



## Interview with Shelly Helgeson (Fistula Foundation)

Catherine Edwards

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**Catherine Edwards: Could I ask you to introduce yourself, your role in your organization, and then give an introduction to the problem that your work is addressing?**

**Shelly Helgeson:** I'm Shelly Helgeson. I'm our Vice President of Partnerships at the Fistula Foundation. We're based in San Francisco, Kenya, and Zambia, but we're a global organization, which I'll get into, I'm sure, in a bit. To tell you a little bit about the problem that we're addressing, the Fistula Foundation exists because we believe that no woman should suffer a life of misery and isolation just for trying to bring a child into the world. That's really at the core of why we do our work.

Fistula Foundation is considered by some to be a niche area of work. Obstetric fistula is the health issue that we work on and it is a traumatic childbirth injury that women can develop if they do not have access to emergency obstetric care. What that means in layman's terms is that many women, in very rural and poor places around the world, are having births at a very young age and/or without a skilled birth attendance, so having the babies at home. Often, if the mother is not old enough or her body is not mature enough to have a baby, or just even with regular complications that happen with all of us when we're having children, a baby can get obstructed or stuck in the birth canal.

In the US or in other high-income places, when that would occur, you would immediately have a C-section to safely remove the baby. But in most places where we work, which again are the most rural and the most economically depressed areas, women aren't able to get emergency care and the baby becomes obstructed. When that happens, the baby usually ends up dying. Ninety percent of women with fistula lose their babies, and it also creates a hole in their vagina that connects either to their bladder or their rectum, which causes the woman to uncontrollably leak for the rest of her life unless she's able to receive surgery.

At the core of what we do, we're a health organization, but we also feel like we are doing a lot more for women when we help them receive care because, as you can imagine, most of the women that we work with that have fistula have been thrown out of their homes for the smell, for



the condition, for the hygienic issues. Their communities ostracize them. They don't understand that the condition that they have has a name, that it has a treatment. Many places where we work, the community believes that their women are cursed because they've lost their baby and now they have this condition.

We feel like, when we help these women, we're helping them have their bodies healed and we're helping them with the mental health support to be able to get over the trauma of what they've been through, both losing a baby and being socially isolated, not able to function within the community. We are also working with them to help boost their skills, empower them to be able to reintegrate in the community and thrive, eventually thrive. That's our goal.

**Catherine Edwards: Thanks so much. That's really sad, but-**

**Shelly Helgeson:** It is sad, but there is a cure, and it's surgery. So that's a big part of what we're doing is spreading awareness to destigmatize the issue in communities so that women are informed and empowered to seek help when it's available to them.

**Catherine Edwards: That leads to my next question. It sounds like there are three different parts of the problem, the actual health issue, the impact of that on the individual woman in terms of health, and then the impact on her from her community, as well. Could you share some details about the work that you do and what you do to address each of those different parts of the problem?**

**Shelly Helgeson:** The great news is that fistula can be cured, but it does take a surgery that requires a highly-skilled surgeon who has received quite a bit of training in the surgical procedures to fix a fistula. In our work, there's four main pillars that we work on, including community awareness and training. Treatment, of course, connecting the woman to treatment. Then what we call reintegration, which is the support that the woman needs to be able to go back to her community and live a full life.

With community awareness, a huge challenge in fistula is informing the community about the issue so that the people do not ostracize the women, think that they're cursed or that it's an act of witchcraft. We want them to know that it's a condition, how the condition occurs – through early birth and not seeking care to deliver in a hospital, but also that it happens during childbirth. It's something that happens that's beyond the woman's control, and that there is a solution, there is a treatment. With the community awareness, we're in 26 countries, globally, mostly in Sub-Saharan Africa and South Asia, where home births are very high and many women live in abject poverty. In these areas, we partner with local community-based organizations, typically, that are already doing community outreach around other health issues, like sexual reproductive health or vaccination awareness.



We'll partner with those communities to help teach them about the signs of fistula, what fistula can look like, how it's prevented, how it's caused, and really try to get the word out as much as possible through a load of different tactics. We do radio broadcasts, television broadcasts, we have outreach workers on motorbikes going to the farthest reaches of places. Whenever there's a community gathering, you better bet there's someone there talking about fistula. That's a big piece of it because I've met with many surgeons across different countries who have said they have the capacity to treat more women, but have trouble just finding them and getting in for treatment. So that's number one.

