Good morning. It is a great honour to be here with you today to discuss the research needs and critical public health priorities around obstetric fistula.

I am going to speak to you specifically about the global Campaign to End Fistula, an initiative led by UNFPA and myriad partners many of whom are well represented in this room today.

I will first begin with a general overview of the Campaign, its nexus and structure, and then give you a taste of what we’ve discovered through country-level needs assessments, explain a bit how we’re working both at the country and global level to address these findings, and lastly, the important lessons learned and outstanding questions that have come up throughout the last few years of implementation.

Following my presentation, my UNFPA colleague from Benin, Dr. Edwige Adekambi, will present the Benin experience in implementing the Campaign to End Fistula.
The Cost of Giving Birth

- Over 300 million women in developing countries suffer from complications of pregnancy, childbirth, abortion
- 529,000 die each year – one woman every minute
- 4 million babies die, 4 million are stillborn
- Lifetime risk: from 1 in 16 to 1 in 2800
- For every woman who dies, between 20 and 50 survive, but suffer from disabilities such as obstetric fistula

Giving birth should be a time of joy. But as you know, for more than half a million women each year, pregnancy and childbirth end in death. For every woman who dies, approximately twenty to 50 women suffer serious injuries or disabilities, which, if untreated, can cause lifelong pain and humiliation.

Women risk death and disability each time they become pregnant. Women in developing countries face these risks much more often, since they bear many more children than women in the developed world.¹

You can see the great disparity in lifetime risk of women dying in pregnancy and childbirth between the developed and the developing world, 1 in 16 women risk death and disability in Africa, compared to 1 in 2800 in developed countries.
Maternal morbidity has been a neglected area in maternal health. Each year, an estimated 15 million women are affected with a chronic morbidity due to childbirth. One of the most severe forms is obstetric fistula. An estimated 2 million women live with fistula, predominantly in Sub-Saharan Africa and parts of Asia and the Arab world.

Due to a lack of concrete data, lack of political will and many other factors, maternal morbidity has been a largely neglected area of maternal health.

As mentioned earlier, for every woman who dies in childbirth, 20-50 survive but suffer from lifelong disabilities, one of the most debilitating being obstetric fistula.
How common is fistula?

**Incidence:**
- Global: 50,000 to 100,000 new fistula cases each year (WHO)
- Kenya: 1 to 2 fistula cases per 1,000 deliveries
- East Africa: 3 to 5 cases per 1,000 deliveries in areas with no access to EmOC

**Prevalence:**
- 2 million worldwide (WHO)
- Kenya – 30,000
- Bangladesh – 70,000
- Nigeria – 400,000 – 800,000

These numbers are very likely underestimates as women affected by fistula are usually isolated and in remote areas and therefore may not factor into these facility-based statistics.

Sources:
Incidence:
Global (WHO estimates from 1989)
Kenya (NEEDS ASSESSMENT OF OBSTETRIC FISTULA IN SELECTED DISTRICTS OF KENYA, MOH/UNFPA – 2004)

Global (same as above)
Kenya (same as above)
Niger (Falandry 1998)
While fistula is obviously a medical condition, there are numerous socio-cultural factors that both dispose women to the condition and which also result from a life with obstetric fistula.

Firstly, fistula primarily affects young, poor women with little or no access to maternal health services. Medical consequences as we all know are incontinence, infection, and possible infertility. Social consequences: isolation, abandonment, stigma, vulnerability.

While the medical and social consequences of obstetric fistula on the life of mother are life shattering, studies have also found the rate of stillbirth to be as high as 90% among women with fistula. So not only is a woman with fistula left with chronic incontinence and shame, but she has also lost what is most often her first child.
The Campaign to End Fistula

Goal:
To make fistula as rare in developing countries as it is in the industrialized world.

The Campaign, led by UNFPA, involves a wide range of partners and over 30 countries in Africa, Asia and the Arab States.

Campaign launched in 2003 by UNFPA with partners, Campaign aims to make fistula as rare in the developing world as it is in the industrialised world.

Photo: Eighteen year-old Doreen is just emerging from the operating theatre at Kitovu Hospital in Uganda. The delivery that caused the fistula took place at home where she endured 5 days of labour, ending in a stillbirth. Both of her parents are no longer living and she and her sister live with their grandparents.
Why focus on fistula?

