteur: Ms. Aisha Camara, UNFPA Uganda		
08.00- 09.00	Compilation of thematic group work into one document	Chair and rapporteur of each thematic group
08.00- 09.00	Video show for participants not involved in the above activity	Optional
09.00 – 09.20	Presentation of the draft outline for the Regional Strategy	Dr. Charlotte Gardiner
09.20 – 09.45	**Discussion**	
09.45 - 10.30	Presentation and Adoption of the Call to Action	Dr. Yves Bergevin
10.30 – 11.00	**Coffee/Tea Break**	
Chair: Prof. Eddie Mhlanga, Nelson Mandela School of Medicine, Durban		
11.00 – 11.30	Summary and Wrap-up	Dr. Mamadou Diallo, UNFPA Mali
11.30 – 12.00	Closing remarks	MOH, SA
12.300 – 14.00	**Lunch** **+ Meeting of OF workshop organizers and donors**	**MOH/UNFPA**

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Regional Workshop on " Making Motherhood Safer by addressing Obstetric Fistula in Africa"

Johannesburg, South Africa. 23 –26 October, 2005

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