An Anthropological Perspective on the Conflation of Health and Justice: the Case of Obstetric Fistula in Sub-Saharan Africa

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Abstract
In a globalized world of seven billion people, the persistence of disparities in accessibility to maternal health services between developed and developing nations is astonishing. Poor health often places women in socially marginalized positions. Recognizing this compels us to emphasize the importance of examining the relationship between women’s rights and women’s health. Contextualizing the case of obstetric fistula in sub-Saharan Africa within the fields of global health and medical anthropology, this paper demonstrates that health is a woman’s right, and that the human rights approach can be used as the primary tool for female empowerment. To address maternal health issues, I suggest a middle path between top down and grassroots approaches. In the final section, I will share some reflections on the background research I conducted in Ethiopia during the summer of 2011.

Disciplines
Anthropology
AN ANTHROPOLOGICAL PERSPECTIVE ON THE CONFLATION OF HEALTH AND JUSTICE: THE CASE OF OBSTETRIC FISTULA IN SUB-SAHARAN AFRICA

By

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Abstract

In a globalized world of seven billion people, the persistence of disparities in accessibility to maternal health services between developed and developing nations is astonishing. Poor health often places women in socially marginalized positions. Recognizing this compels us to emphasize the importance of examining the relationship between women’s rights and women’s health. Contextualizing the case of obstetric fistula in sub-Saharan Africa within the fields of global health and medical anthropology, this paper demonstrates that health is a woman’s right, and that the human rights approach can be used as the primary tool for female empowerment. To address maternal health issues, I suggest a middle path between top down and grassroots approaches. In the final section, I will share some reflections on the background research I conducted in Ethiopia during the summer of 2011.
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Acronyms

HEW | Health Extension Worker program
L10K | Last 10 Kilometers project
MDG | Millennium Development Goals
UN | United Nations
UNFPA | United Nations Population Fund
USAID | United States Department of Agriculture
WHO | World Health Organization

Definitions

Adolescent fertility rate | Number of births per 1,000 women aged 15-19
Global poverty line | Living on less than 1.25 USD per day
Maternal mortality ratio | Number of maternal deaths per 100,000 live births
Obstetric fistula | A childbirth injury that occurs as a result of obstructed labor. During prolonged labor, the head of the fetus compresses tissues against the mother’s pelvic bone. The tissues die, and a hole forms in the tissue, leading to chronic incontinence
Rectovaginal fistula | A fistula between the rectum and vagina
Vesicovaginal fistula | A fistula between the bladder and vagina
Contextualization Within the Fields of Global Health and Anthropology

Global Health In Today’s World

The global population has recently reached a staggering estimate: seven billion (Population Action International 2012). Though women make up roughly half of this record number, they are still widely treated as an unimportant portion of the population. Gendered discrimination continues to affect every aspect of a woman’s life. To curb continued exponential population growth and promote the position of the world’s women, investments in maternal health are key. While such investments do include ensuring the availability of family planning for women worldwide, it is also critical to increase the accessibility of quality emergency obstetric care services to decrease maternal mortality and morbidity.

In our globalized world, an increasing population is also an increasingly interconnected one. It is easier for people to get information and witness the lifestyles of others, whether they are unimaginably wealthy or unimaginably poor. For some, this knowledge of existing disparities spurs a commitment to the international community, as evidenced by the rise of prominent figures within the field of global health. Modern crusaders for individual and population health like Dr. Paul Farmer and Edna Adan, and organizations like the Bill and Melinda Gates Foundation, Intrahealth International and EngenderHealth, are becoming well-known for the admirable work they do and support. Diseases no longer affect populations in isolation. Infectious diseases, in particular, can travel the world at shocking speeds without regard for national boundaries. Even the existence of health problems caused by the social and infrastructural environment in which people live is recognized as disgraceful when compared to the available standard of care. A dizzyingly unequal sharing of the world’s wealth leaves 22% of the developing world below the global poverty line and turns health differences into a discussion of disparity (World Bank 2012).
The current status of global health fits within the framework of human rights violations, particularly in this world of extreme wealth and resource disparities. The differences in health status between people who are well-off and those who struggle for any sort of income are significant – there is abundant research showing a strong correlation between health and socioeconomic status. In short, poverty is recognized as the most significant obstacle to achieving good health (Wermuth 2003:78-9). Amartya Sen, famed economist and humanitarian, emphasizes the value of partial agreement in identifying unjust circumstances to aim for global justice (2009:26). Unequal access to healthcare is unjust. Women dying in childbirth is certainly an unjust phenomenon. Approaching human rights violations from a health perspective allows us to mobilize the “sadly underutilized” power of the medical field (Farmer 2008:454). Dr. Paul Farmer has realized that healthcare providers are often allowed access into areas where those who overtly study human rights violations would not be permitted. He argues that this privileged access should be used to decrease human rights violations related to the inability to achieve the right to health (2008:454). The right to health, however, is but one human right; achieving this right is connected with achieving others, as they are all interdependent (UN High Commissioner for Human Rights 2008:6).

