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ISSUES IN PUBLIC HEALTH RESPONSE

Fistula Fortnight: Innovative partnership brings mass treatment and public awareness towards ending obstetric fistula

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Abstract

Objective: As part of the global Campaign to End Fistula, the Fistula Fortnight, a 2-week mass obstetric fistula treatment project, was organized in northern Nigeria to contribute to reducing the backlog of untreated fistulas and raise awareness regarding obstetric fistulas and safe motherhood. *Methods:* An array of partners joined forces to provide free surgical treatment, strengthen the capacity of existing facilities to manage obstetric fistulas, and utilize media strategies to raise awareness. *Results:* The Fistula Fortnight took place from February 21 to March 6, 2005, at 4 established fistula repair centers in the northern Nigeria states of Kano, Katsina, Kebbi, and Sokoto. A total of 569 women received treatment, with an 87.8% rate of successful closures. The highly publicized event also raised awareness on the issue of obstetric fistula and helped put a face to maternal deaths. *Conclusion:* The Fortnight, which required extensive and thoughtful planning involving many persons cognizant of health system and quality of care issues, was effective in drawing attention to the vast fistula problem and contributed to reducing the backlog of patients.

1. Introduction

Women in most developing countries still risk their lives and their health in childbirth despite the existence of life-saving interventions. In regions such as Africa and Asia, where approximately 95% of annual maternal deaths occur [1], at least 20 women experience an obstetric morbidity for every woman who dies [2]. These unacceptably high rates of maternal mortality and morbidity reflect the dire lack of essential and emergency obstetric care services for large proportions of the population. Yet, there has been limited political commitment to maternal health in most countries, resulting in insufficient investment to improve services. Consequently, women still sustain childbirth injuries. The most devastating of these injuries is probably obstetric fistula (OF), a condition that was virtually eliminated in industrialized countries nearly a century ago. Where fistulas continue to exist they are visible indicators of poor maternal health

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care, and the stories of women living with fistulas provide insight into the challenges that all women face during labor.

Intensive public health campaigns, such as those for immunization and cataract surgery, have been used to provide services where they are unavailable and to draw attention to issues of public health concern. Considering the low level of awareness surrounding OF and maternal health, and the large estimated backlog of patients awaiting care, several partners decided to join forces and organize a mass treatment campaign as part of the global Campaign to End Fistula. The Fistula Fortnight was the result of this decision. During the 2 weeks, hundreds of women with fistulas were provided with free OF treatment at 4 sites in northern Nigeria. However, the project was also designed to have an impact beyond the 2 weeks. By strengthening the fistula centers' capacity, it enabled them to provide regular treatment services, thereby also continuing to raise awareness about the condition. The specific objectives of the project were the following: (A) to contribute to reducing the alarming backlog of untreated fistulas by providing a free standardized treatment plan for approximately 500 women, with a target of 85% of successful fistula closures; (B) to enable existing facilities to manage fistulas through human resource development, facility renovation, and provision of equipment; (C) to raise awareness about OF, its causes, consequences, prevention, and treatment; and (D), to advocate for support and mobilize resources for OF treatment, emergency obstetric care, and safe motherhood.

2. Materials and methods

The Fistula Fortnight took place in northern Nigeria from February 21 to March 6, 2005. Planning and preparations for the project began in May 2004, at which time all the partners were engaged.

2.1. The partnership

A diverse array of national and international and public- and private-sector partners came together for the Fistula Fortnight. These partners included the Nigerian Federal and State Ministries of Health and Women Affairs, 13 expert Nigerian fistula surgeons, 4 international surgeons, the Nigerian Red Cross, the United Nations Population Fund (UNFPA), Virgin Unite, Voluntary Service Overseas, and national organizations.

2.2. Site selection

Nigeria agreed to host this event because of its high estimated OF prevalence (estimates range from 400,000 to 1 million) [3], and because of its expertise, as it may have the largest numbers of experienced fistula surgeons and established fistula treatment centers in any country in the world.

Site selection for the Fistula Fortnight was based on the existence of service and expertise, and the 4 selected were the Laure Fistula Centre at Murtala Mohammed Hospital in Kano State, Babbar Ruga Fistula Hospital in Katsina State, Birnin Kebbi VVF Centre in Kebbi State, and Maryam Abacha Women and Children's Hospital in Sokoto State, all located in northern Nigeria. Three of the centers had provided fistula treatment for more than 10 years, all had wards dedicated to fistula care, and 3 had at least 1 dedicated operating theatre. Two of the sites also provided obstetric services, including the 24-hour availability of cesarean delivery. They were limited to 1 region to ensure geographic accessibility between the sites. Assessments were carried out at various stages of the preparatory period to monitor progress and identify necessary renovations as well as needs in equipment and human resource.