Number two, as I said, is the treatment, which goes hand in hand with training. At Fistula Foundation, we believe very firmly that, if we're going to get a woman to come identify herself as a fistula patient, we help get her to the hospital, which is often many hours away from her community that she's never left before. This journey to the hospital is very long and maybe the first of its kind for this woman. Once we have her go through those steps, we have to be sure that she's going to be met with the highest quality care that she's able to receive.

We never sacrifice quality over anything else. We make sure that the surgeons we refer these women to have the experience, the proper training, and can provide the women with the best chance of being healed. We work very closely with surgeons across networks to train other surgeons to be able to do these operations. We have incredible local surgeons in many places, like the DRC, Kenya, Tanzania, Pakistan, who have dedicated their lives to obstetric fistula and are training the next generation of surgeons in their country to be able to address this issue. There's no money in it, so there's not a lot of incentive for the surgeons to take this on. It's really an act of the heart. So that's part of what we do, too, is recruit these surgeons who will take this on and be willing to treat women.

Treatment is the third piece. We fund surgery. Once identified, a woman is able to get free surgery. Rehabilitation is a key piece of fistula. Not only do they have to go to the hospital to receive treatment, but they have to spend a minimum of two weeks after the surgery in the hospital to make sure that they're healing well, that they're taken care of. There's lots of precautions that you must take after your surgery to make sure that you're not going to re-damage yourself. And we take care of all the after support that is needed for these women.

The fourth piece is the reintegration. So again, we're always partnering with the local community organizations whenever possible to deliver these four kinds of pillars of our program. But the reintegration pillar is really important to partner with the community because it's both the psychosocial support, as well as the economic development that these women go through to be able to reenter the community.



Many of the women that we're helping have been suffering with fistula for 10, 15, even 20 years sometimes. And that means they've been living alone or with just maybe a family member, a mother, a sister, someone who's been willing to take them in, but they haven't been able to work. They typically haven't been able to raise a family. There's a lot of mental health trauma that needs to be supported, and many women who first developed a fistula when they were in their young teenage years, didn't complete school. So we're thoughtful in trying to give them as much support, whether it's education, vocational skills, group counseling, everything that they need to feel ready to reenter society, to go back to their family if that's what they want to do, or start their own business, again, just that they have the best potential to live a full life once they're healed.

**Catherine Edwards: Since these are people who might not have left their community, obviously didn't have medically supervised childbirth, how do you build that trust with them and persuade them to go on this long journey?**

**Shelly Helgeson:** That's a really good question. Again, when I emphasize the community partners, we really rely on the community outreach workers to build the relationship. And you're exactly right, it can take many visits to the woman to convince her that, "This is not your fault. You are not leaking, you are not sick because of something morally wrong that you've done," and so education around that topic shows that it's a condition and this is how you developed it.

There's a lot of education around that. Often, our best community outreach workers are fistula survivors, themselves, women who have gone through this experience and have come out the other side, healed, and their lives changed. Many of them become ambassadors. We call them safe motherhood ambassadors or fistula ambassadors. If a woman is extremely nervous or hesitant to go on this journey, the woman will accompany her. The ambassadors are fistula survivors or community outreach workers who, again, are part of the community and have developed that relationship with the woman. It is such an essential piece for us that it's community outreach workers, people that are representative of the community that they're serving, that can help build that relationship and, hopefully, over time, trust that the journey they will take will lead to a life transformation at the end.

**Catherine Edwards: Are there any strategies you've found over the years that have shifted the attitudes or mindsets?**

**Shelly Helgeson:** We're always trying to be very careful with the context, so it can look different in all 26 countries that we're working in. It's two pieces. One is mass information community-wide about what is fistula so that it reduces the stigma that, if you have this, it's something that's cursed or your fault, that you did something bad. So part of it is just education to the masses



about fistula. And again, that can be through the community or that can be through radio broadcasts, that can be billboards, that can be just the mass media approaches.

Then there's the other piece, the more direct community outreach where you're trying to identify the patients because if you don't have one without the other, it doesn't work. If you find a patient, she's not going to necessarily feel compelled to identify herself as having fistula if there's still such a stigma in the community.

I'll give an example. We were in Tanzania not too long ago, about two weeks ago, and we were going to visit some of our partners. We were in a taxi cab in Dar es Salaam, and the cab driver asked us what we were there for. We said, "We're with Fistula Foundation." And he's like, "Oh, Fistula Foundation, that's on the radio all the time. I know all about fistula. You're doing good work for the women of this country." And okay, great, if the cab driver knows what fistula is, we're effectively reaching this population. He was a man, an urban man in his 20s.