In 2002, global leaders met to determine the priorities of international development, and created the eight Millennium Development Goals. These include lofty goals such as combating HIV/AIDS and improving child health, all ultimately aimed at decreasing poverty worldwide by the year 2015 (UN Millennium Development Campaign). There are two goals that specifically call for improving the condition of women. Goal number three aims to promote gender equality and empower women, focusing on reducing gaps in education between girls and boys (UN 2010 Goal 3). Goal number five aims to improve maternal health, by reducing the maternal mortality
ratio by three-quarters and securing universal access to reproductive care (UN 2010 Goal 5). Understanding the interrelatedness of these two goals is paramount to the achievement of either, and both. As Anne Firth Murray cautions, “women’s health cannot be understood or improved without understanding the contextual relationship– the subordination of women, poverty, and violence” (2008:2). A woman’s place in society, then, cannot be improved without regard for her health. As the 2015 deadline approaches, a push for improving these measures (together) is anticipated.

In this global context, the discourse on women’s health becomes a discussion of women’s rights. By recognizing that women often have poorer health because of gendered discrimination and that poor health places women in socially compromised positions, health becomes a woman’s right. I will examine this conflation of health and justice through a case study of the incidence of obstetric fistula in sub-Saharan Africa.

**Using An Anthropological Lens**

One of the foundational theories of medical anthropology, a relatively new sub-field of cultural anthropology, is that of the Three Bodies: the individual body, social body, and the body politic (Scheper-Hughes and Lock 1998:209). In their pioneering paper, Nancy Scheper-Hughes and Margaret Lock tease apart the human body in sickness and health to describe distinctions and ideologies that are projected onto and reflected within our bodies. This theoretical foundation provides a basis for parsing out what gendered health discrimination reveals about a given society and how it comes about. In addition, applying the three theoretical anthropological bodies to female bodies during the reproductive time frame allows us to understand how they have become so vulnerable to injury in childbirth.
The *individual body* is the grounded, lived experience of the self. In Western cultures, people frequently become caught in the seemingly necessary Cartesian duality of separating the body and mind because they are not practiced in describing “mind-body-society interactions” (Scheper-Hughes and Lock 1998:210). The individual body, however, is a unification of the mind and physical body. It focuses on how the individual being relates to the physical or external environment, acknowledging that, “one’s self-identity changes with the social context” (Scheper-Hughes and Lock 1998:213). Experience, therefore, becomes context-dependent. Focusing on the individual body therefore allows for the distinction between disease and illness. While disease occupies the physical body, the individual’s reaction to the disease, resulting emotions, and conceived bodily changes are referred to as the *illness experience* (Eisenberg 1977:9). Thus the individual body as a concept plays on the boundary between illness and disease. Only the individual body is privy to this interplay, and even giving voice to or describing it re-contextualizes it within a social framework, through drawing on shared cultural experience and use of metaphor (Singer and Baer 2007:74).

The *social body* is the result of social systems of belief projected onto an individual body. The body can be used for metaphorical representation of a given society, where a “healthy body” exists only when the society is also “healthy” (Lock and Scheper-Hughes 1998:215). A “diseased body,” then, is both the product and reflection of a malfunctioning society. While Lock and Scheper-Hughes focus on sickness in the body as a theoretical representation of social disequilibrium, social and infrastructural deficiencies and malfunctions can cause real sickness in the body. This literal view can be applied to the case of obstetric fistula, a childbirth injury largely caused by underlying social rather than biological factors. It is useful to think of a “diseased” society as being the reason for poor women’s health. Additionally, the social body as
symbol can be used as a way to validate socially constructed hierarchies, including the subordination of females to males (Lock and Scheper-Hughes 1998:215). The social body is also a map for acceptable social conduct within a given culture.

