Media and Communication
2026 • Volume 14 • Article 11251
https://doi.org/10.17645/mac.11251

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Open Access Journal

Empowering Vulnerable Women: Communication and Media Strategies for Obstetric Fistula Awareness in Nigeria

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Submitted: 31 August 2025 **Accepted:** 5 January 2026 **Published:** 5 March 2026

Issue: This article is part of the issue "Communicating Risk, Trust, and Resilience Among Diverse and Marginalised Populations" edited by Ian Somerville (University of Leicester) and Jenny Zhengye Hou (Queensland University of Technology), fully open access at https://doi.org/10.17645/mac.i507

Abstract

This article explores the role of media and communication in addressing obstetric fistula, a severe and largely preventable childbirth injury that predominantly affects women in marginalised and underserved communities worldwide. Nigeria, accounting for nearly 40% of global cases, is at the forefront of this health crisis. Despite significant efforts by various organisations, the issue persists due to a combination of socio-economic factors, cultural practices, and inadequate healthcare infrastructure. One question guided this research: How can public health communication for marginalised populations be facilitated through communication and media strategies? An illustrative case study of Bashir Foundation for Fistula and Women's Health, an organisation that stands at the forefront of efforts to raise awareness and support rehabilitation for women affected by fistula, and conventional qualitative content analysis of their publicly available media and communication collateral are used in this article to answer the research question. The article identifies the gaps and helps in exploring best practices for effective advocacy, awareness, sustainability, and community engagement. It contributes to the body of knowledge by highlighting how public health communication for marginalised populations can be facilitated through a combination of strategic media campaigns and direct community engagement, while also highlighting the value of public education in reducing stigma.

Keywords

communication strategies; marginalised populations; media strategies; obstetric fistula; public health communication

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1. Introduction

The prevalence of obstetric fistula globally has been well established, with evidence pointing to major barriers to treatment such as entrenched cultural practices, poverty, and shortages of qualified healthcare professionals (Federal Ministry of Health Nigeria, 2019). Despite this, research examining access to health information (Khamis & Agboada, 2023) and the contribution of media and communication in overcoming these barriers remains scarce, particularly in the Nigerian context. Obstetric fistula, caused by prolonged, obstructed labour, continues to affect thousands of women each year, predominantly in sub-Saharan Africa and Asia, with women of lower socio-economic status being disproportionately impacted (Federal Ministry of Health Nigeria, 2019). Beyond the physical complications, the condition subjects women to intense social stigma, isolation, and heightened economic vulnerability.

Understanding the experiences of women living with obstetric fistula also requires situating them within broader discussions of marginalisation and social exclusion. Marginalised populations are those excluded from full participation in social, economic, educational, and cultural life due to unequal power relations between groups, leaving them disadvantaged and without access to the resources needed for sustainable livelihoods (Burke et al., 2025). Such groups face shorter life expectancies, heightened exposure to harmful environments, and reduced opportunities for education and employment (Burke et al., 2025). By building on existing literature, this article focuses on how communication strategies can be tailored to reach vulnerable groups, ensuring that the message of prevention and treatment is effectively conveyed. It proposes a model for building community awareness through media and communication strategies (Ojeikere et al., 2021) for these populations. The article aims to examine how strategic communication and media interventions can enhance public awareness, build trust, and foster resilience among affected populations. To do this, the article addresses the question—how can public health communication for marginalised populations, particularly vulnerable women, be facilitated through communication and media strategies?—by exploring what is communicated, to whom and where, how, and through which channels these communication and media strategies occur. Additionally, to justify the choice of the illustrative case study, Bashir Foundation for Fistula and Women's Health (BFFWH), several contexts, namely the geographical, socio-economic, and cultural landscape of Nigeria, health and maternity health in Nigeria, and obstetric fistula in Nigeria, are described in greater detail in the following subsections.

1.1. Understanding the Geographical, Socio-Economic, and Cultural Landscape of Nigeria

Nigeria, located in West Africa, has Abuja as its capital, which serves as a central location for political neutrality, and Lagos as its largest city and commercial hub. Nigeria is commonly divided into six geopolitical zones, as shown in Figure 1, for political, cultural, and economic purposes: North West, predominantly occupied by the Hausa-Fulani tribe, is known for agriculture and livestock; North East, which is sparsely populated, is known for farming and fishing; North Central, with a diverse ethnic mix; South West, predominantly Yoruba tribe, is urbanised and industrialised; South East, predominantly Igbo tribe, is known for oil and gas, manufacturing, and trade; and the South South, also known as the Niger Delta, is rich in crude oil (Archibong, 2018).

There is a significant inequality in income distribution in Nigeria, which varies by region, where the South is generally wealthier and more urbanised, and the rural North has higher poverty rates, lower literacy, and higher unemployment (Adeleke et al., 2023). This can be attributed to the literacy and education rate per

region; the country as a whole has an average of 63% literacy rate, higher in the South and lower in the North (MacroTrends, 2018). In addition, there are also major gaps in the availability of, and access to, infrastructure, power supply, transport networks, and healthcare access between the North and the South, with the South having better access than the North (Okoli et al., 2020; Shao et al., 2025).

