Obstetric fistulas: a devastating condition for two million women
All parties should respect access to patients

The Arab world has been wracked by civil unrest and violence since the beginning of the year. What started off as a genuine expression of despair in a fast-evolving context has been quick to react but is finding it hard to access populations that need health care. MSF teams have been supplying and assisting hospitals and health structures where medical staff is facing a marked increase in the numbers of injured people. Teams are also assisting people who are fleeing to neighboring countries.

In Libya, as the conflict intensifies, MSF is seeking to step up its assistance by reinforcing its bases on the ground, sending additional medical supplies, and facilitating the evacuation of wounded and sick patients to safe treatment areas. Despite several appeals and ongoing negotiations with the authorities, MSF has been denied access to the west of Libya on the grounds that there are no medical needs. However, the situation in Misrata is reported to be critical, while medical facilities in other cities are also said to be overstretched.

Following medical ethics and international humanitarian law, it is crucial that all parties respect medical facilities, vehicles, and personnel, as it is the only way patients will receive the urgent medical care they need. MSF calls for respect of unhindered access for health professionals to provide health care to the sick and wounded in secure and safe health facilities. MSF also requests the authorities to allow safe and unhindered access of humanitarian agencies to people living in areas affected by the conflict.

MSF is neutral and impartial, delivering emergency medical care to people caught in crisis regardless of race, religion, or political affiliation. MSF is independent from any political, economic or religious power. Ninety percent of MSF’s overall funding comes from private sources, not governments.

MSF is transparent and accountable. Every year, MSF provides detailed activity and financial reports including audited and certified accounts.

MSF controls the entire chain of its medical services, from the independent assessment of medical needs to the delivery of medical care, and does not subcontract to other organizations.

In 1999, MSF received the Nobel Peace Prize
In 2002, MSF received the Emirates Health Foundation Prize
In 2004, MSF received the King Hussein Humanitarian Leadership Prize

Middle East and North Africa unrest: MSF responds to medical needs

As civil unrest leads to violent clashes in a number of countries in the Middle Eastern and Mediterranean regions, emergency staff from MSF have been helping to fill gaps in the medical services for people injured in protests or conflict.

Libya

In Libya, MSF was able to assist the civilian population through the delivery of medical supplies with the first MSF team able to enter eastern Libya on 24 February. By mid-March, 33 tons of medical supplies had been made available. In addition, MSF teams of doctors and psychologists have been working at frontline points on the border to assist with the medical needs of migrants crossing the border, and small teams in Malta and the Italian island of Lampedusa are offering medical assistance, mainly through mobile clinics, to migrants who have crossed the Mediterranean.

On 3 April, MSF evacuated 71 patients by boat from the Libyan capital of Tripoli, where ongoing violence had overwhelmed medical facilities with injured people. “We managed to dock at Misrata on Sunday afternoon, despite intense fighting in the city over the past few days” said Helym Mekou, an MSF doctor who coordinated the evacuation. “The violence caused an influx of wounded people and it was humane we could be there and get them onto”. Among the evacuated patients were 3 people on life support, 11 people suffering from major trauma, and many others with abdominal wounds and open fractures. Intensive medical care was provided on board as the boat sailed to Tunisia.

However, security conditions are greatly affecting MSF’s work in Libya with teams turned back from some areas and postponing their activities in others. MSF reiterates its call on all parties to allow unhindered access to medical assistance for all Libyans affected by the violence. MSF also calls for the respect of medical facilities, healthcare personnel, and vehicles transporting patients.

Other countries where tension is high

During the protests in Tunisia Square in Cairo, Egypt, MSF supplied medical materials to Egyptian doctors in two hospitals and in an improvised clinic in a mosque. The team also provided training in how to manage a high number of injured people in a short period of time, and helped set up additional emergency preparations systems. In Tunisia, MSF donated orthopedic surgery equipment to two hospitals in the south.