It's really breaking through the masses so that they know what fistula is, they know the issue, and then also doing the individualized, more personalized outreach to the women that are most likely to have this condition.

**Catherine Edwards:** You said there's not many surgeons that can treat it and you're working on training up more. Could you explain why that's the focus as opposed to other routes you could have taken, say, encouraging people maybe to have supervised child births?

**Shelly Helgeson:** That's a good question. It's definitely a holistic approach. Certainly, prevention is a big piece of what we believe in to eradicate this issue altogether, but as Fistula Foundation, we feel that we are experts in fistula treatment. With our community outreach and some of our rehabilitation efforts, we do education around prevention and encourage women to seek facilitated births in hospitals, but we realize that that's not going to be the reality for a long time. There's a lot of initiatives and NGOs and government efforts that are trying to get more women to have in-hospital births, but while we're working on this broader, higher-level systems change work around maternal health, we feel very passionately that the millions of women who are suffering now from fistula deserve to be helped as well.

We see it as both. Yes, we need to work on the higher upstream causes. In our opinion, fistula occurs because of two deep-seated inequalities. It's gender inequality and it's economic inequality. If those two things were solved, fistula likely would not occur. But while we're working on these huge deep-seated issues of inequality, the WHO estimates there's at least two million women that we know of with fistula and 100,000 more women getting it per year. So our mantra is we can't leave these women behind now just because they were born at a time where the health systems weren't serving them, where there were breakdowns in the quality of care they received.



## **Catherine Edwards: How do you measure your success?**

**Shelly Helgeson:** There are definitely numbers that we track and then there's also more of the big picture storytelling successes, too. And I'd love to share both. In terms of the metrics, to start with that, one metric of success is just surgery counts. We're the global leaders in fistula treatment. We're bigger than any government agency. We're larger than the UN when it comes to providing fistula surgeries. So of course, the number of surgeries that we do is one sign of success.

In our existence, we've conducted over 75,000 surgeries. We're on a track, over the next five years, to do 80,000 more, so more than doubling our surgery count. That's obviously a sign of success because that means we're finding more women that have fistula and that we have the capacity with our surgeons that we're training to do the surgeries. That's the most obvious sign of our success.

We also measure our work by what we call disability adjusted life years. I don't know if you've heard this term before. It's another way of looking at the lives that you're improving. The average woman that comes to us with a fistula is in her early 20s. Typically, they've developed a fistula much earlier in their teens, but typically, by the time we find them, they're in their early 20s. If we're able to heal the woman in her 20s, she is going to have decades of life restored. We're averting decades of misery for that woman. We've done the research and, since 2009, we've restored over two million years of continence for the women we've worked with. If you think about it in that way, it's quite astonishing.

The third metric we look at is eliminating the time between a woman developing a fistula and receiving treatment. As I said, some women we meet have been suffering for 10, 15, 20 years, and our long term goal is to completely eliminate that wait. Again, because we're focused on helping the women that have fistula, we know that, in the short term, we're not going to get rid of fistulas from happening, but what we want to eliminate completely is the wait for surgery. We look at how we're reducing that over time. We don't have data across all of our 26 countries, but in Kenya, where we have a really concerted effort with our treatment network, we see that, over time, we're drastically reducing the wait for the women who have fistula.

Then there's the stories that we hear. I'd be happy to share a story I just recently observed. I just went to Kenya and Tanzania to visit some of our partner hospitals. When you get to meet the surgeons in the hospitals, the best part is you always get to meet the patients, as well. We were in a rural part of Kenya about two weeks ago and one of the official survivors named Juan Amisi invited a few of us from Fistula Foundation to her home so that we could hear her story.

Her home was essentially what we would think of as a dirt hut. It was off a gravel road. We had to walk about 30 minutes through a pretty rural dirt path to get to her home. And she shared with us



her story. She developed a fistula in her second pregnancy. She was in her early 20s and her husband threw her out of his home. She, thankfully, was able to go live with her mother, but she suffered for 15 years. Then one day, she was at a funeral, which in Kenya are big celebrations that happen over the course of many days with many people. I've learned that they are a great place to get your agenda across if you have things that you need, so we had a community outreach worker at the funeral and he was telling people about fistula. She found out about fistula at a funeral, realized it's something that she had, and one week later, she was referred to the hospital that was closest to her and she was healed. One week after finding out that she had a fistula, she was completely healed after one surgery.