- Many women are affected
- Fistula is Preventable and Treatable
- Fistula is a strategy for reaching the poorest, most marginalized women
- Fistula puts a human face to reproductive health issues

AFFECTS MANY WOMEN – refer to previous slide at least 2 million worldwide, with up to 100,000 new cases each year – many more are at risk

PREVENTABLE/TREATABLE – we know what needs to be done, not waiting for a new technology. Can do something immediately. Unfortunately many women like Saida (poor, young, illiterate and living in remote regions, do not have access to vital health services to prevent and treat this condition.

Reaching the poor – because typically the poorest women are affected, focusing on fistula helps us to reach the poorest and most marginalized women.

LINKS to MANY ISSUES – provides an effective entrypoint for addressing issues that face women on a daily basis– poverty, malnutrition, lack of education, early pregnancy, inaccessibility of maternal health care, gender inequality and human rights. Fistula also places a human face to reproductive health issues.

When you describe the story of how a woman developed fistula, you are highlighting the great inequities in access to reproductive health care, economic and geographic barriers to accessing care, the great weaknesses in the health delivery system and the social and cultural inequities that women and young girls face.
Before the Campaign was launched, it was apparent that while many individual efforts to manage fistula were underway worldwide, there was no coherent and cohesive effort. In launching the Campaign, UNFPA sought to bring together a wide array of partners to address fistula in a holistic manner, in the context of safe motherhood, looking not only at the facility-based treatment, but also at the critical area of prevention and social reintegration.
You can see from this slide the evolution and history of the campaign, beginning with two fistula meetings with a few organizations who had decided to take action, followed by the launch in 2003, then a groundbreaking series of fistula needs assessments and two additional regional meetings to discuss country level progress and strategy.
As I’ve mentioned, the Campaign brings together many partners at the global level, including international and regional organizations— as well as new partners in the private sector.

A key example of the Campaign’s partnerships in action was a fistula advocacy and training event “the Fistula Fortnight”, which took place in 4 states in Northern Nigeria in February of this year. UNFPA collaborated with Richard Branson’s charitable group, Virgin Unite, the international organization Voluntary Services Overseas, Nigerian Red Cross, Nigerian health providers, and Nigerian state and federal government to repair 545 women, train a total of 12 national surgeons and 40 nurses in fistula management, and to raise awareness about fistula and safe motherhood at the national and global level. A report on the Fortnight is available in your folders.

Many of the organizations you see on this slide are members of The Obstetric Fistula Working Group, which is an alliance comprised of international and regional organizations that coordinate fistula treatment and prevention efforts worldwide. These initiatives are done collaboratively or on an individual organization basis. The group meets two times a year to discuss and coordinate joint publications, and meetings on fistula-related technical issues.
The Campaign is now working in 30 countries in sub-Saharan Africa, South Asia and some Arab states to:

Prevent fistula from occurring
Heal women who are affected
Renew the hopes of those who suffer from the condition

• The Campaign treats each of these three intervention points as equally critical and inextricably linked, viewing prevention as key to fistula elimination, treatment as an entrypoint to prevention, and reintegration as a critical step in prevention, for if healed women are given adequate information, education and training, their chances of planning and spacing their next pregnancy and of having their next delivery in a health facility is that much greater.

• Within the context of safe motherhood, not a vertical programme.

Each of these 30 countries is at various stages of the Campaign.

**Phase I**: Campaign countries first undergo a rapid needs assessment to assess national capacity to manage fistula.

**Phase II**: In response to the needs assessment outcomes, each country conducts, together with partners, a planning stage of six months to develop a comprehensive national strategy. This phase includes raising awareness among relevant national stakeholders, developing national strategies and forming coalitions to address fistula, as well as building capacity through provision of equipment and training to some service sites.

**Phase III**: The planning period is then followed by a comprehensive national action plan which includes advocacy to improve the political environment for addressing fistula; enhancement of accessibility, affordability and quality of health services for prevention and treatment; community awareness raising on maternal health and harmful traditional practices; and coordination of services to help women with repaired fistulas reintegrate into their community.
As mentioned, in 2003, EH and UNFPA conducted the first large-scale mapping exercise in nine countries to build the body of knowledge on the condition of fistula in Africa and Asia.

The nine country assessment was followed by additional similar exercises in other countries.