In Bahrain, MSF is in contact with a number of medical facilities and ready to assist if needed. Earlier this year, an MSF assessment team made contact with medical organizations in the country, visiting Salmanya Hospital in the capital city of Manama to offer support.

Since the beginning of demonstrations in Yemen in January, MSF has been closely following the evolution of the situation and the regular medical activities of MSF in different areas of the country. Continued at the time of writing, MSF was also following the situation in Libya where unrest had recently started in Darnah city.

MSF is an international medical humanitarian organization that delivers emergency aid to populations in distress. MSF’s response is based solely on the humanitarian principles of neutrality, impartiality and independence and on the medical needs of patients.

What is MSF?

Founded in 1971 by doctors and journalists, Médecins Sans Frontières (MSF) / Doctors Without Borders is an international medical humanitarian organization.

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Middle East and North Africa unrest: MSF responds to medical needs

© Jianan Blaisaid. Libyan medical personnel and volunteers work together with MSF teams in Bonghaz to organize tons of MSF medicine and medical materials including surgical sets, burn kits and antibiotics ready to dispatch to health facilities that need them.
Mozambique: HIV/AIDS, malaria and tuberculosis are widespread in Mozambique

HIV/AIDS, malaria and tuberculosis are widespread in Mozambique. 15 per cent of people aged 15 to 49 are infected with HIV making it one of the worst affected countries in the world. Mortality is high and diarrheal diseases are endemic. Furthermore, the national healthcare system was shattered during the 16 years of civil war that ended in 1992, as were most social and economic infrastructures.

All MSF projects in Mozambique are focused on HIV/AIDS treatment and care, including the provision of mother-to-child transmission of the disease. In the capital Maputo, teams work in two districts, supporting two day-hospitals and nine health centers. Teams train staff, and provide psychosocial counseling for HIV-positive patients, including children. 18,000 patients are receiving antiretroviral therapy (ART).

MSF is developing and promoting innovative models to help meet the high demand for healthcare and to lobby the government to introduce a “task shifting” approach in hospitals to help counter the shortage of doctors and nurses. This includes training local medical staff to prescribe ART drugs and administer repeat prescriptions, and permitting the use of lay counselors.

MSF is supporting the care and follow-up of HIV-positive patients in provincial hospitals in the northwest of the country and is providing technical support to health centers. In Teté city, following a decentralization of patient care from hospital to health center level, the project is now focused on training and supervision of Ministry of Health staff, with the view to handing back the project.

During 2009, MSF carried out 240,500 consultations and provided ART to 25,500 patients.

### A look back at 10 years of HIV projects: an MSF special report

In the late 1990s, the introduction of antiretroviral (ARV) treatment transformed AIDS from a death sentence to a chronic lifelong disease. However, the extremely high cost of ARV drugs meant that treatment was restricted to people in richer parts of the world, and the millions of people suffering from the disease in places like Africa remained untreated.

In the late 1990s, the introduction of antiretroviral (ARV) treatment transformed AIDS from a death sentence to a chronic lifelong disease. However, the extremely high cost of ARV drugs meant that treatment was restricted to people in richer parts of the world, and the millions of people suffering from the disease in places like Africa remained untreated.

### The growing number of patients on treatment shows that the scale-up and provision of ARV treatment is indeed possible in a country like Mozambique.

MSF has helped to put HIV/AIDS firmly on the national health agenda and, along with the Ministry of Health, has developed innovative strategies for HIV care and management. MSF’s report ‘A Look Back at 10 Years of HIV Projects’ details MSF’s work and achievements in Mozambique since 2001, where it has been helping the Ministry of Health develop a comprehensive plan for widespread provision of ARV treatment. During the first few years, around half of all patients on treatment were supported by MSF. MSF’s objectives were to demonstrate that it was feasible to provide ARV services in low-resource settings, to explore possible modes of operation and to help create a national capacity for treating people with HIV/AIDS.