Finally, the body politic represents the infrastructural problems that leave a clear mark on women’s bodies. The body politic is an agent of control over individual bodies, and a mechanism for ensuring cultural reproduction (Lock and Scheper-Hughes 1998:217). It is the framework for social control, relating to the maintenance of power structures within the state. The individual body becomes politicized as a site of power struggle. The fight for health of women’s bodies, then, becomes a fight for the woman’s right to assert herself in larger society by upsetting the determined social structure.

The three bodies do not exist in isolation from each other, but are intertwined in the context of varied ideologies. It is important to keep all these bodies in mind when evaluating health disparities, and how each aspect affects each of these theoretical bodies. The bodies are tied together within the sickness experience, as sickness “is a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously” (Lock and Scheper-Hughes 1998:221). What are, for example, maternal mortality and morbidity communicating about a given situation? The three bodies provide a template for maintaining perspective on how structural issues can affect bodily health. They are also a humbling reminder that attempting to solve any global health issue requires addressing all aspects of disease and illness.

Within the medical anthropology field, there is a unique direction called Critical Medical Anthropology (CMA). This method takes a less particular approach than cultural anthropology historically has, by focusing on social determinants of health such as “poverty, discrimination,
violence, and fear of violence” (Singer and Baer 2007:33) rather than classic ethnographic research. This perspective is valuable for the contextualization of global health issues within a given social, cultural, and physical environment. It also provides a mechanism for using this social rather than biological information about disease to counter “suffering in the world” (Singer and Baer 2007:34).

While the above theoretical approaches and sub-fields are part of rather contemporary anthropology, one particularly important older foundational point is important to adjust for use here as well. Franz Boas, often colloquially referred to as the “father of modern anthropology” was the mind behind the idea of cultural relativism. This has classically been understood as the idea that a given person’s beliefs and actions must be understood within the context of their own culture, and not that of the observer’s (Brown 2008:364). In relation to maternal health, I will extend that idea in the application of anthropological theory to the field of global health: to understand an individual’s health we must it as a product of his or her own culture and social circumstance.
High Maternal Mortality and Morbidity as a Reflection of Systemic Ills

The Scale of Maternal Mortality

In a modern world of cesarean sections, contraceptives, and advanced medical knowledge, the scale of continually high maternal mortality and morbidity rates worldwide is astonishing. What is even more difficult to believe is the increasing disparity between the level of available maternal and reproductive care in developed countries compared with the lack thereof in resource-poor nations. In fact, world-renowned professor of obstetrics and gynecology Mahmoud Fathalla has said that maternal mortality “deserves the designation of the health scandal of our time” (1997:245). The figures certainly support his statement. The maternal mortality ratio was 11 in the United States, 8 in France, and 3 in Sweden in 2005. In contrast to these wealthy, developed nations, the numbers from countries in sub-Saharan Africa where such data can even be difficult to collect present a remarkably different scenario. The maternal mortality ratio was 380 in Botswana, 560 in Ghana, and 720 in Ethiopia in 2005 (WHO 2008).

These statistics prompt a multitude of questions. How do these high rates come about? Why are they different in various settings? Most importantly, what do these high rates of maternal mortality and morbidity reflect about a given society, culture, or country? An overarching answer to these loaded queries is that “maternal mortality is one of the starkest examples of gender discrimination in our world.” (Murray 2008:91) While this statement provides an explanation, it in turn causes us to explore the extent of the devaluation of women and limitations on their ability to assert their health needs. Too often, women “lack the right to knowledge and control over their own reproduction” (Murray 2008:91). What are the specific circumstances, then, which cause women not to be able to achieve good reproductive health? Broadly, it is a combination of inadequate women’s rights and infrastructural deficiencies in weak healthcare systems that culminate in the lack of access to emergency obstetric care.
Obstetric Fistula as a Case Study

A childbirth injury like obstetric fistula, then, becomes a useful illustration of gendered discrimination in obtaining health care and of the precise relationship between women’s rights and women’s health. Obstetric fistula is a childbirth injury that comes about as a result of prolonged labor, when a woman does not have timely access to emergency obstetric care. Some people have tried to explain fistula away with biological causes. Even those supposedly “biological” causes, however, can be traced to underlying infrastructural inadequacies and social limitations. Fistula, though, is usually curable and is entirely preventable. That it still exists is a reflection of purposeful lack of investment in women’s health, making this specific kind of maternal morbidity an appropriate case study.
Obstetric Fistula in Sub-Saharan Africa

What Is Fistula?

