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Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

This report is prepared in response to General Assembly resolution 65/188. Obstetric fistula is a devastating childbirth injury that leaves women incontinent, often stigmatized, and isolated from their communities. It is a stark outcome of socioeconomic and gender inequalities, human rights denial and poor access to reproductive health services, including maternal and newborn care, and an indication of high levels of maternal death and disability. The report outlines efforts made at the international, regional and national levels, and by the United Nations system, to end obstetric fistula. It offers recommendations to intensify these efforts, within a human rights-based approach, to end obstetric fistula as a key step towards achieving Millennium Development Goal 5, by improving maternal health, strengthening health systems, reducing health inequities, and increasing the levels and predictability of funding.

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I. Introduction

1. This report is submitted in accordance with General Assembly resolution 65/188, in which the Assembly requested the Secretary-General to submit to it at its sixty-seventh session a report on the implementation of the resolution under the item entitled “Advancement of women”.

2. Sexual and reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, particularly those in developing countries, suffer disproportionately from limitations on their right of access to health care, from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, cervical cancer, sexual and gender-based violence, and other problems related to their reproductive system. Educating and empowering women and girls are crucial for their well-being, and fundamental for preventing obstetric fistula and improving maternal health. Educated women and girls better understand how to exercise their reproductive health choices, the benefits of seeking appropriate care during pregnancy and delivery, why to delay marriage until adulthood and how to ensure the well-being of their children and families.

II. Background

3. Obstetric fistula is a severe maternal morbidity which can affect any woman or girl who suffers from prolonged or obstructed labour without timely access to an emergency Caesarean section. It is one of the most devastating consequences of neglected childbirth and a stark example of health inequity in the world. Although obstetric fistula has been eliminated in industrialized countries, it continues to afflict the most impoverished women and girls in the developing world, mainly those in rural and remote areas. Eliminating obstetric fistula as a global health problem necessitates scaling up country capacity to provide access to comprehensive emergency obstetric care, treat fistula cases, and address underlying medical, socioeconomic, cultural and human rights determinants. To end obstetric fistula, countries must ensure universal access to reproductive health services; eliminate gender-based social and economic inequities; prevent child marriage and early childbearing; promote education and broader human rights, especially for girls; and foster community participation in finding solutions, including through the active involvement of men.

4. The medical and social consequences of obstetric fistula can be life-shattering for women, their children and families. In almost 90 per cent of fistula cases, the baby is stillborn or dies within the first week of life.[1] If a woman survives prolonged or obstructed labour, she may be left with a severe, disabling injury in her birth canal. A woman with fistula is not only left incontinent but may also experience neurological disorders, orthopaedic injury, bladder infections, painful sores, kidney failure or infertility. The odour from constant leakage combined with misperceptions about its cause often results in stigma and ostracism by communities. Many women with fistula are abandoned by their husbands and families and are excluded from daily family and community life. They may find it

[1] L. L. Wall et al., “The obstetric vesicovaginal fistula: characteristics of 899 patients from Jos, Nigeria”, *American Journal of Obstetrics and Gynecology*, vol. 190, No. 4 (April 2004).

difficult to secure income or support, thereby deepening their poverty. Their isolation may affect their mental health, resulting in depression, low self-esteem and even suicide.

5. While precise figures are not available, it is generally accepted by the United Nations that from 2 million to 3.5 million women and girls live with obstetric fistula.[2] Determining the prevalence and incidence, however, is extremely difficult as fistula usually afflicts the most marginalized — poor, young, often illiterate women and girls living in rural areas — and usually requires clinical screening to diagnose.

6. Obstetric fistula can be prevented. Tackling the root causes of maternal mortality and morbidity is essential, including poverty, gender inequality, barriers to education — especially for girls — child marriage and adolescent pregnancy. It requires functioning, accessible health systems. It needs adequately trained professionals, reliable access to essential medicines and equipment, and equitable access to high-quality reproductive health services.

7. Broader economic and sociocultural changes are required to prevent obstetric fistula. Poverty and gender inequality impede women's opportunities, including access to health services. Culture also influences the status of their sexual and reproductive health, the age of marriage, the spacing and number of children. Traditions favouring unassisted home delivery, including the use of unskilled traditional birth attendants and harmful practices such as female genital mutilation and child marriage further inhibit maternal health. Health-care costs can be prohibitive for poor families, especially when complications occur. These factors contribute to the three delays that impede women's access to health care: delay in seeking care; delay in arriving at a health-care facility; and delay in receiving adequate care once at the facility.

8. Adolescent girls are particularly at risk of maternal deaths and morbidities, including obstetric fistula. Although adolescent births represent approximately 11 per cent of births worldwide, they account for 23 per cent of the burden of disease among women of all ages.[3] Sixteen million adolescent girls give birth each year; almost 95 per cent of those births occur in developing countries.[4] Complications of pregnancy and childbirth are the leading cause of death among girls 15 to 19 years old in low- and middle-income countries. Evidence suggests that delaying pregnancy until after adolescence may reduce the risk of obstructed labour and obstetric fistula. Malnutrition among girls may stunt growth. Pregnancies that occur early, before the pelvis is fully developed, can increase the risk of obstructed labour.

9. Child marriage affects one in three girls in the developing world, predominantly the poorest, least educated girls living in rural areas. Although age at marriage is generally rising, millions of girls in developing countries are expected to marry before age 18.[5] Impoverished, marginalized girls are more likely to marry as

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[2] Van Beekhuizen, Heleen J. et al., "Complications of obstructed labour: pressure necrosis of neonatal scalp and vesicovaginal fistula", *The Lancet*, vol. 368, issue 9542 (September 2006).

[3] World Health Organization (WHO), Department of Making Pregnancy Safer, *Adolescent Pregnancy*, MPS Notes, vol. I, No. 1 (2008).

[4] WHO, *Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries: WHO guidelines*, 2011.