2.3. Project management and coordination

Several mechanisms permitted oversight of the coordination of the project. Overall coordination and management, including communication between international and national partners, was provided by UNFPA. A coordinator who was an expert fistula surgeon was hired to monitor preparations overall and to provide technical support at the state level. Local task forces were established and included State Ministries of Health and Women Affairs or of Social Development, State chapters of the Nigerian Red Cross, other relevant local organizations, and UNFPA State advisors. Task forces were formed at all sites with the exception of Katsina, where preparations were largely overseen by the Ministry of Health alone. State task forces were responsible for overseeing the logistics of preparation and coordination before, during, and after the Fortnight.

During the Fortnight, managing teams at each site included Nigerian expert surgeons, a foreign expert or trainee surgeon, a representative from the Federal Ministry of Health and a representative from the Federal Ministry of Women's Affairs, and members of the State's task force. At least 2 UNFPA staff were also on hand to monitor and provide logistic and technical support as needed, and to liaise with the media. At each site, 8 teams made up of persons from the management team and regular staff were also formed to monitor daily issues in the following key areas: clinical care, nursing care, social work, electricity, water and sanitation, security, patient feeding, and records.

2.4. Patient care

Prior to the event, a 3-day meeting was convened with Nigerian expert fistula surgeons, officials from the Federal Ministries of Health and of Women's Affairs, and UNFPA staff to plan the event and determine the standards for treatment care. Standardized screening as well as standardized preoperative and postoperative care were agreed upon, with surgical techniques left to the discretion of the surgeon according to the nature and complexity of the fistula. Based on site capacity, it was determined that approximately 150 repairs could be performed in Kano, Katsina, and Sokoto, with an additional 75 in Kebbi. The expert surgeons also decided to arrive at the sites 3 days before and remain 4 days after the 2-week period to ensure proper screening and postoperative care. The full expert team of 13 Nigerian surgeons was selected based on the number of repairs they had already performed. The international surgeons were first screened by Voluntary Service Overseas, and their candidacies were then reviewed by the Nigerian expert surgeons at the meeting. The Federal Ministry of Health provided authorization for the international surgeons to practice in Nigeria. The national and international surgeons volunteered their time.

A team from Babbar Ruga Fistula Hospital screened patients arriving at the 4 sites during the month leading up to the Fortnight. Patients were re-examined the day before surgery and those who arrived during the Fortnight were fully screened by the expert surgeons on site. Patient assessment included systemic review, medical history, and previous attempts at fistula repair. The standardized history taken for each patient

included name, age, address, occupation, educational status, parity, duration of leakage, duration of labor, outcome of delivery, place of delivery, marital status, age at menarche, last menstrual period, presence of foot drop, presence of a recto-vaginal fistula, presence of a Gishiri cut, previous surgery, and how she learned about the Fortnight. Each patient was given a general physical examination followed by a pelvic examination that included speculum examination. For the surgery, spinal anesthesia using heavy 5% bupivacaine hydrochloride was used with ketamine hydrochloride as a backup. The use of antibiotics was left to the discretion of the surgeons.

During the postoperative period, standard care included bed rest for the first 12 hours; analgesics as needed for the first 24 hours (tramadol hydrochloride and pentazocine); oral fluids as tolerated; visual monitoring of urine output by nurses; and a catheter in situ for 2 weeks, with an optional vaginal pack for the first night. Follow-up care included catheter removal and an examination at 2 weeks; removal of nonabsorbable sutures at 3 weeks (when applicable); and an examination and discharge from the hospital at a minimum of 4 weeks, with instruction to avoid sexual intercourse. Patients were advised to return at 6 months for a final follow-up visit and final discharge. Social workers and nurses also provided preoperative and postoperative counseling. Health education sessions were conducted by nurses and social workers for patients and accompanying spouses and relatives. These sessions, which focused on personal hygiene, the importance of antenatal care, and the necessity of hospital delivery, were not standardized across the 4 sites.