Fistulas are holes that form between the vaginal wall and bladder (vesicovaginal) or between the rectum and vagina (rectovaginal) after obstructed labor. The pressure from prolonged labor compresses vital tissues against the pelvic bone, which then die and disintegrate. This tissue death causes holes that leak urine and/or feces through the vagina, giving off a foul smell that often leads to the woman being shunned from society. Prolonged labor can also cause sacral and perineal nerve damage, resulting in the classic “foot drop” syndrome which limits women’s ability to walk unassisted (Miller 2005:287-289).

Women with untreated fistulas are not able to successfully deliver a baby, are often unable to work, and can suffer from infections in the damaged area from the chronic incontinence. They may become depressed after being socially isolated or abandoned. Tragically, some even resort to suicide to escape their condition (Lewis 2006:4).

In sub-Saharan Africa, the incidence of fistula varies greatly from rural to urban settings. In remote areas, it is about one hundred twenty four cases per 100,000 births, compared with nearly none in cities (Lewis 2006:6). Until recently, the continued occurrence of obstetric fistula had largely escaped recognition. Even now, however, the statistics continue to be mere (under-) estimates, however, as it is far too easy for women with fistulas to go unrecorded by the global community, hidden away from normal life. Even Direct Relief International, which launched an interactive Global Fistula Care Map in February 2012, acknowledges gaps in its data and need for continued monitoring of and improvement available fistula repair services.

Ninety percent of the time, fistula can be repaired through surgery (Miller 2005:290). This surgery essentially involves sewing up the fistula, and monitoring healing to ensure full closure and the end of the incontinence. This can often be accomplished by a single surgery,
though it may require more than one for complete success. After surgery, the cured women are
told to avoid sex until healing is complete and instructed to use family planning for a few years.
They are also told to come to the health center if they become pregnant, to give birth by cesarean
section. For those who have more complicated fistulas and cannot be cured with the typical
surgery, there are other options.

One option is having a diversion, where the urinary tract is directed to empty from
another orifice. This can either mean reattaching the ureters to a detached portion of the small
intestine that is guided through a created hole in the abdomen, to which a pouch can then be
attached outside the body (called an ileal conduit), or diverting urine through the rectum if the
anal sphincter is strong enough. If a woman is not a good candidate for the diversion surgery, she
may be taught to use a vaginal plug, in order to have control over emptying her bladder.
Unfortunately, these more complicated solutions can be difficult to manage in the countryside
where lavatory facilities and personal privacy are limited. Ileal conduits and plugs also require
monitoring as well as resupplying of parts. Women who cannot be cured with typical reparative
surgery may not be able to return home following treatment (Lewis 2006:38-42; personal
interview with Bitew Abebe, August 14, 2011).

Since the incidence of fistula is difficult to accurately record, Table 1 uses the maternal
mortality ratio as a proxy for this measurement. Since obstetric fistula is one type of maternal
morbidity, we can assume that a woman who is at risk for obstetric fistula may also be at risk for
other complications during childbirth. Adolescent fertility rate is used to describe early
pregnancy as an implication of early marriage. The third variable is the percent of births in the
presence of a skilled attendant. Though these statistics are likely to be estimates, the chart is a
useful visualization of the above risk factors.
Biological Causes of Fistula

The size of a woman’s pelvis is affected by both biological and social factors. It is widely believed that there are four commonly identified types of pelvises: gynecoid, android, anthropoid, and platylepoid. The gynecoid pelvis is widest and generally considered to be the best shape for birthing. Most African women, however, have anthropoid pelvises, which are significantly narrower. This pattern may help explain the high maternal mortality rate in Africa. While what type of pelvis a woman has may be determined purely by genetics, which cannot be altered, some authorities, including the Journal of Reproductive Medicine, acknowledge that pelvic shape is also largely determined by environmental and cultural factors (Abitbol 1996:242-250). External factors that could affect pelvic size at first pregnancy include malnutrition due to performance of hard labor and insufficient caloric intake, and age at first pregnancy.