This is part of her success story. I don't know if it would be what I would consider success, but she was very happy that her husband wanted her to rejoin him at his home. It's very important in her community that you're protected, that you have a family, so it was a big success in her mind that she was invited back to live with her husband. That was the home that we were visiting. Through our women's empowerment partner, called Wadadia, she learned hairdressing, a skill that she decided she'd like to learn. After she showed us her home, she walked us to her hair salon and there was a line of people waiting to get their hair done in this small little town in Kenya. I was surprised to see a man wanting his gray hairs treated. She has a thriving hair business and she's actually teaching her husband how to take on the trade, so they're now both working as the community hairdresser.

It was incredible to see, when she was telling her story about fistula and the suffering that she incurred, she was very somber, very sad. Her husband was sitting next to her and we asked him, "Why did you throw your wife out?" And he was like, "It was really hard. I tried to take care of her. I didn't know how. We didn't have what we needed to take care of her condition." But then when they were in their salon, they were just obviously so fulfilled and so happy to be doing something, being reintegrated in the community, being able to support themselves. I think it was a huge point of pride for her to be teaching her husband this trade, as well.

That's a story of how we see this, and I think it hits all four pieces of our program in that the community outreach worked. She found out about fistula, she got cured in one treatment, and then was able to have a thriving business.

**Catherine Edwards: Once people have the medical side treated, it almost sounds like the reintegration happens as a result of that, but is there also an issue of, even once people have been treated, does that stigma sometimes stick with them and how to deal with that?**

**Shelly Helgeson:** Yeah. I'll be very honest, not every woman is cured after one treatment. We always say, if you've seen one fistula, you've seen one fistula because the severity of the issue can





really vary. And so there's women that we've met that have had four and five surgeries and aren't completely healed. It really depends on how severe the issue was. Some women after a surgery are not completely healed and may continue to leak, may continue to have terrible infection, and I think the stigma does carry on with those women because they're still dealing with the issue that they had. But again, that's why we really enforce only surgeons that are very highly skilled to do the surgeries. Even then, there's not a 100% success rate. The surgeries that we enable, we have a 90% success rate. So most of them are, but not all.

Once women are healed, it's usually celebrated quite profoundly in the community. Like I was alluding to before, for me, I have to remove my cultural biases and understand returning to the home where you were thrown out of actually is, in many communities where we work, a celebratory occasion to be reunited, where with my western lens, I'm like, "Don't go back to that man," but it's really a community celebration that they're reunited.

I don't think it's a pervasive issue of, okay, the woman had a fistula, now she's healed, and there's still a stigma associated with her. It's more typically that the community will have now been educated around fistula, as well, so it's a celebration that she's healed and that she can return to regular life and live out her life in this way. We also are helping them give back to the community, as well, through either becoming an ambassador themselves, and/or contributing to the economy with a business.

We don't give up on those women that don't get healed the first time around. Our surgeons are continuously trying and trying again. When I was in Kenya visiting a fistula ward, there was an older woman that came into the ward, and Dr. Mabea, the surgeon there, was like, "She's the most complicated case I've ever seen, but I'm never going to give up on this woman. We will find a solution." So we don't give up on them just because, the first time, it didn't work. We will fund every surgery until they're healed.

**Catherine Edwards: From this wide-ranging experience, what kind of insights or teachable lessons might you have for other people? What are the key insights people should know to get started?**

**Shelly Helgeson:** I think that our key insight is being laser focused on this one issue. We've really benefited from having the strategic discipline of being really narrowly focused on one thing, which is traumatic childbirth injuries, and that's because we don't spread ourselves too thin. We have the biggest database of patient information and trends globally on fistula. We've just been able, over time, develop this expertise and think holistically and comprehensively around one issue.

When we first started, we did surgeries. We didn't do any of the reintegration, but over time, we realized these are key elements of what we do. We are able to, without spreading ourselves too





thin, treat these patients holistically and comprehensively, and then also see it from the socioeconomic angle, the gender equity angle and all of that, but again, without having what some people call mission creep or try to be everything to everyone all at once. That's one of our key learnings that has really benefited us.

The next piece of advice or learning that we would like to give is that our work could not be done without our local partners that we support. Our approach has always been to look for where excellence is already happening and to amplify that and use that to help others, to teach others. When we identify a partner, whether it's a local healthcare facility that's managing fistula or a surgeon or a really great community outreach partner, we commit and we are in it for the long haul. Long partnerships are a sign of success for us.