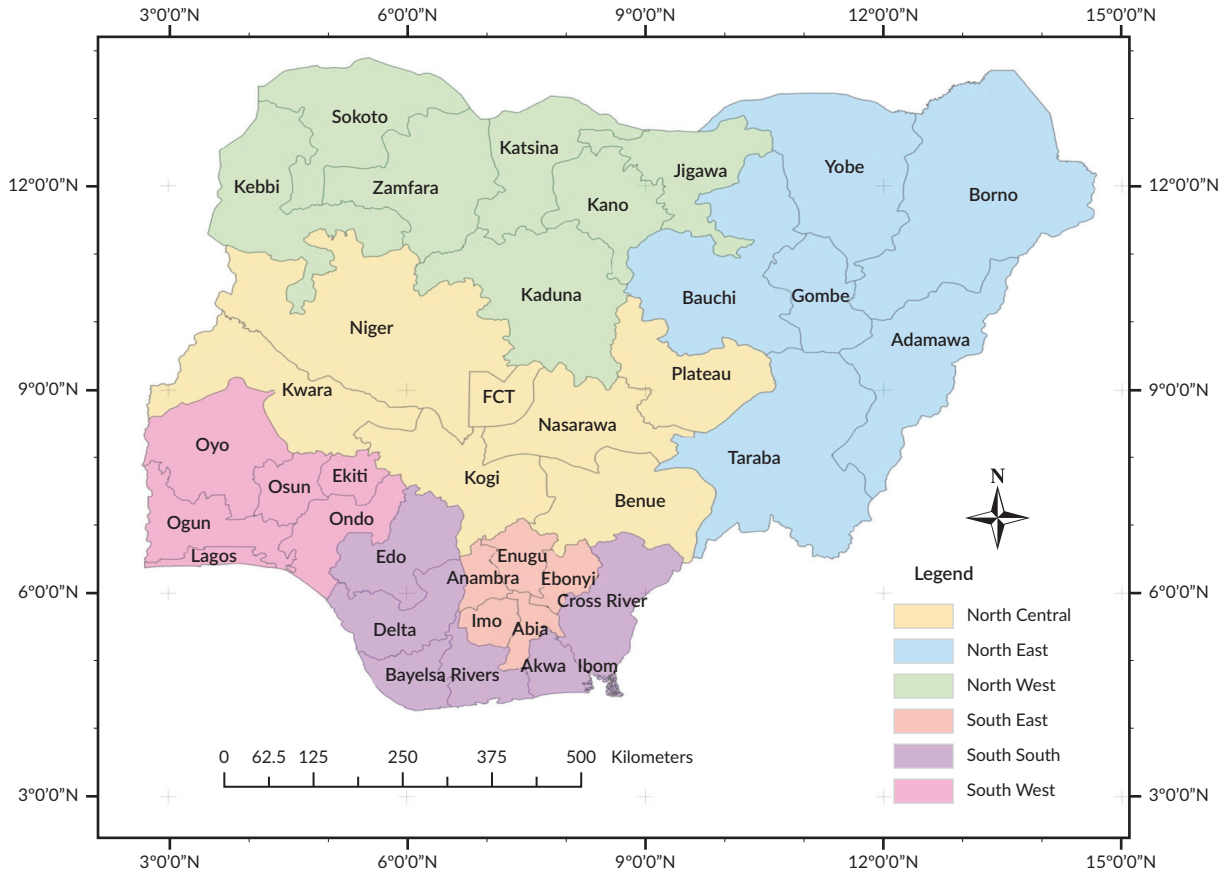

Figure 1. Geographical map and geopolitical zones in Nigeria. Note: FCT = Federal Capital Territory. Source: Akinyemi et al. (2015).

The cultural landscape of Nigeria is a multidiverse one, with over 250 ethnic groups (Ministry of Foreign Affairs, 2025), major ones being Hausa-Fulani in the North, Yoruba in the South West, and Igbo in the South East, and more than 500 distinct languages (Kori-Siakpere et al., 2024), with many more dialects. However, the official language is English, due to the legacy of British colonisation. The country has roughly 50% Muslims (mostly in the North and South West) and 50% Christians (located mostly in the South and middle belt; Ministry of Foreign Affairs, 2025). Therefore, religion is a powerful social and political force in the country. Social and cultural nuances are oriented in collectivist (Ferreira, 2017, pp. 75–94) and high-context structures (Adisa et al., 2021), where respect for elders, hierarchical structures, and religious customs shape interactions (Triguero-Sánchez et al., 2022).