There have now been completed 21 fistula needs assessments and further in-depth research is currently underway.
<table>
<thead>
<tr>
<th>Methodology of Fistula Needs Assessments</th>
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<tbody>
<tr>
<td>✓ Observations at facilities</td>
</tr>
<tr>
<td>✓ Review of theatre logbooks</td>
</tr>
<tr>
<td>✓ Interviews with providers, patients, government, NGOs</td>
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<tr>
<td>✓ Focus group discussions with key informants</td>
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<tr>
<td>✓ Qualitative findings</td>
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Key Findings - Prevention

- Limited access to EmOC; low C section rates
- Low use of ANC and family planning
- High # of deliveries at home or with a TBA
- Harmful cultural practices
- Low awareness of the importance of skilled birth attendance, risks of pregnancy and childbirth
- Poor transport, bad roads, lack of funds for transport and care

The met need for EmOC and C section rates remain well below the minimum acceptable levels. In Mauritania the met need was only 35% and the C section rate is at .5% compared to the internationally recommended standard of 5 percent.

- In Cameroon, 45% of women with fistula did not attend one prenatal care visit throughout their entire pregnancy, reasons being the refusal of the spouse and the long distances to health facilities.

**Many reasons for home deliveries with a TBA**

In many countries such as Eritrea and Kenya: tradition dictates first child born at the grandparent or husbands’ home. 70 to 80% of deliveries in the study district in Kenya were assisted by a TBA.

- Other factors include geographic and financial difficulties in accessing facility-based care
- Positive perception of traditional childbirth remedies and practices
- Poor provider attitudes towards rural women or towards women who hadn’t come in for an antenatal care visit before delivery.

Low cost of TBA services;
Lack of birth preparedness due to the belief that preparations will bring on misfortune

- In Zambia, when asked how women in labour get to the hospital, they said most often women walk if they have no bicycle. Participants in Southern province said ox-drawn carts are a very useful form of transport to a woman in labour.

- In West Pokot Kenya, FGM was also cited as one of the contributors to OF through crude incisions to release scar tissue from infibulation, often injuring the bladder and/or the rectum. – Kenya
Key Findings – Barriers to Treatment

Huge backlog of fistula patients

- Many women unable to receive needed treatment
- Lack of specialized treatment centres
- Extensive barriers to treatment – distance, cost, lack of awareness

Kenya: Estimated 3,000 new fistula per year, only 7.5 percent currently being treated (AMREF treating approx. 500 per year)

In BF, women were reported to wait as long as 60 months for treatment, and record reviews revealed that some women arriving at facilities never received treatment at all.

Cameroon – the cost of 200,000 Fcfa is not accessible to most patients, as 56.3% of camerounais live in poverty.

Eritrea – Many women made long, expensive, and difficult journeys from their home villages to reach fistula repair.

“I heard about it on the radio. I came by bus from Gash Baraka. I left my home at 5 am on the first day and made it to Barentu by 4 pm that day. I left from Barentu at 5 am the next morning and arrived in Massawa at 6 pm. I have been waiting here since Friday night. I came alone and left my children at home.”

32 year-old woman living with fistula for 17 years
Key Findings – Community Perceptions of Fistula

- Lack of awareness of causes, symptoms and treatment options
- Prevalence of traditional remedies
- Shame and taboo associated with fistula
- Beliefs that fistula is brought on by woman’s bad behaviour

In Cameroon it is believed that a woman causes fistula by eating certain things during pregnancy, cheating on her husband, or because the baby is too large.

Similarly in Burkina – widespread beliefs that fistula is caused when a woman offends someone or is unfaithful.

In Eritrea, a woman reported that “They [the health workers] saw it. And they told me that the problem will take care of itself, that it will repair by itself. I was told that all I had to do was eat well.” 35 year-old woman living with fistula for 6 years (Eritrea interviews report)
Key Findings - Human Resources and Infrastructure

- Lack of providers specialized in repair and pre and post-op care
- Lack of protocols & standards for care
- Lack of functioning equipment and supplies
- Lack of transport and communication systems

-Burkina Faso – permanent surgeons are not available on staff at the two university hospitals, or in the five regional hospitals.

- In many of the countries assessed, the majority of doctors repairing fistula had not had any formal training, the rest were trained through On-Job Training.