Fistula Foundation is interesting because we're both a grant seeking and grant making organization. We fundraise to support our efforts, but we make grants to our local partners to, again, support and amplify their efforts. It's all about relationships with us and trusting them to know how best to serve the people in their communities, being humble, taking a step back and saying, "You tell us what is needed to best serve your communities and best tackle the issue of fistula where you are, and then we'll stand by you." Again, a measure of success for us is how long we've been in partnership with someone. That's the best indicator of a successful partnership.

We have a replicable model that we implement across different countries. We have a framework, but each kind of treatment network that we have in each country looks very different because of the cultural context of each place, and how the government and local health systems are already managing or not managing fistula.

**Catherine Edwards: Could you give an example?**

**Shelly Helgeson:** Absolutely. We have what we call the Fistula Foundation Treatment Networks. Our goal is to have these treatment networks in every country where we work, but for now, we have one in Kenya, Zambia, and the DRC. Essentially, we have Fistula Foundation staff on the ground who are helping to coordinate the efforts of all of our partners around the country so that we can make sure that we have coverage countrywide to address the issue of fistula, again, with the goal of reducing wait times for surgery.

In Kenya, there's a very vibrant culture of local NGOs. We only have a few of our staff there. It's really about amplifying the efforts of community-based organizations who can do the outreach, the women's empowerment groups that can do the vocational training that we partner with. We help coordinate, we see where there's gaps, and we try to fill those gaps when needed, but really, it's a community-driven effort.



In Zambia, there's not nearly as many local NGOs or community-based organizations. We had to staff up at the Fistula Foundation in Zambia to do all the community outreach. It's our staff that are on motorbikes driving out to different regions to do the community awareness, it's our staff who are coordinating with the fistula patients to get them on buses or cars to get them to the hospitals. But what's also different in Zambia that's a positive is that the government has a public effort to eradicate fistula in Zambia. We work very closely with the Government of Zambia to create strategic priorities around how to eliminate fistula. With the Kenyan Government, it's not as high a priority on their list, so we work less with the Government of Kenya. We're always trying to leverage the power of our network to engage with them and keep fistula as a priority on their agenda, but in Zambia, we have a very close relationship and half the hospitals we work with in Zambia are government hospitals. So it's just two different models.

In DRC, it's such a hard place to work with all the civil unrest and violence. We really have to think in a very different way about how to find patients and how to give them treatment. So in the DRC, we do more of finding patients, getting a number of patients together at one time that we can then transport together to a hospital where we'll do several weeks of fistula surgeries, where in Zambia and Kenya, it's more of a routine care that, at any point, you could go to a fistula hospital and get a surgery.

**Catherine Edwards: What are the main challenges that you come up against in the work? I think you've already touched on a few different things, but just to summarize, what are the obstacles?**

**Shelly Helgeson:** One of our biggest challenges is what we're working on, the nature of what we work on. Fistula is something that, thankfully, most people in high-income countries will never experience and never even know what it is. They're not likely to know anyone that will ever have an obstetric fistula. So awareness as a global health issue and in the global health donor space can be difficult. Also, the nature of what it is, women's vaginas and incontinence, nobody wants to talk about that. Talk about stigma or taboo. It's not your typical dinner party banter. Getting over that first hurdle of what is fistula – and the ick factor of what it is – is one of our biggest challenges.

The other challenge, too, is I think there's this tension in international development and global health of, "We need to go much bigger. We need to think about the health system strengthening and the prevention piece," which again, we believe in, we want to do that, but we think there's a strong argument for also making sure that the people that are suffering from the problems that we're trying to prevent, they deserve our attention just as much as the prevention piece. You would not think it would be challenging. "Hey, you can help save this woman's life today," is actually much more challenging than you would imagine.



I think, when you meet the women and you see what they're going through, no one would deny that they want to help them, but again, because it's such an abstract issue for many of us, it's hard to build the case around there are millions of women that have lives have totally been destroyed and we can help them right now and we should help them right now. I think that both our laser focus on women with fistula is both a huge strength and can be a challenge selling to other people, but we're really committed. So you're not going to stop us.