At the time, the organization of the Mozambican health system needed to be adapted to allow the development of comprehensive ARV treatment programmes, in terms of human resources (both numbers and skills), laboratory capacity, technical means, and the overall management of HIV/AIDS. MSF has spent a total of 66 million euros on its HIV/AIDS activities in Mozambique since 2001, of which the majority comes from private funding.

The number of patients on treatment has risen dramatically over the last few years. At the end of August 2010, more than 33,000 were being treated with the assistance of MSF.

### Patient story

‘My name is Margarida. I live in a village outside the city of Tete, in northwest Mozambique. Other people know that I’m HIV-positive, but I’m not worried or ashamed of my disease. MSF encouraged me to help others with HIV. I am now the leader of one of MSF’s HIV patient groups. My role is to collect medication at the health center and distribute it to the others in the group. Before, each member used to pay one hundred meticais (US$3.40) to travel back and forth to the health center. Now, each member pays me seven meticais (US$0.24) to support my travel, and I bring the medication to their house. The patients in the group appreciate this, because many don’t have enough money to travel to the health center.

It’s great to be able to help others to take care of their illness. I’m taking medication but I am healthy and working like other people. I want other HIV-positive people to join me and enjoy life.’

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In Tete province, MSF is pioneering a model of HIV patient groups, where a designated group leader is responsible for collecting medicine at the health centre. The leader will then bring the medicine back to the other members of the group. In this way, both patient travelling costs and time are reduced. The number of consultations at the health centres is also reduced, alleviating some of the burden on the health services. Margarida is one of the patient group leaders. Her group members pool together money for her to cover travel costs.

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Kenya
launch of a new vaccine for resource-challenged countries

A vaccine to protect children against pneumococcal diseases—such as meningitis and pneumonia—has been launched in Africa as part of an international program to bring this vaccine to resource-challenged countries. Kenya is the first African country to receive it, and MSF is contributing to this national effort by starting to vaccinate children in its Kenyan projects.

For more than a decade, infants in wealthy countries have benefited from a pneumococcal vaccine, and two improved versions were introduced in Europe and the U.S. in 2000 and 2010. Now, children in developing countries will finally have access to this newest generation of vaccine.

But a look at the financing mechanism to support this program, called the Pneumococcal Advance Market Commitment (PAMC), reveals that two multinational pharmaceutical companies—GlaxoSmithKline (GSK) and Pfizer/Wyeth—are contributing to this national effort by starting to vaccinate children in their Kenyan projects.

Democratic Republic of Congo
measles epidemic spiralling out of control

MSF is raising the alarm and calling for concerted action to halt the spread of a measles epidemic which has been sweeping through the Democratic Republic of Congo (DRC).

“Pneumonia is a primary morbidity for young children in Dayahaley Camp where we provide health services to Somali refugees and we are excited about adding this vaccine. During our conversations with the Ministry of Health about the roll-out, the plans for continuing to use it in the rest of the country after the GAVI supply were unclear though, and we are concerned about whether Kenya will be able to purchase it. We plan to continue emphasising the importance of keeping it in the vaccine schedule.”

—Dr. Niyi Utsey Rij, Medical Coordinator for MSF in Kenya

The treatment and vaccination needs are huge and the requirements in terms of human resources, finances and logistical capacity mean that MSF cannot be the only organization providing a hand-in-hand response throughout the entire country. “We are asking the Ministry of Health to launch a response immediately to outbreaks that occur in the other provinces or in any area that needs that is affected,” said Gina Hart, MSF Head of Mission in Katanga.

“Meanwhile, the Ministry of Health is working on a response plan in the rest of the country,” said Patrice Misiti, MSF operations manager in Katanga.

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“At the same time, we are asking international donors and institutions, and health organizations with activities in the DRC—particularly UN agencies (such as the WHO and UNICEF), and NGOs—to take action immediately. If this international response is not rapid, it will be impossible to check the spread of measles in the DRC.”