[5] United Nations Population Fund, *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*, 2007.

children and give birth during adolescence than girls with greater education and economic opportunities. Child marriage is a key driver of early pregnancy and childbearing before adolescent girls are physically or emotionally ready, which heightens their risk of maternal death and morbidities, including fistula. Married adolescent girls often have difficulty accessing reproductive health services for reasons including social isolation and lack of awareness of their reproductive rights. All adolescent girls and boys, both in and out of school, married and unmarried, need access to comprehensive sexuality and human rights education, life skills education, and health services including sexual and reproductive health, to protect their well-being.

10. There is consensus in the global health community on the three most cost-effective interventions to reduce maternal mortality and morbidity, including obstetric fistula. They are: universal access to family planning; a trained health professional with midwifery skills at every childbirth; and timely access to high-quality emergency obstetric and newborn care. Prevention is a core component of effective strategies to end fistula, of which abandonment of harmful practices, such as child marriage, is crucial.

11. The same interventions that reduce maternal mortality reduce fistula. Several low-income countries, including Bolivia (Plurinational State of), Eritrea, Nepal, Rwanda and Yemen, have made progress in reducing maternal mortality over the past 10 years. In Afghanistan, antenatal care and skilled delivery coverage more than tripled from 2003 to 2010, thereby significantly reducing the maternal mortality ratio from an estimated 1,400 per 100,000 live births in 2008 to 460 in 2010.[6] The Islamic Republic of Iran, with a maternal mortality ratio of 30,[7] is one of 10 middle-income countries that have reached the Millennium Development Goal 5 target of reducing the maternal mortality ratio by three quarters by strengthening maternal health systems.[8] In Egypt, the Ministry of Health made reducing the maternal mortality ratio a national priority and concentrated on regions with the highest incidence of maternal death.[9] The maternal mortality ratio in Egypt declined from 230 in 1990 to 66 in 2010.[8] The Russian Federation has successfully cut its maternal mortality ratio by more than half over the past two decades, from 74 to 34. Algeria and Chile reduced their maternal mortality ratios by over 50 per cent from 1990 to 2010. The Arab States have made commendable progress, reducing the maternal mortality ratio by 65 per cent or more in Morocco, Oman and Yemen; around 50 per cent or more in Qatar, Tunisia and the United Arab Emirates; and over 40 per cent in Jordan, Libya and Saudi Arabia. Qatar and the United Arab Emirates have achieved maternal mortality ratios below those of many other countries, including the United States of America.[8]

12. Most cases of obstetric fistula can be treated through reconstructive surgery. Women can then be reintegrated into their communities with appropriate psychosocial care. However, research suggests that there is a huge gap between the need for fistula treatment and available services. Currently, few health-care facilities

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[6] *Trends in Maternal Mortality: 1990 to 2010*. Estimates developed by WHO, UNICEF, UNFPA and the World Bank, 2012; Afghan Public Health Institute et al., *Afghanistan Mortality Survey*, 2010.

[7] See www.unicef.org/infobycountry/iran_statistics.html.

[8] *Trends in Maternal Mortality: 1990 to 2010*.

[9] See www.womendeliver.org/assets/Maternal_mortality_success_stories.pdf.

are able to provide high-quality fistula surgery, owing to the limited number of health-care professionals with the necessary skills. Facilities that do exist may not function at maximum capacity for lack of trained health professionals, equipment and life-saving medical supplies. When services are available, many women are not aware of, or cannot afford or reach the services, owing to such barriers as transportation costs. A global fistula mapping exercise conducted in 2010 by Direct Relief International, the Fistula Foundation and the United Nations Population Fund (UNFPA) found that fistula treatment reaches only a fraction of fistula patients annually — approximately 14,000 cases compared to the estimated 50,000 to 100,000 new cases each year[2] — highlighting the need for intensifying resources to bridge this large gap.[10]

13. UNFPA launched the global Campaign to End Fistula in 2003, with partners, with the goal of making fistula as rare in developing countries as in the industrialized world. The Campaign focuses on three key strategies: prevention, treatment and social reintegration. It is active in over 50 countries in Africa, Asia, the Arab States and Latin America and brings together more than 75 partner agencies at the global level and many others at the national and community levels. Since the Campaign began, UNFPA has directly supported over 27,000 women and girls to allow them to receive surgical treatment for fistula, and partners such as EngenderHealth supported thousands more.[11] As the tenth anniversary of the Campaign to End Fistula approaches, numerous challenges have still to be met. Many women and girls continue to suffer isolation for want of treatment. According to an independent evaluation in 2010, the Campaign has enhanced the visibility and knowledge of obstetric fistula worldwide, yet it is critically underresourced and requires far more financial and human resources to achieve its goal of eliminating fistula.

14. UNFPA serves as the secretariat for the International Obstetric Fistula Working Group — the main decision-making body of the Campaign to End Fistula. The Working Group promotes effective, collaborative partnerships and generates consensus and evidence regarding effective strategies for preventing and treating fistula and reintegrating women living with fistula into society.

III. Initiatives at the international, regional and national levels

A. Major international initiatives

15. For more than two decades, the United Nations and the international community have campaigned to reduce maternal mortality and morbidity. Global commitments were first made in 1987 at the International Safe Motherhood Conference in Nairobi. The Programme of Action adopted at the International Conference on Population and Development in Cairo in 1994 recognized maternal health as a key component of sexual and reproductive health. In 1995, at the Fourth World Conference on Women in Beijing, Governments, adopting the Platform for Action, recognized entrenched patterns of social and cultural discrimination as major contributors to sexual and reproductive ill-health, including maternal death and disability. Member States have upheld the right of women and girls to the

[10] www.globalfistulamap.org.

[11] See www.endfistula.org.

highest attainable standard of mental and physical health, including sexual and reproductive health, through the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities.