- In Malawi, although the services are available, pre- and post-operative guidelines/protocols are not available in most of the institutions. As a result, nursing personnel are not very sure on how to manage a fistula patient post operatively and patients are given different types of information on abstaining from sex, family planning, nutrition, pelvic floor exercises, etc. It was noted however that all health facilities advised the patients on future pregnancies in terms of early antenatal care and delivery through caesarean section.

- In many countries, such as Cameroon, no training opportunities available in the entire country.

- Treatment facilities were found to be lacking in adequate equipment and supplies.

- Burkina: four facilities able to repair fistula, but equipment old, success rate only 60%, waits as long as 60 months for treatment

- Cameroon, equipment mostly available, but the state of equipment and supplies are very weak.

- Somalia - Public sector hospital buildings are old and deteriorated, sometimes destroyed by war. Lack of maintenance was observed at all public hospitals and MCHs visited. Very basic and limited set up for fistula surgery was seen at 2 public hospital sites visited.

- Nigeria – a great number of facilities providing repair throughout the country, however no theatres could be said to be fully equipped as of the time of the assessment, they were either lacking or broken down, and some of the theatres do not have special instruments needed for VVF repair, except in a few cases.
Key Findings – Social and Economic Consequences

• Abandonment and isolation
• A cycle of poverty: social and physical effects make women unable to work or participate in community life
• Anxiety and other psycho-social effects
• Parents often assist fistula survivor with social and economic support
• Husbands often consider fistula survivors to be “flawed”

“Our life is difficult. You cannot even get close someone to be comforted. A hard life. I get a little aid from the government. I survive from that and by what people share with me and with my work braiding. I used to braid hair, but now I don’t do that anymore. My body is weak. I stopped that about six months ago. My husband does not help me. After I got this problem he left me.” 36 year-old woman living with fistula for 14 years (Eritrea interviews report)

It appeared that the main thing that would encourage a man to stay with his wife after the fistula occurred was the presence of children. Those who had children already would stay, while those who did not have any living children with the woman would leave: Those who already have children care and want their wives to be healed. Those men whose wives are young and don’t have any children leave their wives if they develop this problem.” Father of an 18-year old woman living with fistula for 2 years (no living children) (Eritrea interviews report)
Key Findings – Reintegration

- Reintegration programmes not widely available
- Family planning and contraception counselling currently not provided by most rehabilitation programmes
- Community beliefs that sensitization and reintegration programmes are needed and not readily available
- Financial challenges in establishing reintegration programmes

Overall, there were great shortfalls in the provision of reintegration services, most countries not providing such care in any consistent manner.

- In Malawi, after fistula repair patients are not referred for social services. The health workers indicated that once the patient is dry, everyone would accept her so there is not need for referral.
- In Chad, No physical rehabilitation is done at the hospital level. Parents are advised (if present) about exercises possible for muscular therapy. No process of social reintegration is known.
- In Nigeria, The major challenge in rehabilitation is that this is often capital intensive and difficult to sustain.
Key Findings - Policy Environment

- Lack of awareness
- Shortage of data
- No national programmes, policies or plans
- Other pressing health concerns – maternal health not a priority

In many countries such as Mauritania and Cameroon, OF isn’t identified as a health problem, doesn’t appear in public health policies and had no specific programme.

As fistula is widely not seen as a pressing health problem in many countries, there are no questions on it in routine national data collection, therefore the approximate numbers are unknown. Although I must note that presently several countries such as Rwanda, Mali and Niger, are working to include fistula questions in their countries’ DHS survey.
In response to the needs assessment findings, each country then embarks on a national level planning and advocacy phase which includes activities to raise awareness, form networks and partnerships in various sectors, use needs assessment data as tools to leverage political support – all in preparation for the development of a national level strategy to eliminate fistula.

• To date, 11 countries developed national strategies through innovative and diverse partnerships including government, UN agencies, NGOs and health professionals.

• In Niger a dynamic and diverse partnership of 40 members responsible for advocacy and development of a national action plan for fistula is called the Network for Fistula Eradication or REF. It has been created and spearheaded by UNFPA and includes reps from the MOH and Soc. Dev., NGOs, medical associations, health professionals, donors and media.