Measles is an extremely contagious disease that can cause medical complications such as pneumonia, malnutrition, severe dehydration, infections and eye infections that can lead to blindness. Mortality rates vary considerably depending on the context. When a population has not been vaccinated, measles can kill between 1 and 15 percent of afflicted children. The mortality rate can rise to 25 percent if people have limited access to health care, as is the case in many health zones in the DRC.

MSF is expanding its emergency response in three provinces: Tshikapa in Kasaï Occidental province, at Katanga and Luvungi in South-Kivu province. More than a million children will be protected by these emergency vaccinations. “Since September 2010 we have counted more than 21,000 measles cases in the DRC,” says MSF’s Gáel Hakenne. "Concerned action needs to happen right now."
Obstetric fistula affects two million women worldwide, mostly in Africa, and can be a cause of great shame. MSF is working to improve the treatment of this condition.

"The sun should not rise or set twice on a woman in labour." Despite this proverb, endless labours before delivery are legion in Africa, where a majority of women give birth at home. When they finally come to the hospital, it is often not only too late for the newborn, but sometimes for the mother.

Among women who survive this ordeal, many emerge altered. Obstetric fistula is one of the most serious consequences of obstructed labour and occurs when the soft tissues of the pelvis are compressed by the baby’s head. The lack of space can result in urinary incontinence, women with fistula in the area and are often rejected by their own families and communities.

An estimated two million women live with fistula worldwide, mostly in Africa. This problem is largely hidden because it often affects young women who live in poor and remote areas, with very limited or no access to maternal health care.

Today, MSF treats obstetric fistula in three permanent centres in Burundi, Chad and Nigeria.

Three permanent centres in Burundi, Chad and Nigeria

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The latest location to open its doors is the Urumut centre, backed by the regional hospital in Gitga, in the heart of Burundi, and opened its doors in July 2010. This is the first centre specialising in fistula in Burundi, able to treat women seven days a week and MSF has built four houses to accommodate the patients before surgery and during rehabilitation.

"This kind of project ensures a better monitoring of patients and it is possible to do research to improve treatment," said Geert Morren, surgeon and fistula specialist at MSF in Brussels and who operated on many of the women in Gitga.

The objective is to operate on 350 women per year over three years. This time frame should allow us to train three Burundi surgeons and to transfer our activities to the Ministry of Health.

Fistulas are largely preventable and have disappeared in developed countries where there is universal access to obstetric care.

The operation to close a fistula is delicate and requires specific skills. Depending on the severity of the case, the operation may take several hours. In order to operate on fistula, a long and specific training is needed and there is only a few specialised centres in Africa.

Treat fistulas far exceeds the surgical aspect. Because of the flow of urine and faeces, affected women can develop multiple infections or skin diseases. Following childbirth, they may also have difficulty walking and, because of their exclusion, they are likely to suffer from malnutrition. After surgery, in case of residual incontinence, patients often require physiotherapeutic rehabilitation. Psychosocial care is also needed in order to reintegrate the affected women into their communities.

In Burundi, in addition to the specialised centre in Gitga, MSF built a maternity unit in another region of the country. The plan is to prevent the occurrence of fistulas by improving the obstetrical care available in Burundi.

In Abéché, eastern Chad, the project ‘butterfly’ started in 2008. The butterfly symbolises the transformation of women who lived secluded lives and can begin a fresh start after their operation.

In Abéché, eastern Chad, the project ‘butterfly’ started in 2008. The butterfly symbolises the transformation of women who lived secluded lives and can begin a fresh start after their operation. In 2009, MSF built a ‘village of women’ to accommodate patients with fistulas during their weeks-long stay. During the first consultations, a prospective evaluation is done to screen malnutrition cases that will be taken care of before the surgical intervention. After their operation, counselling and rehabilitation sessions allow them to regain a place in society.

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MSF works with a Chadian surgeon, Dr. Valentin Valandi, who graduated in Dakar, to specialising himself in fistulas thanks to the visit of international experts. "Each case is different, I learn every day," he said. "In Chad, too many women have already been operated upon inappropriately, which further complicates the procedure.”