16. In 2000, world leaders reaffirmed their commitment to improve maternal health, adopting Millennium Development Goal 5 to reduce the maternal mortality ratio by three quarters by 2015.[12] The target of universal access to reproductive health under Goal 5 ensures full coverage of all factors necessary for improving maternal health. Goals 3, 4 and 6 are also essential for women's health, well-being and survival. Achieving Goal 1, eradicating extreme poverty, will significantly contribute towards eliminating maternal mortality and fistula. In 2010, data showed for the first time good progress towards reaching Millennium Development Goal 5; however, an estimated 96 countries will not reach the target until at least 20 years after 2015 if the current pace continues.[13]

17. The General Assembly first recognized the problem of obstetric fistula in 2005 in its resolution 60/141 on the girl child. It identified early childbearing and limited access to sexual and reproductive health as key factors in the persistence of obstetric fistula and maternal mortality.

18. In 2007, the General Assembly for the first time acknowledged obstetric fistula as a major women's health issue by adopting resolution 62/138 on supporting efforts to eliminate obstetric fistula. In 2010 the Assembly adopted resolution 65/188, sponsored by a record-breaking 172 States, calling for renewed focus and intensified efforts for eliminating obstetric fistula. States reaffirmed their obligation to promote and protect the rights of all women and girls and to contribute to efforts to end fistula, including to the global Campaign to End Fistula.

19. Launched in 2008 by UNFPA and the International Confederation of Midwives, the Midwifery Programme helps countries to strengthen their midwifery programmes and policies. The programme aims to improve skilled attendance at all births in low-resource countries. It supports national midwifery training and education; developing strong regulatory mechanisms promoting quality midwifery services; strengthening and establishing midwifery associations; and advocating with Governments and stakeholders to encourage investment in midwifery services. The programme is active in over 30 countries in Africa, Asia, the Arab States and Latin America. More than 2,000 midwives have been trained and 150 midwifery schools provided with books, clinical training, equipment and supplies.

20. The High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, in 2010, revealed that Millennium Development Goal 5 had the least financial support and lagged behind all other Goals. Of the 68 countries that account for most maternal and child deaths, only 16 per cent were on track to reach Goals 4 and 5 by 2015. In response, a Global Strategy for Women's and Children's Health was launched with the objective of saving the lives of more than 16 million women and children by 2015. The Global Strategy, or Every Woman Every Child,

[12] See A/56/326.

[13] Lozano, Rafael et al., "Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis", *The Lancet*, vol. 378, issue 9797 (24 September 2011).

presents a road map to enhance health financing, strengthen policy and improve services on the ground for vulnerable women and children.

21. In 2011, the Human Rights Council adopted a landmark resolution on preventable maternal mortality and morbidity and human rights (resolution 18/2), applying a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity.

22. The Commission on the Status of Women, in March 2012, adopted the biannual resolution 56/3, on eliminating maternal mortality and morbidity through the empowerment of women, calling for the elimination of preventable maternal mortality and morbidity and strengthening comprehensive health services for women and girls, including access to sexual and reproductive health.

23. Reaffirming the need to promote gender equality and the empowerment of girls and young women in all aspects of youth development, the Commission on Population and Development adopted resolution 2012/1.

24. In response to the substantial unmet need for family planning services worldwide and recognizing family planning as a key component of reproductive health, including fistula prevention, in July 2012, at the London Summit on Family Planning, donors committed over $4 billion for family planning. This initiative aims to give 120 million more women in developing countries access to voluntary family planning by 2020.

B. Major regional initiatives

25. Concerned about insufficient progress on Millennium Development Goals 4 and 5, the African Union, with United Nations support, has intensified efforts to improve sexual and reproductive health throughout Africa. In 2003, the African Regional Reproductive Health Task Force called for the development of national road maps to accelerate the reduction of maternal and newborn mortality. The plan, endorsed by the World Health Organization (WHO), UNFPA, UNICEF, the World Bank and others, aims to help Governments to plan and mobilize support for skilled attendance during pregnancy, childbirth and the postnatal period, and to strengthen national health systems. To date, more than 42 African countries have developed road maps, and 9 have conducted midterm reviews and created implementation plans.

26. In 2006, African Union Heads of State endorsed the Continental Policy Framework on Sexual and Reproductive Health and Rights. The Framework, or the Maputo Plan of Action, addresses reproductive health challenges in Africa and includes a substantial component on obstetric fistula, calling for health sector strengthening and increased resource allocations for health. While some progress has been made in implementing the Maputo Plan of Action, resources remain very limited, few countries having a budget line for sexual and reproductive health.[14] Leaders have extended the Maputo Plan of Action from 2010 to 2015.

27. The Campaign on Accelerated Reduction of Maternal Mortality in Africa promotes intensified implementation of the Maputo Plan of Action in Africa. UNFPA, UNICEF, WHO, bilateral donors and civil society organizations support the

[14] See www.unfpa.org/public/home/publications/pid/4197.

Campaign at the national and regional levels. The Campaign initiates policy dialogue, advocacy and community mobilization to secure political commitment, increase resources and effect societal change in support of maternal health at the country level.

28. At the regional conference on obstetric fistula and maternal health in Côte d'Ivoire in 2008, an African network of civil society organizations was launched. The network leverages technical and financial resources and promotes South-South cooperation to address obstetric fistula and promote maternal health.

29. In 2009, the Association of Southeast Asian Nations (ASEAN) adopted the Joint Declaration on the Attainment of the Millennium Development Goals in ASEAN, which includes the development and implementation of a road map for achieving the Millennium Development Goals. In 2011, the ASEAN Intergovernmental Commission on Human Rights organized a conference in the Philippines, which identified region-specific good practices for reducing maternal mortality and morbidity. It called for renewed efforts to improve maternal health with increased budget allocations, and legislation to promote women's right to reproductive health, including safe pregnancy and affordable family planning services.