Proper bone growth and development requires specific essential vitamins and micronutrients, such as vitamin D and calcium (Whitney 2011:506). Young Ethiopian women who are deficient in these nutrients may enter puberty later and develop more slowly, “causing childbirth to be a ‘traumatic experience’” (Hamlin 2001:257). In this way, malnutrition may also be considered a factor that puts young women at risk for obstructed labor (Miller 2005:288). Malnutrition often results from both high rates of poverty and consequent lack of available nutrient-dense food, as well as girls being required to perform hard physical labor before they are fully developed, stunting their growth (Lewis 2006:2,6). These findings suggest that the issue of pelvic size could begin to be managed through nutrition programs, which could help girls on the trajectory toward proper pubertal development and subsequently lower their risk for harrowing childbirth.
The final recognized biological cause, while still related to development, is more socially dependent. Early pregnancy is more likely to occur when girls get married early. Early pregnancy as a product of early marriage may be considered a significant factor among a multitude of others, contributing to a high incidence of fistula. As discussed above, malnutrition can contribute to delayed pubertal development. If a young woman’s pelvic bones are not properly developed and she becomes pregnant, she will be more likely to have a high-risk delivery. Adolescent girls are especially at risk for obstructed labor, because of their underdeveloped pelvises (Lewis 2006:3). In countries like Ethiopia where most women become pregnant after marriage, the easiest way to decrease rates of early pregnancy would be to discourage early marriage.

It is important to note that there are other types of fistula besides obstetric. Fistulas can also be caused by sexual violence. This in turn can occur through gross rape, or aggressive violation of a woman’s body with sharp objects such as a stick. Such acts of damaging a woman’s body, as during wartime in the eastern Congo when sexual violence was used as a weapon (Kristof and WuDunn 2009:85), are also clear infringements of human rights. Victims of sexual violence who suffer from fistulas should also be included in treatment programs and offered similar support as obstetric fistula patients.

Despite the importance of understanding the underlying causes of obstetric fistula such as malnutrition, a true definition of the condition would include the social ills that prescribe it. Placing too much weight on the biological precursors may cause the more potent social factors to go unaddressed. Examining the biological causes is ultimately superficial, as fistula would be eradicated if every woman had timely access to emergency obstetric care worldwide. Thus it is of the utmost necessity to examine closely the ways that women lack access to such care instead
of focusing exclusively on the biology of each individual patient. Approaching the problem from a wider perspective avoids placing blame for reproductive problems on the women themselves rather than on the causative interactions between social expectations and bodily realities (Doyal 1995:16).

Social Causes of Fistula

Studying the social and infrastructural causes of fistula reveals why obstetric fistula is particularly reflective of the interplay between women’s rights and women’s health. As alluded to in the previous section, early marriage is considered a risk factor for obstetric fistula. Obstetric fistula primarily affects women during a vulnerable time of their life – when they are young and newly married. They may be expected to bear children and prove their worth to their husband as a wife. In “failing” to do so and developing obstetric fistula, they may end up divorced or abandoned (Lewis 2006:15). In such a scenario, the young woman is valued for her reproductive capacity, and little else. Dr. Catherine Hamlin of The Fistula Hospital in Addis Ababa, Ethiopia, who has treated countless women with fistulas, describes poignantly how a young girl’s destiny to suffer through childbirth becomes shaped at a very early age. First, a girl is expected to be obedient and listen to her father; if her father tells us she will get married, she must comply. Often, discussions of marriage begin when the girl is eight or nine years old, and are finalized by the time she is 14 (Hamlin 2009:255-257).

In contrast to the stories of many Ethiopian women, the constitution of Ethiopia states that, “marriage shall be entered into only with the free and full consent of the intending spouses” (Ethiopian Const., art 34. Sec. 2). Yet the persistent lack of enforced women’s rights oppresses them, limiting their freedom to make decisions about their lifestyle, and in particular about their
health. Who, then, has the decision-making power? Typically, men – first the girls’ father, and subsequently her husband. Because women do not have much agency in achieving and maintaining good health, they are often incapable of accessing resources such as obstetric care that may be available. Women also do not have the ability to own property or achieve any type of wealth, despite a recorded legal right for “equal rights with men” to “acquire property” (Ethiopian Const., art. 35 sec. 7). This lack of actualized ownership makes collecting money to travel for obstetric care quite difficult, and is a product both of women being marginalized as well as general widespread poverty.