1.2. Health and Maternity Health in Nigeria

The general health landscape in Nigeria is a concerning one, with the lowest life expectancy rate globally for women (Galan, 2025). Nigeria faces major health challenges from infectious diseases such as malaria,

tuberculosis (Adewumi, 2025), and Lassa fever (Eneh et al., 2025) to non-contagious diseases such as hypertension and stroke (especially in urban areas; Adesola et al., 2024; Ajisegiri et al., 2021). A major determinant of this is the major health infrastructure gaps that the country faces, such as a lack of human resources, as well as a doctor–patient ratio of 3.9 per 10,000 (Wariri et al., 2024), where the World Health Organisation recommends 49 per 10,000 (World Health Organisation, 2023). These issues are also compounded by the limited coverage of the National Health Insurance Authority, which only covers a small fraction of the population (Bashar et al., 2025).

Maternity health in Nigeria is also critical, with a maternal mortality rate that is among the highest globally (Integrated African Health Observatory, 2023). In conjunction to the causes listed previously such as lack of human resources, funding, and infrastructure, there are other direct causes of this maternal mortality rate, such as lack of skilled birth attendance (Olawade et al., 2023), and other barriers to maternal health which are (a) geographic, as many rural women live far from functional facilities; (b) cultural, as there is a preference for traditional birth attendants (Ntoimo et al., 2022); (c) gender norms limiting women's mobility (Simona, 2022); and (d) decision-making often dependent on male family members (Kalindi et al., 2023). Several other contexts, related specifically to culture, affect maternal health in Nigeria, one of which is related to pregnancy secrecy, as many women delay antenatal visits due to fear of spiritual attack or stigma (Agwu et al., 2025). There is also the issue of resorting to traditional medicine, such as herbal remedies and spiritual consultations, which often complement or sometimes replace antenatal care (Ntoimo et al., 2022). Lastly, there is the influence of religious and faith leaders, who can strongly sway maternal health behaviours (Agwu et al., 2025).

1.3. Obstetric Fistula in Nigeria

The justification for choosing obstetric fistula as a focus angle of this article is due to its significant link with vulnerable women, maternal health, stigma, and marginalised populations. Obstetric fistula is a severe public health problem and largely preventable childbirth injury that predominantly affects women in marginalised and underserved communities worldwide, with an estimated global burden of half a million cases (United Nations, 2022), with the majority of cases in sub-Saharan Africa and Asia (Federal Ministry of Health Nigeria, 2019), of which Nigeria contributes 12,000 new cases of obstetric fistula every year (Daniyan et al., 2021), accounting for 40% of global cases (Daniyan et al., 2021). The most affected regions are those in Northern Nigeria, including Sokoto, Zamfara, and Katsina, which are particularly affected due to factors like early marriage and poor access to maternal healthcare (Federal Ministry of Health Nigeria, 2019).

Despite significant efforts by various organisations, the issue persists due to a combination of socio-economic factors, cultural practices, and inadequate healthcare infrastructure. The condition not only causes significant physical harm but also leads to severe social stigma, isolation, and added economic hardship, due to the prohibitive cost of further care. Although the global burden of obstetric fistula has been widely documented (Bello & Lawal, 2025; Chanie et al., 2025), with studies highlighting the significant barriers to treatment, including cultural practices, poverty, and the lack of skilled healthcare workers (Federal Ministry of Health Nigeria, 2019), there is limited research on the role of media and communication in addressing these barriers, particularly in Nigeria.

2. Literature Review

2.1. Public Health Communication

Health communication is increasingly recognised as a cornerstone of efforts to promote well-being and prevent disease in contemporary societies. Defined as "cognitive interventions aimed at facilitating the improvement of individuals' and populations' health" (Caeiros et al., 2024), it operates across multiple levels, including individuals, groups, organisations, media systems, and cultures (Niederdeppe et al., 2025). It encompasses diverse forms such as textual, oral, aural, visual, and verbal, delivered through interpersonal conversations, doctor–patient interactions, social media, mass media, advocacy campaigns, and policy briefs (Niederdeppe et al., 2025). Therefore, public health communication is best understood as the strategic use of communication to inform, empower, and mobilise populations toward better health outcomes (American Public Health Association, 2025). It goes beyond one-way dissemination of information or clinical exchanges, requiring the establishment of a common ground to foster informed decision-making and align societal goals (Chou et al., 2025; Niederdeppe et al., 2025).

Building on this foundation, public health communication is central to advancing population health, strengthening communities, increasing life expectancy, and supporting economic stability. To achieve these outcomes, messaging must be resonant, persuasive, and culturally sensitive, ensuring that public health institutions articulate their value, foster trust, and establish cross-sector collaborations (Niederdeppe et al., 2025; Schuh et al., 2025), thus generating more culturally aware and socially sensitive public health policies. A growing body of research highlights the importance of values in shaping how people interpret scientific information, form opinions (Chou et al., 2025), and adopt medical innovations and interventions (Kurpas et al., 2025). While traditional approaches to value-based communication often emphasise tailoring to distinct audience preferences, current evidence suggests that appealing to shared values and identities can be more effective in minimising resistance and bridging divides in polarised contexts (Chou et al., 2025).