30. Promoting the theme, "Neglected no more — dignity restored", UNFPA supported a regional conference on fistula in Pakistan in 2011 bringing together 1,200 participants from 14 countries, including 10 international fistula surgeons. The event was an important milestone in highlighting obstetric fistula in Pakistan and secured the strong commitment of the Pakistan Ministry of Health to establish a national task force for fistula.

31. The South Asian Association for Regional Cooperation (SAARC) initiated a regional project to reduce child and maternal mortality through improving the skills of health professionals, providing comprehensive mother-and-child primary health care and improving infrastructure and equipment at the district and subdistrict levels. The project is financed by the newly established SAARC Development Fund.

32. In the Latin American and Caribbean region, a Regional Inter-Agency Task Force for the Reduction of Maternal Mortality was established. It supports countries in implementing the recommendations of the WHO Commission on Information and Accountability for Women's and Children's Health. Members include United Nations agencies, bilateral donors, development banks, non-governmental organizations and medical professional associations.

33. South-South collaboration is a key strategy of the Campaign to End Fistula. Since 2010, UNFPA and its partners have supported the sharing of knowledge, skills and resources among many countries. The Niger welcomed a team of doctors and surgeons from Haiti; in Ethiopia the Hamlin Fistula Hospital treated complex fistula cases from the Sudan; and South Africa treated fistula cases from Swaziland. Bangladesh provided training on fistula surgery, management and counselling to health professionals in Nepal and performed complicated fistula surgeries on women in Timor-Leste. Doctors from Pakistan travelled to Kenya for training on new techniques in post-surgical incontinence. In Benin, UNFPA, in partnership with civil society and the USAID Integrated Family Health project, supported the training of fistula surgeons from Chad and Mauritania on the latest techniques in fistula repair. A Senegalese fistula surgeon performed fistula surgery in Chad, Gabon and Rwanda.

Lesotho sent fistula patients to South Africa for treatment. The ministries of health in South Sudan and Uganda signed an agreement enabling South Sudanese students to commence midwifery studies in Uganda.

C. Major national initiatives

34. Improving reproductive health must be a country-owned and country-driven process. To accelerate progress towards reducing maternal mortality and ending fistula, countries urgently need to allocate a greater proportion of their national budgets to health, especially reproductive health. Countries also require intensified, additional international technical and financial support. Progress has been made on integrating obstetric fistula into countries' national health policies and plans, including in Bangladesh, Burkina Faso, Ghana, Guinea, Guinea-Bissau, Mali, Madagascar, Mozambique, Sierra Leone, the Sudan and Uganda. In Afghanistan, the revised reproductive health policy and strategy focused on male involvement, emergency obstetric care, fistula and gender-based violence. In May 2012, the Government of Chad organized a conference to strengthen implementation of the national strategy for the fight against fistula, and to revitalize the National Task Force for Fistula.

35. To facilitate coordinated planning and interaction between partners working on all aspects of obstetric fistula, several countries have created a National Task Force for Fistula. These task forces are typically led by ministries of health, and comprise civil society organizations, medical providers and United Nations agencies. To date, 14 countries have developed national task forces for fistula, including Afghanistan, the Central African Republic, Mali and South Sudan. The Uganda task force serves as a role model, meeting regularly to enhance dialogue and coordination of fistula activities.

36. Countries around the world are reinforcing policies and strategies to better protect women and girls, and address multiple forms of gender-based violence, including human trafficking, sexual violence and exploitation, female genital mutilation/cutting and child marriage. The Government of the Niger has made gender equity, access to reproductive health, and zero tolerance of violence against women and girls constitutional rights. Most countries with high rates of child marriage, including Bangladesh, Burkina Faso, the Central African Republic, Eritrea, Ethiopia, India, Malawi, Mali, Mozambique, Nepal, Nicaragua and Uganda, have enacted legislation setting the minimum age of marriage at 18. Others are eliminating differences in the legal age between boys and girls. Enforcing such national laws is often challenging in rural and remote areas, however.

37. In 2011, UNFPA, jointly with United States Representative Carolyn Maloney and Campaign to End Fistula partners, organized a Congressional briefing in Washington, D.C., entitled "End fistula forever". The briefing aimed to educate members of Congress about fistula and to discuss the impact of United States support for fistula programmes globally.

IV. Actions taken by Member States and the United Nations and remaining gaps

A. Prevention strategies and interventions to achieve maternal health goals and eliminate obstetric fistula

38. Research shows that averting maternal death and disability, including fistula, is accomplished most effectively when universal access to three key interventions is ensured, namely, family planning, skilled birth attendance at every delivery, and access to emergency obstetric and newborn care.[15] To accelerate progress in maternal and newborn health and boost support to high maternal mortality countries, UNFPA launched the Maternal Health Thematic Fund and the Global Programme to Enhance Reproductive Health Commodity Security. The Maternal Health Thematic Fund supports the global Campaign to End Fistula and national fistula programmes in priority countries.

39. In regions with high maternal mortality and morbidity, the proportion of births attended by skilled health professionals has risen from 55 per cent in 1990 to 65 per cent in 2009, with vast disparities across regions and the lowest levels of skilled care in Africa and South Asia.[16] Midwives play a crucial role in preventing obstetric fistula by providing high-quality skilled delivery care, identifying when a woman's labour is prolonged or obstructed, through tools such as the partograph, and referring her to an obstetrician, gynaecologist or doctor when emergency obstetric care or Caesarean section is required. Midwives and doctors are vital to ensuring early management of new fistulas, as is referring women suffering from fistula to trained, expert fistula surgeons for care.

40. Several countries in Africa and Asia have taken steps to improve access to services by reducing or removing user fees for basic health care. Sierra Leone launched a major initiative in 2010 to provide free health care for pregnant women, lactating mothers and children under 5. Togo subsidizes 90 per cent of the cost of Caesarean sections since 2011. Bangladesh piloted a voucher scheme encouraging women to access antenatal and delivery services. Countries should ensure free or subsidized maternal health care for all poor women and girls who cannot afford it.