2.5. Site preparation and strengthening

At each of the 4 sites, substantial renovations were funded and carried out by the state government ministries, and in one case a new center was built. Tents and mattresses were loaned by the Nigerian Red Cross for each of the sites to increase bed capacity for the duration of the Fistula Fortnight. Additional equipment was procured by UNFPA with donor support, including operating tables and equipment, surgical instruments, and consumables and supplies. Sutures and needles were provided through an in-kind donation from Johnson & Johnson (New Brunswick, NJ, USA). Additional supplies and drugs were provided on site throughout the Fortnight as the need arose. Each woman was provided with a hygiene kit from Virgin Unite.

Preparations for the Fortnight, overseen by the state-level task forces, also included feeding arrangements for patients and staff; beds and lodging space for patients; hygiene and sanitation arrangements; stable electricity and water supply; transport of patients between sites where necessary and to their homes; and staffing and volunteer requirements.

To ensure service sustainability at the sites, health professionals from each of the states were trained prior to the Fortnight. The State Ministries of Health were asked to select physicians and 10 nurse trainees for each site, and committed to retain them at the sites for at least 3 years before posting them to another facility. A 1-month training period in the basic preoperative, intraoperative, and postoperative care of fistula patients was provided by Dr. Kees Waaldijk at the training centers in Kano and Katsina. Most trainees had additional exposure during the Fortnight and plans are underway for some of the physicians to receive further training. Two of the participating international surgeons were also trainees during the Fortnight and both have returned to Nigeria for further training.

Orientation in preoperative and postoperative counseling was also provided for 10 social workers selected by the State Ministries of Women's Affairs or Social Development and 5 volunteers from the Nigerian Red Cross from each state. Grassroots Health Organization of Nigeria, a national nongovernmental organization, coordinated the orientation. It included interactive sessions on the social determinants of OF; on OF prevention and treatment; and on counseling women and guiding their rehabilitation once their fistulas are repaired.

2.6. Awareness raising/social mobilization

A clearly defined strategy was elaborated for social mobilization for the Fistula Fortnight, which included 3 crucial components: (A) patient recruitment for the 2-week treatment period; (B) mobilization of traditional and political leaders and other key stakeholders; and (C) awareness-raising among the general population about obstetric fistulas, including their causes, consequences, prevention, and treatment.

To recruit patients for the Fortnight, a multimedia approach was adopted to ensure that the message was widespread. A radio message was developed and translated into the Hausa dialects spoken in each of the 4 states. The message, which began airing in January 2005 (more than 1 month prior to the event), enjoined the women who were leaking urine and who had not had previous repairs to go to any of the 4 sites for free treatment. In addition, the Sultan of Sokoto and the Emirs of Kano, Katsina, and Arugungu personally delivered televised messages urging women with fistulas to go to the centers. In the State of Kano, local government authorities identified women with fistulas as well.

A comprehensive media strategy was developed for the Fortnight to raise general awareness about the condition and contribute to its demystification. Its objective was to ensure extensive coverage by local, regional, and global media. A team of media experts from UNFPA worked directly with the site coordinators to ensure that information from all sites was made available to the media on a daily basis. Press materials were developed and distributed to media within and outside Nigeria, and a Web site displayed daily updates and stories from the event. In addition, a number of opportunities to inform the media were planned. A live television debate was organized and press conferences with national media were arranged before and after the Fistula Fortnight. National and regional media representatives were also invited to the formal launch hosted by the Katsina State government, a ceremony attended by officials from the federal and state governments and international and national partner organizations. In addition, an international film crew was hired to film at the site in Katsina, and the footage was distributed for use by television media.

2.7. Data collection

Because of the weakness of the record-keeping systems at the facilities and to ensure adequate follow-up in the 4 centers, the expert surgeons agreed on standardized patient records at the pre-meeting mentioned earlier. For each patient a standard chart and a social work form were completed. Patients were given special serial numbers for the project in addition to the regular hospital number. The standard charts, completed by the surgeons, included patient history, preoperative assessment and examination results, laboratory investigation results, operation

Table 1 Patient characteristics

Characteristic	Frequency, no. (%)
Age, y	
<20	118 (15.5)
20–29	305 (40.0)
30–39	191 (25.1)
≥40	148 (19.4)
Educational status	
None	309 (40.6)
Nonformal	381 (50.0)
Primary	63 (8.3)
Secondary	7 (0.9)
Higher	2 (0.3)
Marital status	
Single	41 (5.4)
Married	470 (61.7)
Separated	70 (9.2)
Divorced	176 (23.1)
No response	5 (0.7)
Parity at occurrence of fistula	
0	381 (50.0)
1	103 (13.5)
>1	278 (36.5)

notes, and follow-up care. Social workers were trained to administer the social work forms, which were piloted during orientation. The forms, completed for all women presenting for treatment, included age at first marriage and first delivery, educational background, ethnicity, marital and familial status, livelihood, description of the index labor (resulting in a fistula), and level of social support provided by family and community since the fistula occurred. During informed consent counseling the patients were informed that they would be asked about their condition, about previous attempts at treatment, and about the consequences of their fistula on their lives.