• In Senegal, fistula has been undertaken by the National Committee to Monitor Progress in the fight against maternal and neonatal morbidity and mortality. The group is ensuring that fistula prevention and management are included in updates of reproductive health policies, standards, protocols and services for all levels of the health system.
Key Components of National Strategies

- Connections with **Safe Motherhood**
- **Building capacity for fistula treatment**
- **Social interventions** that promote women/girls’ empowerment and reintegration
- Community and religious leaders engaged and community participation enabled
Interventions to Prevent Maternal Mortality/Morbidity

The key to ending fistula is preventing it from happening in the first place. The Campaign works to achieve this by:

1. Increasing access to skilled attendance at birth and emergency obstetric care
2. Delaying early pregnancies, spacing births and limiting the number of pregnancies through a wide range of family planning services.
3. Promoting girls’ education and gender equality to ensure that women can freely make decisions about their reproductive lives. Studies have shown that where they can pursue school or work, women overwhelmingly choose to delay the birth of their first child and to have fewer children. Both choices lead to fewer problems with childbirth, and to healthier mothers, children and families.
4. Educating and engaging men and women about the need for maternal health care

In Malawi, the Campaign is working to ensure that women and girls have full access to quality obstetric care services, through the provision of equipment and supplies and plans are being made around the development of guidelines and standards for provider training.

Also, in Sierra Leone, the Network of Women Ministers and Parliamentarians has formed maternal mortality and morbidity monitoring groups and is advocating for the welfare of pregnant women. Community awareness campaigns have also begun in some districts to advocate that all women deliver in a hospital and to ensure that emergency preparedness support is available for all pregnant women.

Eritrea is currently initiating a pilot project for safe motherhood and prevention of obstetric fistula through community mobilization and education. Efforts will increase knowledge of danger signs for obstetric complications, promote the creation of household and community solutions to problems of transport and referral and work to increase the frequency of delivery with a skilled attendant. Interventions will consist of training local health centre staff and community maternal health volunteers to work with communities on utilization of antenatal care, malaria prevention, recognition of danger signs, the importance of prompt referral when complications occur and the importance of using SBAs.
Our needs assessments showed great shortages in teams of skilled practitioners, well-equipped facilities as well as barriers such as cost keeping women from accessing treatment.

• The Campaign is working to ensure that women have access to quality surgical and post-operative care

Working to train health professionals, strengthen hospitals

Making sure that care is free of charge (as most women are too poor to pay for it)

Working to develop universal training standards and protocols

• In the Asia Region, Bangladesh made significant progress in the treatment of fistula. UNFPA is working with the Government to develop a National Fistula Centre at Dhaka Medical College Hospital. While the National Fistula Centre is being constructed, an operation theatre and hospital ward dedicated to fistula have temporarily been assigned by the hospital. Fistula surgical repair is now provided three days per week, resulting in 135 complicated cases treated during 2004.

Bangladesh has also moved forward with training government and NGO health providers in fistula management. In 2004, a national curriculum for fistula surgery was developed as a joint effort of the government, UNFPA and Engenderhealth, and published and, during the year, 24 Doctors and 10 Nurses were trained using this curriculum.

Also, in Mali, UNFPA provided support to Point G hospital, the main hospital in Bamako. An operating theatre specifically dedicated to fistula repair was renovated and fully equipped. As a result, the hospital saw its treatment capacity increased from 4 to 16 repairs a week.
Obstetric fistula is now recognized as more than a medical issue - both the causes and consequences of fistula are deeply rooted in sociocultural factors. While some of these issues must be addressed at the policy level, concrete interventions are also necessary at the community level, including rehabilitation programmes that promote income generating activities and provide psychosocial counselling to allow treated women to resume a normal, full and productive life. It is also critical that all treated women and their families fully understand how fistula is caused and the steps they must take in order to prevent the condition from happening during their next pregnancy.

In Niger, UNFPA worked closely with the NGO DIMOL to ensure effective reintegration of treated women back into their communities. DIMOL had been providing income-generation training and small grants to treated women. The NGO also has teams comprised of an attending practitioner, a social worker and a representative from DIMOL accompany the treated women to their villages and hold public meetings to discuss topics such as early marriage, importance of antenatal consultations and assisted childbirth, girls’ education, post-operative care, STIs and HIV/AIDS and obstetric fistula.