41. To intensify support to countries with some of the highest numbers of maternal and newborn deaths, in line with the Global Strategy for Women's and Children's Health, the "H4+" health agencies (UNAIDS, UNFPA, UNICEF, UN-Women, World Bank, WHO) launched the High Burden Country Initiative. The Initiative supports health system strengthening in Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, India, Mozambique, Nigeria and the United Republic of Tanzania, which account for nearly 60 per cent of global maternal and newborn deaths.

42. Access to services — particularly skilled birth attendance and emergency obstetric care — is the greatest challenge in preventing maternal mortality and

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[15] For every 500,000 population and every subnational area or district, a minimum of five basic primary health facilities, with at least one of those facilities offering comprehensive emergency obstetric and newborn care.

[16] *Trends in Maternal Mortality: 1990 to 2010*; and *The State of the World's Midwifery 2011: Delivering Health, Saving Lives*.

morbidity.[17] Maternity waiting homes, low-cost or free accommodations located near or in a health facility, are a promising option to help bridge the geographical gap in access to care. They allow rural and "high risk" women to await delivery and, when labour begins, or earlier in case of complications, to be transferred to a medical facility nearby. They are also crucial to helping ensure access to elective Caesarean sections for fistula survivors who become pregnant again, to prevent fistula recurrence and increase the chances of survival of mother and baby. Although more evidence is needed, maternity waiting homes can have a positive impact on rural women's health and help to reduce maternal and newborn deaths and disabilities, as demonstrated in Cuba, Eritrea, Nicaragua and Zimbabwe.

43. Access to family planning helps to ensure that every pregnancy is wanted, planned and occurs at an optimal time in a woman's life. It is essential in reducing the risk of recurrence of fistula in future pregnancies of fistula survivors. UNFPA has advocated for building and maintaining political and financial commitment to family planning within maternal health strategies. In 2011, UNFPA supported the regional Conference on Population, Development and Family Planning in Francophone West Africa, held in Burkina Faso, and the International Conference on Family Planning in Senegal. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security has mobilized $450 million since 2007 to ensure reliable supplies of contraceptives, condoms and medicines.

44. While preventing fistula from occurring is a top priority, it is essential not to forget treated fistula survivors who may be at risk of a further obstructed labour, and a new fistula, or even dying in subsequent pregnancies. This is an often overlooked, yet critical issue, on which the Campaign to End Fistula is placing new emphasis to ensure the survival of mother and baby and prevent recurrent fistula, through elective Caesarean sections for fistula survivors. This remains a neglected issue, however, and requires significantly intensified commitment and action.

45. Community sensitization and mobilization are key components of preventing obstetric fistula and maternal deaths. Fistula survivors can play a vital role as advocates in raising awareness about the need for timely antenatal, skilled delivery, and post-partum care.

46. The United Nations Inter-Agency Task Force on Adolescent Girls, in 2010, signed a joint statement to increase support to developing countries to advance key policies and programmes to empower the hardest-to-reach adolescent girls. To date, 20 countries have received support in planning comprehensive programmes addressing vulnerable girls.

B. Treatment strategies and interventions

47. Although prevention is the ultimate means of eliminating obstetric fistula, treatment is critically important for women living with the condition as it enables them to reclaim their lives, hopes and dignity. Countries have increased access to fistula treatment through upgrading health facilities and training health personnel. In 2011, significant progress was made to scale up treatment, and more than 7,000

[17] General Comment 14 of the Committee on Economic, Social and Cultural Rights defines accessibility as having four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.

fistula surgeries were directly supported by UNFPA, a 40 per cent increase from 2010. Hundreds of thousands of women and girls worldwide still await treatment, however, and global treatment capacities are severely deficient in reaching and healing them all. A tremendous backlog of patients continues to grow. A dramatic and sustainable scaling-up of quality treatment services and trained fistula surgeons is needed. Closing this gap is an important challenge currently facing countries and the Campaign to End Fistula.

48. Many poor women and girls cannot afford fistula treatment despite the fact that some countries now offer fistula treatment at no cost. Therefore, all countries should ensure access to free fistula treatment services. There is an urgent and ongoing need for committed national and donor support to provide the resources necessary to reach all women and girls suffering this condition. Increased multi-year commitments are critical to ensure sufficient, sustainable and continued programming.

49. Many women and girls living with fistula are not aware that treatment is available. For those who are, a major obstacle in accessing fistula repair services is the high cost of transportation to health facilities, particularly for those living in remote areas. In the Sudan, geographical accessibility was improved by locating fistula repair services close to remote communities. In 2011, the Aberdeen Women's Centre, Sierra Leone, set up a special toll-free hotline to provide information and care options for women with fistula, enabling over 220 patients to get treatment. Comprehensive Community-based Rehabilitation in the United Republic of Tanzania and the Freedom from Fistula Foundation in Kenya provide free fistula repair surgeries and developed a mobile telephone initiative to help those who cannot afford transportation costs. Using M-Pesa mobile-to-mobile banking technology, funds are transferred to fistula patients to cover transport costs. To facilitate access to fistula treatment services and improve quality of care, many countries, such as Angola and Yemen, are integrating fistula services into strategically selected hospitals, shifting away from the "mission or camp" approach for treating fistula. While intermittent missions or camps provide surgical repairs to high numbers of women, and are useful for training fistula surgeons, they have limited scope and potential. Moving forward from the mission/camp approach, countries should strive to establish integrated fistula services in strategically selected hospitals which are continuously available and provide the full continuum of holistic care and support for treatment, rehabilitation and crucial follow-up for fistula sufferers.