A total of 762 women presented for treatment and the social work forms for all 762 were analyzed. However, because of time and space constraints, only 569 women were treated during the Fortnight, the others receiving treatment following the project period. The forms were checked for accuracy, entered in a database, and analyzed using the statistical software SPSS, version 12 (SPSS, Chicago, IL, USA). Categorical data were presented as frequencies and percentages; quantitative data were summarized as median and range or mean and standard deviation, as appropriate.

3. Results

3.1. Patient care

Approximately 80% of the women were from the participating states (246 from Sokoto State, 169 from Kebbi State, 124 from Kano State, and 83 from Katsina State), with 26 (3.4%) coming from the neighboring Republic of Niger. Most (95.3%) belonged to the Hausa and Fulani ethnic groups. Their ages ranged from 10 to 60 years (mean ± SD, 28.8 ± 9.8 years). More than two-thirds (70.9%) were aged 15 through 34 years, with 6 younger than 15 years. Half had nonformal education in Qur'anic schools and approximately 40.6% had received no basic education. Almost 90% (669) were married between the ages of 11 and 19 years (median age at first marriage, 15 years). An overview of patient characteristics is provided in Table 1.

More than half of the women (52.8%) developed a fistula as a complication of their first delivery. For the rest, the fistula occurred during their second (14.3%) or a subsequent delivery (32.9%). Only 159 women (22.1%) had antenatal care during the index pregnancy. More than two-thirds (70.3%) of the women were in labor for more than 48 hours, and almost three-quarters reported being delivered at a health clinic or hospital. A total of 502 women (65.8%) reported having a skilled attendant (nurse/midwife or doctor) at delivery, while 194 (26.9%) were assisted by traditional birth attendants and the remaining 25 (3.5%) by women relatives. Almost half (48%) had spontaneous vaginal deliveries, about one-third (32.7%) had cesarean deliveries, and the remaining (19.3%) had forceps or vacuum extraction deliveries.

The women reported leaking urine and/or feces for periods ranging from 1 month to more than a decade. More than 30% of the women were divorced or separated from their husbands while 61.7% were still married. Just more than half of the patients (52.2%) received financial support from parents and relatives, 42.9% were supported by their husbands, and 4.9% catered for themselves. Most (67.3%) of those who were still married said that their husbands were supportive after the condition occurred, and the remaining 32.7% said that their husbands were not. For the most part (95.8%), the women agreed that their family members were supportive of them. A preponderance (91.5%) said that members of the community were sympathetic to their plight. In contrast, 5.4% and 3.1%, respectively, said the community was not supportive or indifferent.

During the 2-week duration of the Fistula Fortnight surgery was performed each day on a total of 550 women, while another 19 were treated by indwelling catheter. Because 22 women had a recto-vaginal fistula in addition to a vesico-vaginal fistula, 572 surgical interventions were performed, all vaginally under spinal anesthesia. The distribution of the procedures by type and site is shown in Table 2.

Table 2 Distribution of treatment procedures by center

Center name and state	Catheter treatment	VVF repair	RVF repair
Babbar Ruga Fistula Hospital, Katsina (*n*=135)	7 (5.2)	123 (91.1)	5 (3.7)
Laure VVF Center, Kano (*n*=169)	5 (3.0)	153 (90.5)	11 (6.5)
VVF Centre, Birnin Kebbi (*n*=102)	4 (3.9)	94 (92.2)	4 (3.9)
Maryam Abacha Fistula Hospital, Sokoto (*n*=184)	2 (1.1)	180 (97.8)	2 (1.1)
Total (*N*=591)	19 (3.2)	550 (93.1)	22 (3.7)

Abbreviations: RVF, recto-vaginal fistula; VVF, vesico-vaginal fistula.
Values are given as number (percentage).