In Abéché, MSF also supports the regional maternity hospital, next to its “butterfly” centre. The objective is to improve obstetric care in order to prevent new cases of fistula occurring because of poor management of difficult deliveries.

In Nigeria, finally, MSF works with the staff of the Ministry of Health at a hospital in Jahun in the north of the country. The teams provide obstetric and neonatal care to the local population. The objective is not only to reduce maternal and infant mortality but also to prevent and treat fistulas. In 2010, the MSF team carried out 400 fistula repair surgeries. Upon discharge from the hospital, women receive six months of outpatient follow-up care to ensure the fistulas has healed and that continence is maintained.

In 2010, MSF teams operated and treated about 1000 women suffering from obstetric fistula.

This story is continued in the photo essay on page 13.
Sudan: insecurity remains a reality

With almost 99 percent of the Southern Sudanese population voting for secession from North Sudan, the newest country of the world is expected to become officially independent in July 2011. But at such a pivotal time and amidst the hope for a better future, the humanitarian situation in Southern Sudan remains precarious at best. Moses Chol Maper, a medical technician and the emergency coordinator for MSF in Southern Sudan, gives his perspective.

“There are big hopes now that the referendum for independence has taken place. Take most people here, I am happy with the result. I am from Lakes State and the civil war has been present almost my whole life. Now I am slightly optimistic. There are so many open questions however. Abyei, the oil-rich region disputed between the North and the South is still a tinderbox. If the peace agreement is broken, violence can escalate very quickly. Insecurity remains a reality and we have the capacity to deliver the services and without capacity to deliver the services and without authorities do not have enough resources and transportation is often too expensive and unaffordable to a population where 80 percent live on less than one US dollar per day. Moreover, during the rainy season, many regions are very hard to reach. I know of many patients who have come to our clinics after weeks or even months of being sick. The local authorities do not have enough resources and capacity to deliver the services and without organizations like MSF, the situation would be even worse.

“Far too many people in Southern Sudan die of diseases like diarrhoea or malaria. Many children and adults do not have enough to eat. When they have to flee from insecurity, they may not have safe drinking water, and are more vulnerable to diseases. Last year, our emergency team had to respond to a massive increase of malnutrition in Unity State. In 2010, we also experienced a very high prevalence of kala azar, a neglected tropical disease that is in most cases deadly if not treated. We saw eight times the number of cases than in the previous year.

“Without your help we would not be alive” – these are words I have heard from our patients several times. But our work will also be at risk if fighting increases, as we can only treat people who manage to get to our clinics or those we have the access to reach. The insecurity can make it impossible for us to only treat people who manage to get to our clinics or those we have the access to reach. The insecurity can make it impossible for us to help many people. In spite of all difficulties, I am very happy to work here and have the chance to contribute to improving the situation for some people.”

MSF has been providing emergency medical-humanitarian assistance in Sudan since 1979. Currently, MSF runs 13 projects across 7 states of Southern Sudan, providing a range of services, including primary and secondary healthcare, responding to emergencies as they arise, nutritional support, reproductive health care, kala azar treatment, counselling services, surgery, paediatric and obstetric care.

In one year, in programmes and projects around the world, MSF provided 109,755 individual mental health consultations and 7,055 counselling or support group sessions. Here, we take a closer look at one of MSF’s mental health programmes, this one being run for vulnerable Palestinian refugees living in and around Burj al-Barajneh camp in southern Beirut.

The programme in and around the Burj el-Barajneh camp has been running since 2008, during which time, more than 1,000 people have received more than 8,000 consultations. The programme is based on a community approach which brings together psychiatric and psychological care with social and community support.