50. To improve the quality of care and ensure that all women receive the best treatment possible, the International Society of Obstetric Fistula Surgeons, promotes knowledge-sharing, professional development and quality assurance among fistula surgeons and health-care providers. The International Federation of Gynaecology and Obstetrics, with support from UNFPA and the International Society of Obstetric Fistula Surgeons, developed a competency-based training manual on obstetric fistula to harmonize surgical approaches and techniques among fistula centres. UNFPA is developing a supplementary document for Campaign to End Fistula partners and ministries of health that gives strategic recommendations on training fistula surgeons. Quality assurance remains a challenge. One primary concern is that many trained health providers in fistula management have limited support to practise their skills. Intensified efforts are needed to ensure that trained personnel have optimal working conditions, fully-equipped, functional health centres and incentives to

retain them to provide fistula repairs. Ensuring that providers respect pre-operative criteria, including patients' adequate nutritional status and fitness for surgery, to optimize surgical outcome, is also a challenge.

C. Reintegration strategies and interventions

51. Healing fistula requires not only surgical intervention but also a holistic approach, including psychosocial and economic support. Previously, very few countries reported on women who received reintegration on rehabilitation services, a key component of the continuum of care. In 2012, about 19 countries, including Afghanistan, Cameroon, Guinea-Bissau and Nepal, reported providing such services, reflecting increased commitment. However, follow-up of fistula patients is a major challenge. In most countries, only a fraction of fistula patients are offered reintegration services, despite significant needs. All fistula-affected countries should track this indicator to ensure access to reintegration services. Intensive social reintegration for inoperable or incurable fistula patients remains a major gap.

52. Reintegration services include counselling — throughout all phases of treatment and recovery, from the first point of contact, through post-discharge from hospital, reproductive health education, family planning, and income-generating activities, combined with community sensitization to reduce stigma and discrimination. In Pakistan, four fistula centres offer rehabilitation activities for fistula patients, including Koohi Goth Hospital in Karachi, started by a local doctor, Shershah Syed. Over 70 patients received rehabilitation support in 2011, with periodic follow-up to evaluate the impact.

53. Connecting fistula patients to income-generating activities provides a much needed livelihood, renewed social connections and sense of purpose. In the Congo, treated fistula patients are provided with a tutor to help create a business based on existing or desired skills. Patients are entitled to a bank account and training in business and financial literacy. Fistula Foundation Nigeria supports women with inoperable or incurable fistula with a training programme in various trades including embroidery, knitting and photography. In Ethiopia, a partner of the Campaign to End Fistula, Healing Hands of Joy, is implementing an innovative model of healing, empowerment and reintegration for fistula survivors, trained as "safe motherhood ambassadors". Despite these good practices, too few fistula survivors benefit from such vital socioeconomic reintegration services.

D. Data collection and analysis

54. Information on fistula-related activities is scarce, scattered, incomplete and difficult to obtain. Concerted efforts have been made to improve availability of data, including the launching of the first Global Fistula Map early in 2012. A standardized fistula module for inclusion in demographic and health surveys has been developed and used in Cameroon, Guinea and Guinea-Bissau. The Geneva Foundation for Medical Education and Research and WHO developed an online database that allows centralized data entry, analysis and comparison across programmes. Burkina Faso and Ghana have included fistula in their national health information systems. Development of a compendium of indicators is ongoing to assist countries in

selecting key indicators to monitor their fistula programming. Obtaining data remains a challenge, owing to inadequate data recording and reporting systems.

55. The Global Fistula Map will help to streamline the allocation of resources, raise awareness of fistula, and capture the landscape of worldwide fistula treatment capacity and gaps. Tragically, in the countries with the highest levels of maternal deaths and obstetric fistula, such as Burundi, Chad, the Central African Republic, Somalia and South Sudan, the map reveals the greatest gaps, with a severe lack of fistula treatment centres. It highlights the tremendous efforts made by many partners to treat fistula, and can be used as a tool to facilitate South-South collaboration. Data gathered shows that, while the availability of surgical treatment for fistula is growing, only a fraction of fistula patients receive treatment annually. More than half of reporting facilities treated fewer than 50 patients each in 2010. Only five facilities worldwide each reported treating over 500 women. The map will be expanded and continuously updated with information provided by experts and practitioners around the globe about fistula repair and rehabilitation services.

56. Maternal death and near miss[18] reviews are an increasingly recognized and utilized means to improve quality assurance. Maternal death surveillance and response was adopted by partners as a framework towards maternal mortality elimination as a global public health burden. Inter-agency consultations, as part of the Commission on Information and Accountability, have been organized in all regions, addressing needs for the institutionalization of maternal death reviews and maternal death surveillance and response. Benin, Burundi, Ethiopia, Ghana, Madagascar and Malawi are moving towards systematic maternal death audits to improve quality of care. In Bangladesh and Nepal, a national surveillance system is being initiated, with UNFPA support, to identify and treat “hidden” fistula cases.

57. In partnership with UNICEF, WHO and the Averting Maternal Death and Disabilities Programme of Columbia University, New York, UNFPA supported emergency obstetric and newborn care needs assessments in countries with high maternal mortality. The assessments map the current level of care and provide evidence needed for planning, advocacy and resource mobilization to scale up emergency services in every district. By 2011, about 24 countries had completed or initiated such assessments.

58. Far more research is needed to effectively address the problem of obstetric fistula. Johns Hopkins University, with UNFPA and WHO, is conducting a multi-centric study to examine the links between surgical prognosis and treatment and long-term health, psychosocial and reintegration outcomes following fistula surgery. This landmark study, launched in 2010, is ongoing in Bangladesh, Ethiopia and the Niger. Study results will help to develop a prognostic-based classification system for obstetric fistula, guide advocacy and inform cost-effective programmes and national strategies. Progress is slow, however, for lack of funds.