Furthermore, communication strategies must address the needs of marginalised or hard-to-reach populations through inclusive media approaches that educate the broader public while sustaining long-term interventions. When common values or identities are not immediately apparent, communicators must invest in building foundational trust and shared understanding to advance preventive goals (Chou et al., 2025). Ultimately, by linking shared values (which in this case refers to principles held in the family, community, culture, and other principles or beliefs that are held in high esteem) with evidence-based practices, public health communication serves as a critical mechanism for fostering resilience, equity, and cohesion in the face of evolving health challenges.

2.2. Communicating Risk, Trust, and Resilience Among Diverse and Marginalised Populations

Inclusive risk communication has become increasingly recognised as essential to addressing the needs of diverse populations, particularly those most vulnerable to crises such as health emergencies, environmental threats, or security incidents (Aliska et al., 2025). Despite this recognition, uncertainty persists about what inclusive risk communication fully entails and how to integrate it into current practices. Barriers include limited access to communication channels, inadequate accommodations for diverse needs, and governance systems that privilege top-down approaches rather than participatory engagement. Overcoming these

barriers requires co-creation strategies that meaningfully involve vulnerable stakeholders in risk governance, fostering both mutual learning and trust (Aliska et al., 2025). Risk communication, broadly defined as the interactive process of sharing information about hazards with affected or interested stakeholders (Suslov, 2025), must therefore move beyond one-way dissemination toward approaches that are inclusive, culturally sensitive, and responsive to community dynamics. Tools and guidelines such as the "downstream-upstream" analogy (Zola, 1972) provide insights into how public health communication can expand its authority into more areas of daily living and facilitate more culturally and socially sensitive policies. Building trust is particularly vital, as lack of trust in authorities and the absence of accessible, tailored messages have repeatedly undermined the effectiveness of official communications (Aliska et al., 2025).

Strengthening resilience among diverse and marginalised populations requires communication strategies that not only transmit accurate information but also empower communities to take ownership of solutions. Community engagement, long emphasised in international development and humanitarian practice, ensures that populations participate in decision-making and co-own the processes that affect their well-being (Tam & Peh, 2025). However, because simplistic notions of *community* can obscure underlying hierarchies and marginalise certain groups, drawing on social science insights and local expertise to design robust interventions is critical (Tam & Peh, 2025). Public health emergencies reveal the acute vulnerabilities of women, children, the elderly, migrants, refugees, people with disabilities, and others who face structural disadvantages, stigma, or poor living and working conditions (Liu & Sun, 2025). These groups often struggle with healthcare access even before crises, and their disproportionate suffering exposes systemic weaknesses in healthcare systems and institutional preparedness (Liu & Sun, 2025). Addressing their needs through inclusive, trust-building risk communication strengthens not only individual and group resilience but also the collective resilience of entire communities. In this sense, communication that foregrounds inclusivity, trust, and equity is not a peripheral concern but a central strategy for building societal resilience against present and future emergencies.

2.3. Awareness and Community Engagement for Vulnerable Populations

The level of risk experienced by vulnerable populations during health emergencies is shaped by the type of disease, national context, severity of the crisis, and pre-existing social, cultural, and economic disadvantages (Liu & Sun, 2025). When these groups are overlooked, they experience disproportionately poor physical, mental, and social outcomes. Risks are compounded for individuals who belong to multiple vulnerable categories, as overlapping socio-economic, structural, and health-related disadvantages intensify their challenges (Liu & Sun, 2025). This is in agreement with the theory of intersectionality as outlined by Crenshaw (1991), which highlights how different aspects of a person's identity (in this case, gender and socio-economic class) combine to create unique experiences of discrimination and privilege. As vulnerabilities are context-specific and sometimes unpredictable, effective interventions require first identifying at-risk populations and designing solutions tailored to their needs. Without such targeted awareness and engagement, emergency responses risk perpetuating inequities and undermining community resilience.

Women and girls in societies with entrenched gender inequality may have limited autonomy in seeking care, restricted financial resources, and lower literacy, hindering their access to and understanding of public health guidance (Lwamba et al., 2022). As primary caregivers, they also face greater exposure to disease and significant mental and emotional burdens. Indigenous communities similarly confront geographical isolation,

limited infrastructure, language barriers, and historical mistrust of authorities, all of which restrict access to healthcare, emergency support, and effective communication (Liu & Sun, 2025). Standardised messaging approaches are often insufficient; therefore, culturally sensitive, context-specific strategies that incorporate local practices and build trust are essential. Addressing intersectional discrimination (Tinner & Curbelo, 2025) and implementing programmes such as community health worker programmes have proven effective in reaching remote populations, bridging gaps in access, and fostering local awareness (Liu & Sun, 2025).