**Catherine Edwards: Do you have any things that are helping to overcome either or both of those challenges or are they still works in progress?**

**Shelly Helgeson:** I think we've definitely been successful in a few ways and, of course, we're still overcoming a lot of the challenges, but what has been really incredible for us is that we've had some great ambassadors for fistula. There's a journalist, Nick Kristof, he's a New York Times journalist, and he's written about the issue of fistula over the years. He also wrote about fistula in his book, *Half the Sky*, that he wrote with his wife. And I have to say that's been one of the single biggest things to help move or put fistulas on the map as a cause that we should be concerned about, as an issue of justice.

Journalism has helped us tremendously, which is why I was excited to talk to you. Again, just building that awareness. The stories of the women are also just so incredible when you hear them, that just as many opportunities as we have to uplift the voice of the women and tell their stories is always a success for us.

We're primarily supported by female philanthropists. It's an issue that I think women, even though we're really removed from the issue in the West, once you have a baby and you understand all the things that had to happen correctly to bring this life into the world, opens your eyes to how terrible things would be if it went wrong. We do have a lot of really amazing women who support our cause and have found us through Nick Kristof and other ways, but I think the challenges still remain in terms of convincing people to support the poorest of the poor women who are suffering. Fistula won't kill someone, but it kills their spirit, it kills their opportunity, it kills their livelihood, that's something that deserves our attention. That's still challenging and it's mind boggling when you meet these women and see them and their experiences, but it's still a challenge to make fistula a priority to many governments and global health funders.

Quality of life, I think, is something that is so important. And thankfully, we are seeing more emphasis on mental health and how important mental health is for people everywhere so that, hopefully, with the rise of attention on mental health, this will also help raise the issue of fistula, because like I said, it's not just a maternal health condition, it's also a mental health condition, it's



a socioeconomic condition, it's an issue of equality. It's the manifestation of all of these issues embodied in one woman.

**Catherine Edwards: You mentioned earlier you're on track to treat 80,000 more women over the next five years. How else is the work going to evolve over the next five years?**

**Shelly Helgeson:** In a couple of ways. One, we're about to launch our five-year plan, which is our plan to build the infrastructure to eradicate the suffering of fistula in five new countries. I mentioned we have these integrated comprehensive treatment networks that are currently in three countries and our plan is to launch a new treatment network in one country per year over the next five years. We're launching in Tanzania this year. That will help us get to 40% of the population that has fistula and, if we continue this plan over the next 10 years, we'll reach 70% of the population. Our work, again, reduces wait times from 10 years to two weeks. All the places where we have treatment networks, a woman, once identified with fistula, receives treatment in one to two weeks. We want to continue to scale that to more countries so that, again, we're eliminating the wait for treatment. That's one way that we're expanding the work.

The other is, just recently, we've also expanded the work to include more surgeries and treatment for women that have other types of childbirth injuries. Over the past eight or nine years, we've been focused on fistula, but now what we're hearing from our partner hospitals and surgeons is that women are coming to them that have very similar symptoms as fistula, but they're actually caused by severe perineal tears during birth that aren't fixed. Again, this is something that happens in the West, but you would never leave the hospital without being repaired. So these are women that have had traumatic birth injuries and then aren't treated. The baby survives, but they're not treated.

We're expanding because that's what we're hearing from our local partners, that there are women suffering from other injuries that also are repairable and treatable. We're going to expand the number of women we're serving, the number of women whose lives we are restoring, and also, again, having a larger presence with our treatment networks within more countries in South Asia and Sub-Saharan Africa.

**Catherine Edwards: Is there anything that we haven't covered this morning that you wanted to touch on just before we wrap up?**

**Shelly Helgeson:** The only thing we didn't talk about, and it's related to what you asked me about just now, is just that we have all these incredible local partnerships, but we're also partnered with larger organizations, as well, that help us do the work. And we're always looking for partners. As an example, we partner with FIGO, which is the International Federation of Gynecologists and Obstetricians, and they're essential in our work. They're the ones that we support to train fistula



surgeons. That's just one example of an INGO that we're working with that helps advance our work. And we're always looking for partners who can help us ensure safer surgeries, who can help us think more holistically, even on a larger scale around treating patients, prevention, and sexual reproductive health education. Any way that we can help advance the mission and grow the work, We're very excited to do that and we couldn't exist without our local partners, but we understand growth will happen when we also grow, locally and globally.

**Catherine Edwards: Thank you so much for talking to me today. It's been a really insightful conversation.**

*Catherine Edwards is a journalist and content strategist based in the UK, having also lived and worked in Germany, Italy, Sweden and Austria. She supports newsrooms and mission-driven organisations with content strategy, audience development and constructive journalism.*

*\* This interview has been edited and condensed.*