59. Finding ways of providing fistula repair services efficiently and cost-effectively, without comprising surgical outcomes and the overall health of the patient, is paramount. The Special Programme of Research, Development and Research Training in Human Reproduction of UNDP, UNFPA, WHO and the World

[18] A near miss is commonly understood as a severe life-threatening obstetric complication necessitating an urgent medical intervention in order to prevent the likely death of the mother (WHO, *Beyond the Numbers*, 2004).

Bank, jointly with EngenderHealth, is conducting a facility-based multi-centre randomized controlled trial in some African countries to examine whether short-term (7-day) catheterization following surgical repair of “simple” fistula cases is inferior to longer-term (14-day) catheterization in terms of fistula repair breakdown.

60. As midwives are the “front-line workers” in the fight to prevent obstetric fistula and maternal mortality, a skilled midwifery workforce is vital. Data on midwifery in the hardest-hit countries is, however, lacking. To fill the data gap, the Midwifery Programme launched by UNFPA and the International Confederation of Midwives, in 2011 issued the first *State of the World’s Midwifery* report. This joint effort involved 30 global partners to generate data on midwifery workforce services and policies from 58 low-resource countries representing 91 per cent of the global burden of maternal mortality and 82 per cent of newborn mortality. Twenty-seven needs assessments and gap analyses were conducted and subsequent country action plans developed to strengthen midwifery policies and capacities.

E. Advocacy and awareness-raising

61. National champions and global activists support the Campaign to End Fistula. The First Lady of Sierra Leone, Mrs. Sia Nyama Koroma, fistula survivor Sarah Omega from Kenya, Natalie Imbruglia and Christy Turlington Burns are among many advocates worldwide who continue mobilizing support. Policymakers, national and local religious and community leaders and health professionals have a critical role in advocating for the rights of women and girls, and challenging harmful practices and gender inequities that threaten their well-being.

62. The Campaign to End Fistula was one of a few initiatives featured in *MDG Good Practices*, a publication by the United Nations Development Group which highlighted the innovative, comprehensive programmatic and advocacy approach of the Campaign. This approach has the potential to be significantly magnified at the global level to further strengthen advocacy and awareness-raising for ending obstetric fistula and will require intensified mobilization of human and financial resources.

63. Globally and nationally, there has been a stronger focus on coordinated advocacy and communication efforts to end obstetric fistula. However, developing the most high-impact, cost-effective and culturally appropriate means to convey health messages remains a challenge in many countries. Human rights concepts are key. Using the media, including social media, for awareness-raising and advocacy, utilizing radio, television and the press to send important messages on fistula prevention, treatment and social reintegration to effectively reach families and communities would narrow this gap.

64. Community-based communication and mobilization help to overcome barriers to obstetric fistula prevention and identify solutions that are culturally acceptable. One of the most innovative and successful approaches has been involving fistula survivors in community mobilization. There is no more powerful voice for promoting prevention and safe delivery, and helping “invisible” fistula survivors to access treatment, than a woman who has survived fistula. Eighteen countries have supported fistula survivors to sensitize communities, provide peer support and advocate improved maternal health at both community and national levels.

65. In 2011, for the first time in the history of the Campaign to End Fistula, fistula survivors participated in the annual meeting of technical experts of the International Obstetric Fistula Working Group, bringing a vital, yet previously missing, link to the table. This was not only a symbol of the international recognition of their valuable advocacy work with "One by one let's end fistula" in Kenya, but, more importantly, a key contribution to programmatic and strategic efforts at the global level. As a result of continued efforts by the Campaign's secretariat, many organizations are now working with fistula survivors and advocates to reach women and girls living with fistula, advocate for prevention, women's empowerment, men's engagement and political commitment to end fistula. In Bangladesh and the Niger, mobile telephones were provided to fistula advocates to improve coordination efforts and elicit greater involvement with communities in their villages.

F. Global support and resource mobilization

66. The Every Woman Every Child initiative aims to put the Global Strategy for Women's and Children's Health into action. By February 2012, about 217 commitments had been made. Some countries made important commitments, including free Caesarean section in subsequent pregnancies of fistula survivors, establishment of treatment centres and free fistula services. More than 25 business organizations have made commitments to the Strategy, including the first grant from Johnson & Johnson to a joint United Nations programme in Ethiopia and the United Republic of Tanzania.

67. A major challenge facing countries is the insufficiency of national financial resources for maternal health and obstetric fistula. This problem is compounded further by low levels of official development assistance directed for Millennium Development Goal 5. Contributions to the Campaign to End Fistula are vastly insufficient to meet the needs globally, and have steadily declined in recent years, in part because of the ongoing global financial crisis. Thus, urgent redoubling of efforts is required to intensify resource mobilization to ensure that fistula does not once again become a neglected issue.

68. Other initiatives that support maternal health and fistula prevention to accelerate the achievement of the Millennium Development Goals include the G-8 Muskoka Initiative on Maternal, Newborn and Child Health, the Partnership for Maternal, Newborn & Child Health, and the Health Eight.

V. Conclusion and recommendations

69. **Obstetric fistula is an outcome of socioeconomic and gender inequalities and the failure of health systems to provide accessible, equitable, high-quality maternal health care, including family planning, skilled attendance during childbirth and emergency obstetric care in case of complications. Over the past two years, considerable progress has been made in focusing attention on maternal deaths and disabilities, including obstetric fistula. Despite these positive developments, many serious challenges remain. It is a grave injustice that around the world, in the twenty-first century, the poorest, most vulnerable women and girls suffer needlessly from a devastating condition that has been virtually eliminated in the industrialized world.**

70. **Significantly intensified political commitment and financial mobilization are urgently needed to accelerate progress towards eliminating this global scourge and closing the gap in the unmet need for fistula treatment. Special attention should be paid and support intensified to countries with the highest maternal mortality and morbidity rates, especially those struggling to make sufficient progress towards Millennium Development Goal 5, for example, Burundi, Cameroon, the Central African Republic, Chad, the Congo, Guinea-Bissau, Lesotho, Sierra Leone, Somalia, South Sudan and Zimbabwe.**