“MSF always tries to set up a community-based and multidisciplinary approach,” says Pierre Bastin, MSF’s mental health advisor in Geneva. “This means that we do not limit ourselves to prescribing drugs, but try to provide comprehensive care the psycho-social care. We like using this model. As the factors behind the illness are of a biological, psychological, and social nature, the treatment must also address these three issues. In practical terms, this means that the biological factor will be treated with drugs by the psychiatrist, and the psychological aspect will be treated by the psychologist working with the patient and possibly relatives. As for the social side, there are also social conditions that must be addressed to help the patient improve.”

Good mental health is the cornerstone of individual and communal well-being. MSF’s medical teams offer care and social support through home visits as well as consultations in its consultation rooms and clinic. Visits to the specialized mental health clinic are increasing, while MSF also ensures that mental healthcare forms part of the primary health care on offer in medical facilities throughout the camp. This approach is helping to spread the idea that good mental health is an essential part of general physical health because of its influence on the way people behave, perceive the world, and interact with others.
Afghanistan: “This is our reality”, is an MSF slideshow featuring testimonies of Boost hospital patients and caregivers.

In Afghanistan today, the war has spread to almost all provinces. Thousands of people have to travel long distances on dangerous roads to reach functioning health facilities. In 2009 MSF started working in Boost hospital in Lashkar Gah, the capital of Helmand province. It restored the 145-bed Boost hospital into a functioning referral, weapon-free hospital, one of only two for the whole of southern Helmand. Around 1200 patients are treated monthly.

In “This is our Reality”, patients tell us how it is for them living in Afghanistan today, and especially the challenges of accessing healthcare in a war-torn country. This moving account of their lives is available for viewing at www.msf-me.org.

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EUROPE! HANDS OFF OUR MEDICINE

Millions of people in developing countries rely on affordable generic medicines produced in countries like India to stay alive. But the European Commission is pushing aggressive policies that will severely restrict people’s access to these life-saving medicines. The attack is taking a number of different forms – free trade agreements, international treaties, customs regulations. If Europe succeeds, millions of people across the developing world could see their source of affordable medicines dry up, as generic companies will no longer have the space to produce or sell them.

“Europe! Hands Off Our Medicine” is MSF’s campaign to push Europe to back down.

“We depend on access to affordable generic medicines like those produced in India to treat all kinds of diseases. We buy 80% of our AIDS medicines from India - medicines that keep 160,000 people alive today,” said Dr. Unni Karunakara, President of MSF’s International Council.

“On their behalf, we cannot remain silent as Europe works to close the door on every aspect of drug supply – the production of a generic medicine, its registration, and its transportation to patients in other parts of the world. So today we are launching a campaign demanding ‘Europe! HANDS OFF our medicine.’

“Europe! Hands Off Our Medicine” is MSF’s campaign to push Europe to back down.

“What the Europeans are doing is effectively snatching the medicines out of our hands,” said Dr. Marius Müller, MSF’s Medical Coordinator in Kenya. “Because generic medicines are more affordable, we have been able to put more and more patients on AIDS medicines. This has meant a lot of hope for our patients who can work again, who can bring up their children again. But if Europe has its way and shuts off this source, we risk killing the success of what has been achieved here in the last five years.”

For more information on this campaign, including actions for you to take, please visit our website www.msf-me.org.
Approximately two million women in Africa have a fistula, which is a hole between the vagina and the bladder or rectum, through which urine or faeces leak continuously. Fistulas can be caused by prolonged obstructed labour and childbirth or sexual violence in addition to lack of medical facilities. Women with fistulas are often abandoned by their communities because of the smell associated with the leaking of urine/faeces, and in some cases they are abandoned by their husbands. Therefore, to have their fistulas repaired are slim, as many hospitals or health clinics do not have the proper instruments or knowledge and skills to carry out such a procedure.

A fistula patient walks with her two-year-old daughter. This woman has had four pregnancies. One child died soon after birth, and her three remaining children are six, four and two years old. She developed a fistula after being in labour for 12 hours.

First thing in the morning, fistula patients empty and rinse the buckets which hold their urine.

A woman rests in MSF’s fistula camp.

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