Addressing these intersecting vulnerabilities requires inclusive communication strategies that combine information delivery with genuine community engagement. Engagement, understood as enabling marginalised populations to exercise greater control over decisions affecting their lives (Burke et al., 2025), can occur through institutional initiatives, grassroots projects, and community development programmes that amplify voices and co-create solutions. Marginalised groups, including low-income populations, ethnic minorities, refugees, individuals with disabilities, and the elderly, face heightened health risks and reduced capacity to respond to crises, underscoring the need to consider intersectional factors such as gender, age, and socio-economic status (Ojeikere et al., 2021). This article, therefore, asks: How can public health communication for marginalised populations, particularly vulnerable women, be facilitated through communication (what is communicated, to whom) and media strategies (where, how, and through which channels)?

3. Methodology

This study uses qualitative methodology to answer the research question. This methodology was chosen for its aptness in exploring context-specific and complex issues, especially in obtaining detailed insights into unique perspectives. The adaptable nature of the qualitative methodology supports credible findings by revealing the processes underlying social phenomena at both individual and organisational levels (such as subtle themes in words, stories, and testimonials), making it valuable for exploring how new developments influence daily practices (Duncan & Williams, 2008). Through the analysis of meanings and narratives attributed to events, this methodology also facilitates unravelling of the constructs that link specific variables (Barbour, 2008; Duncan & Williams, 2008), therefore prioritising the validity and contextual accuracy of the data being explored (Taylor et al., 2015).

Hence, in this article, the strategies employed to address the obstetric fistula crisis in Nigeria, as well as the outcomes of the strategies, so far as they relate to marginalised populations, are explored. Using an illustrative case study, BFFWH, the research focuses on the unique ways in which local geographical, socio-economic, and cultural values and nuances are incorporated into the strategies for tackling public health crises, which are adopted for effective advocacy, awareness, and community engagement.

To explore the communication and media strategies for obstetric fistula awareness in Nigeria, this study adopted the conventional qualitative content analysis method by Hsieh and Shannon (2005). This widely cited inductive approach prioritises direct derivation of insight from data without relying on preconceived assumptions or categories. Rather, the researcher immerses themselves in the textual data through repeated readings and code development, allowing meaning to organically emerge (Hsieh & Shannon, 2005). Therefore, this method is suitable for examining complex areas of communication and media interventions,

portrayals of social movements, and cultural discourses, which are key concerns in the areas of communicating to and for marginalised populations.

3.1. Case Study: BFFWH

BFFWH serves as an illustrative case study for understanding the impact of communication and media strategies on fistula advocacy in Nigeria. The aim of using an illustrative case study (Yin, 2009) is to provide a detailed description and clarification of the situation in order to enhance understanding of the phenomenon at hand. Since its inception in 2018, BFFWH has been at the forefront of efforts to raise awareness, provide surgical interventions, and support rehabilitation for women affected by obstetric fistula ("Nigeria needs new measures," 2021). The foundation employs a strategy that blends hands-on community involvement with targeted media campaigns to raise awareness and combat stigma, while emphasising sustainable practices and empowering women through education and skill-building initiatives (BFFWH, 2024). The work BFFWH conducts to promote awareness, resilience, and education adequately qualifies it as a suitable illustrative case study for this article.

The communication materials selected and analysed in this article are an archive of examples of how BFFWH has effected change through their communication engagement strategies. By focusing on communication and media strategies, this study examines how strategic communication and media interventions, as well as community engagement, can enhance public awareness, build trust, and foster resilience among affected populations, and how they can be tailored to reach vulnerable groups, ensuring that the message of prevention and treatment is effectively conveyed (BFFWH, 2024). This case study was chosen to illustrate how public health communication for marginalised populations (in this case, vulnerable women) can be facilitated through communication and media interventions.

3.2. Conventional Qualitative Content Analysis

This analysis was initiated by identifying and gathering publicly available data of BFFWH that reflects the communication and media strategies in practice, and to highlight the varied strategic messaging across different media formats and scenarios, for empowering vulnerable women affected by a significant health issue. Content such as news releases, flyers, and testimonials were sourced from conducting a specified desktop search on "Bashir Fistula Foundation" and "obstetric fistula." The news releases were gathered through the Google News search tab and one from a physical newspaper, while the flyers were sourced from the official BFFWH website, and testimonials from the organisation's Facebook account. These publicly available data, consisting in 22 files in total, were gathered for the conventional qualitative content analysis. The data gathered span the period from December 2019 to July 2025. Specifically, the Facebook search spanned from January 2025 to July 2025; this limit was implemented due to the high volume of posts on the Facebook account. The search for flyers did not have a timeframe attached; however, the flyers found were all from December 2019. Lastly, the search for news releases was also not restricted to a timeframe; however, the news releases found were from between December 2019 and May 2025.