Obstetric fistula is a condition that pushes already (impoverished) marginalized women into even more distant social peripheries through isolation and prohibition of social participation. It has both severe physical and psychological consequences. Women’s inability to control their reproduction and make decisions about their bodies are “social realities which have an adverse impact on their health” (UN High Commissioner for Human Rights 2008:12).

Discouraging early marriage can be a difficult cultural obstacle to overcome, as it is often a deeply embedded traditional practice (Lewis 2006:7). Instead of focusing specifically on delaying marriage, initiatives should be directed toward improving a woman’s rights. In countries like Ethiopia, where a legal framework for increasing the average age of marriage is already in place, addressing this risk factor becomes a question of law enforcement. Informing young women, men, and their families about the law and educating villagers on the dangers of early pregnancy could be a non-judgmental method to approaching the problem. In such discussions the use of contraceptives should be promoted as well. EngenderHealth, an organization that provides technical assistance, has programs currently running in Ethiopia aimed at involving men in dialogues on gender-based violence and family planning. EngenderHealth
runs male discussion forums and promotes vasectomy as a method of family planning among males (personal interview with Deputy Director of Programs Jamal Kassaw, August 17, 2011). This non-confrontational approach fosters open discourse and avoids the mistake of excluding men from addressing women’s rights-related problems.

*Infrastructural Causes of Fistula: Accessibility of Care*

The direct cause of obstetric fistula is giving birth without a skilled attendant who can provide access to emergency obstetric care in case of prolonged labor. This singular idea is easily illustrated by studying the history of fistula worldwide.

In the past, fistula was a worldwide health problem. Presently in developed countries like the United States, however, the majority of women have access to the appropriate prenatal care and assistance during labor, predominantly in a hospital setting (Cron 2003:3). In countries where access to or availability of skilled birth attendants and emergency obstetric care is severely limited, fistula continues to be a significant problem (Lewis 2006:4-5).

The WHO defines a skilled birth attendant as someone who has “been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications” (WHO 2002:1). This definition is particularly useful in outlining the expected scope of work and in designing training programs for rural non-physician health workers. What it neglects to do is place the skilled birth attendants within a larger healthcare framework, suggesting referral for “obstetric complications” without discussing the possibility that there may not be someone to whom the patient can feasibly be referred. A referral is a multi-step process, and the ability to refer requires functional and accessible transportation, a place to
refer to, capable physicians who will be available to communicate and perform a cesarean section if necessary, paying for services, and so on.

Access to healthcare services not only implies their existence and quality, but their being physically and financially obtainable. It also means that people are permitted to seek this available care in the first place (UN High Commissioner for Human Rights 2008:4). A lack of access to adequate services, then, is the culmination of a variety of barriers and limitations along the way. The WHO describes the three major delays in accessing emergency obstetric care that can result in the development of obstetric fistula.

The first delay results from not acknowledging the initial need for care because of a lack of knowledge of the signs of a high-risk delivery. This delay usually comes about from limiting sociocultural factors, like the expectation of women to bear the pain of labor and give birth at home. In studying this first delay, one encounters countless horror stories of women laboring for two, three, or even eight or more days before reaching a health center on foot, stretcher, or bus before miscarrying and suffering from obstetric fistula.

The second delay occurs after a woman or her community has decided that she needs care, and relates to actually reaching a facility. This delay can be caused by lack of transportation (including nonexistent ambulance services), the inability to pay for any available transport, poor roads (especially during a rainy season), or prohibitive distance from remote areas.

The third and final delay occurs once the woman arrives at the health center. She may not be able to receive care upon arrival, for reasons including: patient overflow, lack of human or material resources, or only poor quality care being available. It could result from something as obviously limiting as there being too few beds to accommodate the number of women in labor at any given time (Lewis 2006:14). A purposeful lack of investment in maternal health and
infrastructural improvements that would allow for better access to healthcare, which particularly affects women in emergency situations such as childbirth, is a social pitfall that must be overcome.