Successful closure was determined by vaginal examination 6 to 8 weeks postoperatively by the team from Babbar Ruga Fistula Hospital, which visited each of the 4 sites. Of the 591 fistulas treated, 519 were successfully closed, for an overall rate of 87.8%. A breakdown of the success rates by type can be seen in Table 3. For 40% of all patients, this was at least the second repair. In 98% of the women the fistulas were of obstetric origin. The main complications encountered during the postoperative period were expelled and blocked catheters, which were replaced. A few women developed fever, and some were given treatment free of charge for malaria, urinary tract infection, and respiratory tract infection. Four deaths occurred at the hospitals during the postoperative period (for a 0.7% mortality rate), at Days 6, 13, 19, and 31, in women ranging in age from 17 to 42 years. Autopsies were not performed owing to cultural restrictions, but the causes of death were attributed to malaria, hypoglycemic coma, hypertension, and leukemia, respectively. About 60% of the women returned for the 6-month follow-up visit, and more within the next 6 months, but some have not yet returned.

3.2. Facility strengthening

The 4 facilities underwent significant renovation, creating a better environment to provide treatment services both for the Fortnight and after. New equipment, which remains at the sites, was also provided (operating tables, operating lights, and surgical instruments). A total of 10 physicians received training in fistula management, including in surgical techniques. In addition, 40 nurses received training for the preoperative and postoperative care of women with fistulas. Because 60 social workers and Red Cross volunteers were trained for the Fistula Fortnight, the sites are also now better able to provide counseling services.

3.3. Awareness raising/social mobilization

Through the targeted advocacy efforts that surrounded the Fistula Fortnight, national attention and support were drawn to the issue. The number of women recruited for the event was beyond expectations. A remarkable number of requests for fistula treatment caused the states to develop new plans. The role of the traditional leaders in bringing credibility to the project and assuring communities that it was acceptable for women to be treated was vital for recruitment.

The project provided an entry point for raising government officials' awareness of the issue and mobilizing their commitment at both state and federal levels. In their efforts to strengthen the capacity of the centers and implement the project, the governments of the 4 involved states made notable investments in financial and human resources. Other states have also now committed to addressing the issue. For example, Borno State has since commissioned a new fistula hospital, while Zamfara State has re-established regular fistula treatment services and Jigawa State undertook a smaller mass treatment exercise in October 2005. The contributions of other stakeholders have also strengthened the treatment facilities. As a result of their collaboration during the project the expert Nigerian surgeons now work together nationwide, and new partners such as the Nigerian Red Cross have joined in the national effort to eliminate OF.

There was a high level of media attention during the Fortnight. Throughout the 2 weeks, national radio and television programs aired interviews with partners involved in the Fortnight, some providing coverage on an almost daily basis. A live television debate on fistulas was also aired on a station with a viewership of approximately 100 million. The Fortnight was covered extensively by international media, both during and after the event. The messages included in the media coverage were about fistula prevention and treatment, and made critical links to the broader issues of poverty, gender inequality, and poor access to quality maternal health services at the source of OF.

Table 3 Successful closure rate by fistula type

Type and procedure	No. of procedures	No. of fistulas closed	Success rate, %
VVF, catheter	19	19	100
VVF, surgery	550	479	87.1
RVF, surgery	22	18	81.8
Total	591	519	87.8

Abbreviations: RVF, recto-vaginal fistula; VVF, vesico-vaginal fistula.

4. Discussion

The Fistula Fortnight was the largest surgical effort to date to provide treatment for women with vesico-vaginal and recto-vaginal fistulas. Although treatment services are regularly available at these centers, the large numbers of women who presented during the Fistula Fortnight and since its conclusion indicate that information about treatment and women's ability to access treatment are likely still low. Because the treatment was offered free of charge, it may have also drawn larger numbers of women. Prior to the Fistula Fortnight, patients were charged between N5000 and N15,000 (US$40–US$118) and often were required to provide consumables. In addition, the short duration of leakage among almost 30% of the patients (1 year or less) and the high rate of recurrence highlight the urgent need to improve prevention in these regions.

This effort did not merely result in the provision of services during a limited time. It was a focalizing event bringing together health professionals, government officials, and organizations to work toward a common issue. Because of the long planning and the unique contribution of each partner, all of the expected results were achieved and, in some instances, surpassed. National and local attention was drawn to the issue of OF and the need to increase efforts to prevent and treat the condition. Partners that had been working in isolation were brought together, paving the way for future collaboration. The state and federal governments and national organizations made substantial commitments of financial and human resources. In addition, by upgrading infrastructures and boosting human resources, preparations for the Fortnight increased long-term capacity at 4 centers for fistula treatment services.