3.2.1. Codes and Themes

To analyse data using the conventional qualitative content analysis method by Hsieh and Shannon (2005), content gathered from the refined search of "Bashir Fistula Foundation" and "obstetric fistula" was read exhaustively to become deeply familiar with the content and reach a central understanding. By doing this, close attention is paid to key phrases, expressions, and ideas that were used to present the organisation's methods, strategies, and actions to facilitate communication and engagement for and to affected communities. The content was then read again to identify patterns, whereby codes of analysis were then formed (Hsieh & Shannon, 2005).

In the coding phase, elements of data that were outstanding in relevance to the objective of this research were labelled and then broken down into small units of information, i.e., codes, to represent important components of the content without depending on predetermined categories for analysis. Once codes were constructed, the content was then categorised into themes (Kahl, 2014) depending on shared similarities (Hsieh & Shannon, 2005) to reflect the inductive nature of the process. The process of coding, although carried out manually, was conducted in the NVivo software, a platform for data tracking and management (Welsh, 2002). Following the coding of all gathered content, theme development commenced. These themes, by consolidating similar codes to simplify the data analysis, provide a clear picture of the data by revealing larger patterns in the data, as outlined further in the Findings section.

4. Findings

The case study of BFFWH revealed several ways in which public health communication can be promoted through communication and media interventions amongst vulnerable and marginalised populations. This case study, by way of conventional qualitative content analysis, generated 12 codes: access, advocacy, approach, awareness, purpose and focus, challenges, stigma, education-general, education-targeted, sustainability, community engagement, and call to action. From these 12 codes, four themes emerged: advocacy, challenges, sustainability, and mobilisation. This section explored illustrative examples derived from the content analysis, highlighting the different streams of public health communication in the unique context of Nigeria.

The theme, challenges, emerged from the codes, challenges and stigma. This theme illuminates the challenges faced by organisations as well as the stigma faced by affected populations. The dataset of the content from which the theme was derived is outlined in Table 1. Content in this theme includes, for example, "about 70 percent of deliveries are still done at home in northern Nigeria, which [is] why [fistula] is on the increase" (News article 7), as well as "women, who suffer from this kind of health condition, besides the physical pain they go through, there are so many emotional and psychological traumas that such people pass through" (News article 11). Other examples include, "there is a lot of misconception about fistula which is not helping the issue" (News article 10), and "despite the realisation of obstetric fistula and its diverse adverse effects, it largely remains a neglected and 'hidden' disease" (News article 12).

The second theme, sustainability, emerged from the codes, education-general, education-targeted, and sustainability. This theme represents efforts for community education and for the sustainability of support for women even after the medical condition has been treated. This theme speaks to aspects that work to fix

and, in the long run, eradicate this health issue. Some examples of content are "we encourage them to embrace family planning. We also advise them to have family planning immediately after delivery" (News article 7), "the project will provide post-surgery support, including psychological counselling and skills training, to help patients reintegrate into society" (News article 4 and 5), "calling on pregnant women to enquire about the centres before their delivery date" (Newspaper article), and "not only provide medical treatment but also offer vocational training, helping survivors rebuild their lives and reintegrate into society" (News article 14).

The third theme, advocacy, was derived from the codes, access, advocacy, approach, awareness, and purpose and focus. This theme highlights the advocacy efforts, drive, accessibility, and approach taken by the case study to engage with the affected communities in Nigeria. It highlights focus areas for communication, accessibility in terms of location based on affected communities, and advocacy strategies

Table 1. Dataset.

ID	Outlet/Platform	Date	Headline/Caption
Newspaper article	New Nigerian	12 May 2025, Page 8	"BFFWH to hold awareness walk in Kaduna, Abuja to mark IDEOF 2025"
News article 4	The Sun	19 October 2024	"140 women to receive life-changing fistula surgeries in Nigeria"
News article 5	The Nation Online	18 October 2024	"140 women to receive life-changing fistula surgeries in Nigeria"
News article 6	Vanguard	18 October 2024	"140 women to receive life-changing fistula surgeries in Nigeria"
News article 7	Authentic News Daily	27 May 2024	"2030 target: Kaduna govt doing a lot to end vesicovaginal fistula—Officials"
News article 8	Sun News Online	27 May 2024	"Zaria: Bashir Foundation facilitates 500 VVF surgeries, empowers 20 survivors"
News article 9	The Sun	3 December 2019	"Female genital mutilation: Rigasa women suffers highest number of VVF in Kaduna—Kaduna govt"
News article 10	Healthwise Punchng	22 May 2021	"Minister laments increasing burden of obstetric fistula in Nigeria"
News article 11	Healthwise Punchng	23 May 2021	"Nigeria needs new measures to end obstetric fistula"
News article 12	Authentic News Daily	18 October 2024	"Obstetric fistula: Bashir Foundation launches initiative to eliminate condition in Nigeria"
News article 14	Tribune Online	10 May 2025	"Tackling obstetric fistula in Nigeria"
Flyer 1	Bashir Fistula Foundation	5 December 2019	"Day 3—Female genital mutilation eradication project"
Flyer 3	Bashir Fistula Foundation	2 December 2019	"Day 1—Female genital mutilation eradication project"