71. **There is global consensus on the key interventions necessary to reduce maternal deaths and disabilities. Countries are increasingly investing in and promoting prevention, treatment and reintegration services for women living with obstetric fistula as part of holistic efforts to achieve Millennium Development Goal 5. There is, however, an urgent need to scale up the three well-known, cost-effective interventions, emphasizing the crucial role of midwives to reduce the high number of avoidable maternal deaths and disabilities.**

72. **Better understanding of the social and economic burden resulting from poor reproductive and maternal health has led to multi-sector approaches to address linkages between poverty, inequities, gender disparities, discrimination, poor education and health. Efforts to improve women's health should systematically include educating women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives to increase the age of marriage and delay early pregnancy.**

73. **Specific, critical actions, within a human rights-based approach that must be urgently taken by Member States and the international community to end obstetric fistula include:**

(a) **Greater investment in strengthening health systems, ensuring adequately trained and skilled human resources, especially midwives, obstetricians, gynaecologists and doctors, as well as investments in infrastructure, referral mechanisms, equipment and supply chains, to improve maternal health services and ensure that women and girls have access to the full continuum of care;**

(b) **Equitable access and coverage, through national plans, policies and programmes that make maternal health services, particularly family planning, skilled birth attendance and emergency obstetric and newborn care and obstetric fistula treatment geographically and financially accessible. Countries should ensure access, particularly in rural and remote areas, through the establishment and distribution of health-care facilities and trained medical personnel, collaboration with the transport sector for affordable transport options, and promotion and support of community-based solutions;**

(c) **Integration of fistula prevention and treatment and socioeconomic reintegration into national plans, policies, strategies and budgets, and systematic follow-up of fistula patients. States should ensure comprehensive multidisciplinary national action plans and strategies for eliminating fistula with emphasis on prevention. Emphasis must be placed on primary prevention at the levels of the law, policy and programmes. Women's and children's well-being and survival must be protected, including preventing recurrence of**

subsequent fistulas by making post-surgery follow-up and tracking of fistula patients a routine and key component of all fistula programmes;

(d) **Increased national budgets for health, ensuring adequate funds allocated to reproductive health, including for obstetric fistula. Within countries, policy and programmatic approaches to redress inequities and reach poor, vulnerable women and girls must be incorporated into all sectors of national budgets. Countries should provide free or adequately subsidized maternal health care as well as obstetric fistula treatment for all women and girls in need who cannot afford it;**

(e) **Enhanced international cooperation, including intensified technical and financial support, in particular to high-burden countries, to accelerate progress towards Millennium Development Goal 5 and fistula elimination;**

(f) **Establishment or strengthening of a National Task Force for Fistula, led by the Ministry of Health, to enhance national coordination and improve partner collaboration;**

(g) **Ensuring access to fistula treatment through increased availability of trained, expert fistula surgeons as well as permanent, holistic fistula services integrated into strategically selected hospitals. This should be accompanied by quality control, and improved monitoring mechanisms to ensure that only trained, expert fistula surgeons provide treatment to address the significant backlog of women awaiting care;**

(h) **Developing a community- and facility-based mechanism for systematic notification of obstetric fistula cases to ministries of health, in a national register;**

(i) **Ensuring that all women who have undergone fistula treatment have access to social reintegration services, including counselling, education, skills development and income-generating activities. Countries should provide holistic services including intensive social reintegration support for the forgotten women and girls with incurable or inoperable fistula. Linkages with civil society organizations and women's empowerment programmes should be developed to help to achieve this goal;**

(j) **Empowering women who are survivors of obstetric fistula to contribute to community sensitization and mobilization as advocates for fistula elimination and safe motherhood;**

(k) **Mobilizing communities, and women in particular, to be involved, informed and empowered regarding reproductive health services and maternal health needs, utilization of services and support to women to access such services. Promoting the enhanced engagement of civil society and local religious and community leaders in raising awareness and reducing stigma, discrimination, violence against women and girls and harmful practices such as child marriage. Ensuring the involvement of men and boys as key stakeholders in advocating for and supporting women's access to reproductive health care and rights, gender equity, ending violence against women and girls, and preventing child marriage, recognizing that the well-being of women and girls has a significant positive effect on the survival and health of children, families and societies;**

(l) **Strengthening awareness-raising and advocacy, including through the media, to effectively reach families and communities with key messages on fistula prevention, treatment and social reintegration;**

(m) **Strengthened and expanded interventions to keep girls in school, especially post-primary and beyond, end child marriage, and protect and promote gender equality and the empowerment of women and girls. Laws prohibiting child marriage must be adopted and enforced, and followed by innovative incentives for families to avoid marrying girls off at early ages, including in rural and remote communities;**

(n) **Strengthening research, data collection, monitoring and evaluation to guide planning and implementation of maternal health programmes including obstetric fistula. Countries should conduct up-to-date needs assessments on emergency obstetric and newborn care and for fistula, and routine reviews of maternal deaths and near miss cases, as part of a national maternal death surveillance and response system, integrated within their national health information system.**

74. **As the Campaign to End Fistula approaches its tenth anniversary, the challenge of putting an end to obstetric fistula requires vastly intensified efforts at the national, regional and international levels. Such efforts must be part of the strengthening of health systems, gender and socioeconomic equality and human rights, aimed at achieving Millennium Development Goal 5. If Goal 5 is to be achieved, additional resources must be forthcoming to accelerate progress. Funding must be increased, predictable and sustained. Significantly increased support should be urgently provided to countries' national plans, United Nations entities, including the Maternal Health Thematic Fund, the Campaign to End Fistula, and other global initiatives dedicated to achieving Millennium Development Goals 3 and 5 by 2015.**