Care was provided to more than 500 women with fistulas, with 87% successful closures, surpassing the initial target of

85%. For a large percentage (40%) of the patients, this was at least the second repair. While it is difficult to compare this success rate with those published in other studies—owing to variations in classification—it is at the high end of the range of reported success rates for fistula closure [3,4]. Unfortunately, 4 deaths occurred during the postoperative period. While the mortality rate following fistula treatment has been estimated to be between 0.4% and 1.5% [5–7], with the Fortnight rate of 0.7% fitting within this range, the cases are being reviewed to draw lessons to improve quality of care. The patients' characteristics were found to be similar to those reported in other case studies.

Fistula surgery is highly technical and requires specialized training. The Nigerian surgeons selected for this exercise had repaired hundreds or thousands of fistulas with high success rates. Many women were treated for at least the second time at the Fistula Fortnight, probably because many surgeons are attempting fistula repair without the appropriate skills—although some recurrences were due to a delivery following a successful repair. The problem of recurrence has been noted in assessments of the situation in Nigeria [8], and as mentioned, access to emergency obstetric care is inconsistent. In Kano, for instance, this care is provided free of charge, but patients often need to purchase consumables when supplies are low. At the other sites, although cesarean deliveries are performed, they cost between N7000 and N15,000 (US$50–US$118).

Naturally, a new project, and one of such magnitude, encounters some challenges when implemented. The relatively long postoperative period is a key difference between fistula treatment and the treatment of other conditions that have been addressed through large surgical campaigns. Hence, the burden on health facilities, including the infrastructure and the staffing, was much higher. Ensuring adequate bed space was a challenge at some sites, and additional beds had to be procured to meet the number of patients. In addition, adequate staffing to ensure quality postoperative care meant that nurses were required to work extra hours. Some of the new staff hired and trained to help meet this need lacked practical experience and needed more supervision. The Fortnight provided exposure to the new trainees, whose skills improved, but it was difficult to provide thorough training in this context. There was also an unanticipated shortage of supplies and drugs; many of the social workers were ill-equipped to provide counseling; and the large caseloads made it difficult to provide comprehensive rehabilitation care.

A long and extensive planning process is needed for an event of this size. The planning should be done by a multidisciplinary team providing many perspectives as well as clinical, programmatic, logistic, and communications expertise. Intense resource investment is also needed, especially for capacity building, which, however, lasts beyond the duration of the project. Project duration and the number of repairs should be considered at the planning stage. Rather than 2 weeks, it probably should last 1 week, or the number of surgeries per day should be less, to ensure quality of care and reduce the burden on the facilities. Regardless, while the intense moment is the 1- or 2-week surgical campaign, planning for patient care, including staffing, food, and supplies, needs to include at least 1 week prior for patient screening and 2 weeks after for postoperative care. Expert nurses are a vital component and they need to be involved not only in the implementation but also in the planning processes. Each site should have at least 1 ward nurse and 1 experienced operating theater nurse. In addition, assessing the social workers' skills is needed to determine their training needs.

5. Conclusions

The Fistula Fortnight restored hope to more than 500 women, their families, and their communities. While 500 repairs addressed only a small portion of the backlog, the Fistula Fortnight provided a strategic opportunity to raise awareness and motivate action among policy makers, national and local leaders, and the general public about the need to increase efforts to prevent and treat OF. By providing fistula treatment in such a visible manner, the condition was highlighted and demystified, thereby helping to open discussion and spark commitment for maternal health, particularly concerning OF. Mass treatment campaigns, such as the Fistula Fortnight, are useful to gain national and international attention and to reduce the backlog of women awaiting treatment. In some remote areas, this type of concentrated surgical campaign, albeit at a smaller size, may be the only option for treating women. However, long-term elimination will require the regular availability and accessibility of quality treatment services. And perhaps more importantly, available and accessible quality obstetric services are urgently needed to turn off the tap of new cases and ensure that the right to safe pregnancy and delivery is achieved for all women.

Conflict of interest

K. Ramsey and L. Idoko are staff members of UNFPA, one of the partner agencies. Z. Iliyasu was a consultant hired by UNFPA at the time the project occurred and during the data analysis.

Role of the funding source

The funding sources for the event included the Federal Government of Nigeria; the Nigerian State Governments of Kano, Katsina, Kebbi, and Sokoto; Americans for UNFPA; UNFPA; Virgin Unite; the Governments of Finland and Sweden; the SK Foundation; and the TTT Foundation. As, noted the authors are or have been employed by UNFPA and were involved in organizing the event. Although the other donors did not participate in the writing of this article, some were involved in the organization of the project.

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