Note: Table 1 is not a comprehensive list of all data sources used in this study. It only identifies data sources that have been explicitly highlighted in Section 4.

used. Some examples are "BFFWH to deliver 140 surgeries across three strategic locations: Abuja, Gwarinpa General Hospital, Life Camp, Kaduna: Barau Dikko Teaching Hospital, Zamfara: Vesico Vaginal Fistula (VVF) Center, Gusau" (News article 6), "training and orientation for 'FGM [female genital mutilation] eradication champions' to conduct house-house campaign in the community on the abandonment of female genital mutilation" (Flyer 1), "free fistula repair surgeries and comprehensive care on a first come first serve basis" (News article 5), and "the foundation has also conducted sensitization programs for over 1,000 young girls in communities across Kaduna, Kano, Zamfara, and Niger, providing free surgery for those affected" (News article 8).

The fourth and final theme, mobilisation, was formed from the codes, community, engagement, and call to action. This theme covers the aspects of engagement and mobilisation of the community to ensure that efforts are sustained throughout various levels. This theme works in unison with the previous theme of sustainability. Some examples of this are "traditional and religious leaders' sensitisation" (Flyer 3), "community mobilisation" (News article 4), "training healthcare workers" (News article 4, 5, 6, and 11), "through partnerships with government agencies, international donors, and community stakeholders" (News article 4, 5, 6, and 11), "we have dialogue sessions with boys and young men in communities because they will grow to become decision-makers for these women" (News article 8), and "called on all stakeholders, including religious bodies to join in the fight against early marriage and increase in school enrolment for girls, and seeking skilled birth attendants for delivery of babies" (News article 9).

Using conventional qualitative content analysis (Hsieh & Shannon, 2005), approaches to communicating with and engaging vulnerable and marginalised populations have been explored, illustrating how this communication can be effectively carried out. The findings reveal four major insights into the themes, challenges, sustainability, advocacy, and mobilisation, which are described further in Section 5.

5. Discussion

This discussion is informed by the "downstream-upstream" analogy (Zola, 1972), credited to the medical sociologist Irving Zola (the downstream-upstream analogy is informed by National Academies of Sciences, Engineering, and Medicine, 2019, and National Collaborating Centre for Determinants of Health, 2014), to conceptualise the different insights generated from the findings as outlined in Section 4, and as shown in Figure 2. The downstream-upstream analogy was originally developed to represent the underlying challenges faced by the healthcare delivery system in the United States (Robichaux & Sauerland, 2021). In this discussion, this analogy is employed as it outlines how public health is socially constructed, highlighting how public health policies can expand authority into more areas of daily living. In doing so, it outlines various layers of intervention as they influence significant levels of social constructs.

At the upstream is where we find the bases and foundations of the social determinants of health, as outlined by Gray et al. (2020), while midstream is where the effects of upstream determinants are seen. Midstream, as the name implies, serves as a mediation point for the results of upstream and downstream outcomes of health (Gray et al., 2020). Lastly, downstream represents the end point of health-related issues that result from the social determinants of health at the upstream and midstream (Gray et al., 2020).

Figure 2, derived from the conventional qualitative content analysis process undertaken in this article, using the downstream-upstream analogy, depicts the paths that organisations looking to effectively communicate with, and engage vulnerable and marginalised communities, are recommended to take to achieve lasting results. Upstream highlights mobilisation, midstream highlights advocacy, and downstream highlights challenges and sustainability.

Figure 2. Pathway for communication and media strategies targeted at vulnerable and marginalised populations.

In the case of this article, the communication, media, and engagement strategies outlined at the downstream address the population that is already stigmatised and in need of medical care and other forms of empowerment, while also exploring the challenges faced in reaching marginalised populations and the importance of building trust within these communities. Some of the challenges include unsupervised home deliveries, which represent approximately 70% of deliveries in Northern Nigeria (Adedokun & Uthman, 2019). Another is that many of the women affected by obstetric fistula are victims of female genital mutilation (Bello et al., 2020). One other fundamental issue faced at the downstream level is the lack of supplies to carry out treatment for affected individuals, which then leads to these vulnerable populations living with physical pain and psychological trauma for extended periods of time. A summary of this is presented in Table 2.

Downstream, sustainability efforts are considered. In the study carried out in this article, education has been identified as a major area of potential sustainability for Northern Nigeria (as this region of Nigeria, the one mostly affected by obstetric fistula, is not exposed to many educational outlets to inform its decisions). Sustainability initiatives provide avenues for community education and support even after the medical condition has been treated. This works to resolve the underlying lack of education in order to eradicate this issue from a fundamental level. The strategies of downstream are in a direct loop to work with those implemented on a population level at higher streams—midstream and upstream.

Midstream represents advocacy initiatives for those already on the verge of being affected, as well as how this can be mitigated on a community level. This level analyses the communication strategies employed by BFFWH, highlighting how they have contributed to increased awareness and access to treatment for fistula patients.