FORWARD - Nigeria
-Housed for 9 months at centre where provided with education, income-generating skill building, IGA 0% interest loans, and psychosocial support, also participate in food preparation and vegetable cultivation
-Follow-up with women once returned to villages to document situation and provide any further support. After, women also contribute by sharing experiences with other women and conducting outreach programmes
-Challenges: transport unreliable and infrequent makes treatment and prevention services inaccessible – leads to recurrence of fistula

Delta Survie - Mali
-Training in textile dying and production and opportunity to work in a workshop
Global and Regional Advocacy

- Extensive media coverage
- Published journal articles
- Presented at numerous global/regional technical fora
- 4 international/regional fistula meetings
- Campaign Website, brochure, logo
- Celebrity spokesperson: Natalie Imbruglia
- Innovative PR campaigns with private sector
- Fistula as a compelling issue to mobilise a diverse funding base

At the global and regional level, the Campaign has been extremely active in raising awareness and mobilizing support and critical resources.
The Campaign also works at the global level to engender consensus around a range of specific technical issues related to fistula.

19-20 April 2005, UNFPA hosted a meeting of the Obstetric Fistula Working Group on Training for Fistula Management in Niamey, Niger. While fistula treatment initiatives have been underway worldwide, up until now there has been a lack of consensus around training for fistula management. This was the first forum to date held to arrive at consensus around, universal training standards for fistula treatment providers.

The objectives of the Training for Fistula Management Meeting included the following:

· To come to agreement on basic standards for training doctors and nurses including minimum qualifications for trainees, number of cases needed to be qualified to provide repair, and basic competencies for each level of trainee.

· To explore existing training guidelines and map out a plan of action for developing technical guidelines for training.

· To review recent findings and recommendations from EngenderHealth’s meeting on fistula counselling.

· To map training needs and capacities as determined by needs assessments and training questionnaires.

· To explore the advantages and disadvantages of different training models.

The group was able to come to consensus on many issues and develop recommendations for training. A number of the recommendations are preliminary and meant to guide national and regional planning for training in fistula management, with the understanding that more research is needed in this area.
At the Campaign’s Africa Regional Fistula Meeting held in Accra in 2004, it was agreed that a standard monitoring and evaluation framework, including concrete indicators, needed to be established to measure performance and results and to allow for comparability both within and across countries. The meeting in Niamey represented the first opportunity to dedicate two days exclusively to development of the Campaign results framework. Members from the Planning, Monitoring and Evaluation Working Group participated in addition to other key partners, including a number of expert fistula surgeons. The objectives of the meeting were to:

- Achieve consensus on the Campaign goals, objectives and strategies at the national level
- Agree on the results (outcomes and outputs) for the Campaign
- Develop a set of indicators for measurement and tracking of the Campaign’s outcomes and outputs
- Craft a draft Campaign Results Framework based upon the above for further review and refinement

Through two days of group work and presentations, a draft results framework was developed. The framework is still being reviewed within UNFPA and should be ready for country adaptation soon.
Lessons Learned from Country Implementation

- Comprehensive approach is needed, including prevention, treatment and social reintegration, in the safe motherhood context
- Emphasis should be placed on prevention as the key to elimination
- Fistula is effective for SM advocacy
- Needs assessments important first phase for both planning and advocacy
- Diverse, multi-sectoral partnerships at all levels ensure a comprehensive and coordinated response

Throughout the past two years of country level implementation and global and regional advocacy, a wide range of valuable lessons learned have been generated. At the Africa Regional fistula meeting in Accra, in June of 2004, some of these key lessons were shared.
Lessons Learned from Country Implementation, Continued

- Need to build national capacity to provide high quality treatment services (training, protocols, standards, strengthening facilities)
- Treatment services should be available before public awareness activities are undertaken
- Social support services should be provided for women with fistula before, during and after treatment
- Support services should include psychosocial, social and economic components
Global Lessons Learned

- Fistula is an effective entrypoint to reaching the poor, addressing reproductive health and gender equity
- Fistula puts a “face” to reproductive health issues and can generate a great deal of support and awareness about maternal health
- Collaboration is key

At the global level, we have learned that
Areas for Further Research

- Incidence and prevalence
- Cultural perspectives and social dimensions, linkages with poverty
- Operations research on training modalities, BCC campaigns, reintegration programs, etc.
- Epidemiology of fistula – causal links to FGM, malnutrition, early childbearing, etc.
What the Campaign is really about is HOPE:
It is about fulfilling each woman’s hope for a safe pregnancy and childbirth – and to help women already living with fistula restore their hopes and dreams. And with more support, together we can make this happen.