At midstream, the advocacy efforts, drive, accessibility, and approach taken by the organisation to engage with the affected communities in Nigeria are highlighted. Focus areas for communication include: accessibility of care, mostly location-based, for affected communities; advocacy strategies such as training for the eradication of female genital mutilation; and dialogue sessions for men in the communities, as they tend to be the decision makers in the affected communities.

Upstream represents strategies for mobilisation and prevention before a cure is needed. This level highlights the role of community engagement, media, and call-to-action initiatives in shaping public perceptions and their potential to drive policy change, while emphasising the need for a coordinated approach that includes both traditional and digital platforms ("Minister laments increasing burden," 2021; "Nigeria needs new measures," 2021). Some of the strategies highlighted through the study conducted in this article are sensitisation of traditional and religious leaders as they are major opinion leaders in affected communities (see Saputra et al., 2024, for a similar case in Indonesia), and partnership with government agencies and other community stakeholders to facilitate this sensitisation. At this level, several calls to action are also communicated through media outlets and ambassadors, such as nudging religious bodies to join the fight against early marriages, to increase school enrolment for girls, to seek skilled attendants for the delivery of babies, and to stop the practice of female genital mutilation.

Table 2. Social determinants of health for obstetric fistula in Nigeria.

Stream	Social Determinants of Health
Downstream	Unsupervised home deliveries; Victims of female genital mutilation; Availability of medical supplies.
Midstream	Sensitisation of decision makers (men and religious leaders); Physical access to medical help; Provision of medical supplies; General awareness and education.
Upstream	Social policies (focusing on the welfare of vulnerable women); Traditional and religious leaders; Early marriages; Low school enrolment for girls; Female genital mutilation.

Through the use of the downstream-upstream analogy, strategies for empowering vulnerable women through communication and media strategies and community engagement are presented. The study conducted in this article highlights social determinants of health for fistula as well as current approaches being taken to empower the affected population. Although this study is unique to the cultural and geographical location of the case study, it highlights several problem areas and strategies that can be implemented when dealing with vulnerable populations across various cultural, geographical, and socio-economic contexts. This article underscores the importance of understanding cultural contexts, culturally sensitive messaging, community involvement, and sustained engagement to ensure that vulnerable populations are not only informed but also empowered to seek support and treatment.

6. Conclusion

In this study, several learnings have emerged, notably outlining the specific causes of public health issues affecting women in Northern Nigeria. Secondly, the ripple effect of social policies such as early marriage and female genital mutilation on the increasing cases of obstetric fistula in Nigeria. Third, the significance of community in eradicating obstetric fistula in Nigeria, as well as avenues to support and empower affected women in Nigeria. Based on the learnings from this study, the following recommendations to enhance the effectiveness of fistula advocacy can be made.

The first is integration of local voices. This involves community leaders and fistula survivors in the design and dissemination of communication materials to ensure cultural relevance and resonance. For example, BFFWH did this through the use of testimonials of survivors, as well as the sensitisation events designed for community leaders and men in the community. Secondly, the use of multi-platform media and communication campaigns. By combining both traditional and digital media, organisations and advocates can reach a wider audience, including hard-to-reach rural communities. BFFWH is exemplary in how they combined news releases, social media, flyers, and in-person communication to reach the affected communities. Lastly, capacity building initiatives. Organisations are encouraged to invest in training for healthcare workers and community advocates to improve communication skills and the delivery of key messages related to fistula treatment and prevention. This is exemplified by BFFWH in their efforts to empower women in affected communities, educate and train health care workers, and in their partnerships with government and community leaders. This article contributes to a broader spectrum of the ways in which communication materials can be designed and disseminated to involve community leaders at different levels of home (at downstream), health (at midstream), and government (at upstream), to ensure cultural relevance and resonance with marginalised or minority populations.

This article opens a number of avenues for future research and development for communicating with and engaging communities of vulnerable and marginalised populations. One exemplary case study was used to conduct this study; therefore, further research would do well to investigate how communication and engagement are facilitated in other unique cultural, geographical, or health contexts. Additionally, other methods, particularly observation and focus groups, can be conducted to gather insight first-hand, and specifically from the individuals who facilitate this communication and engagement and those that the communication and engagement are targeted towards, to get a better sense of the efficacy of the methods and further strengthen the approaches for developing more effective strategies.

Acknowledgments

I sincerely thank the reviewers for their time and valuable feedback, which helped to enrich the article on multiple levels. I also acknowledge the Bashir Foundation for Fistula and Women's Health for pointing to publicly available documentation relevant to this study.

Funding

Publication of this article in open access was made possible through the institutional membership agreement between the University of New South Wales and Cogitatio Press.

Conflict of Interests

The author declares no conflict of interests.

Data Availability

The data analysed in this study consist of publicly available documents described in the Methodology section. Data are available from the author upon reasonable request.

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