All of the above issues touch on the apparent lack of valuing of women in their female bodies and understanding the importance of women’s health during pregnancy and childbirth. The biological causes of fistula can only be addressed after the fact, through reparative surgery. A narrow pelvis that places a woman at risk for fistula cannot be easily changed. Though fistula is fully reparable in more cases than not, that it occurs during a painful, drawn-out labor requires intense preventive efforts. Even the notable Dr. Catherine Hamlin has admitted reservations about simply “sewing these women up” and not focusing enough on prevention during her time in Ethiopia (personal interview, August 18, 2011). She is hopeful about fistula eradication, however, because the Hamlin Fistula Hospital’s medical director and urologist, Professor Gordon Williams, aims to focus his efforts on prevention and holistic treatment. It is possible to eradicate fistula by addressing social causes and establishing a successful maternal health care infrastructure.
Health As A Human Right

Whereas good health was once considered to be a privilege, within the global health field there has been a relatively recent trend in advocating for health to be widely accepted as a human right. Such an ideological shift also implies that not only does everyone deserve to have the opportunity to be healthy, but requires access to the current standard treatment of care. Accepting this view may prompt a re-evaluation of the motives behind improving women’s health worldwide.

Update on the Millennium Development Goals

The approaching 2015 deadline for the achievement of the MDGs creates an opportunity for promoting women’s rights in conjunction with crucial improvements in maternal health. Goals three (promoting gender equality and empowering women) and five (improving maternal health by reducing the maternal mortality ratio by three quarters and achieving universal access to reproductive health) are particularly relevant to this quest. That both goals are included among the top five indicates their importance and potential relatedness. United Nations Secretary General Ban Ki-Moon believes the Goals encompass basic rights including the right to health (Millennium Development Campaign Background). The Goals are undoubtedly promising and were formulated with good intentions – but is it possible for the global community to achieve them in the next few years?

It is clear that Goal three, promoting gender equality, will not be entirely accomplished. Plan International’s “Real Choices, Real Lives” cohort study following 142 rural girls from birth to age nine in 2015, reveals that the participants still lack access to proper healthcare and school programming. The target of Goal three is to eliminate gender disparity in primary and secondary education. Though a family may view their girl’s education in a more progressive light than in
the past, with limited funds they will still opt first to fund their son’s education (BIAAG report 2010). The proportion of girls aged fifteen to nineteen who are married by the age of fifteen is still incredibly high in many countries, ranging from 12.2 percent in Guinea to 28 percent in Niger (BIAAG report 2010). In light of this data, it is clear that much work still needs to be done on the elimination of gender inequality.

Goal five, reducing maternal mortality by three-quarters, on the other hand, is on its way towards achievement. For example, the Campaign To End Fistula has promoted needs-assessment to eradicate fistula in many countries, drawing attention to the need for funding improvements in maternal care (UN 2007). Though the number of women using antenatal care and assistance during childbirth is increasing, disparities in obtaining access to care are still severe, especially since most deaths are due to avoidable causes. Overall maternal mortality, as a result, is “declining only slowly” (UN 2010).

Despite the slow progress towards achieving these goals by the (looming) proposed deadline, Ki-Moon is still hopeful that the all-encompassing Goals have “set the course for the world’s efforts to alleviate extreme poverty by 2015” (UN Millennium Development Campaign). It is perhaps worth noting, however, the use of the phrase “extreme poverty”—a category separate from the poverty advertised on the Goals’ website. While it can be difficult to believe that “we can end poverty” truly by 2015, the idea of the MDGs as a guideline for public health goals has trickled down to a local level. In a health clinic in Dejen, Ethiopia, maternal health officer Yenaw Fentie uses the hand-drawn poster of the MDGs in Figure 2 to remind him of the direction the current challenges he faces in everyday care need to take (personal interview August 16, 2011).
The Right to Reproductive Health

Prominent medical anthropologist and physician Dr. Paul Farmer has worked tirelessly as a “partner to the poor” (Saussy 2010:title) for the past two decades, both independently and worldwide through his own organization *Partners In Health*. Besides his medical skill, his fame is largely due to provocative ideas that seemingly complex and expensive treatments can be successful in any setting, however resource-poor, because each person deserves the best care possible. He strongly advocates for health to be considered a human right. Throughout his career he has promoted this principle, proving with thorough research and diligent passion that his ideas are valuable. Not only does he strongly believe that health is a human right, but poignantly notes the strong relationship *between* (women’s) health and (women’s) rights:

“I wish that someone had told me when I first traveled to Haiti, in 1983, that to promote human rights there, we’d need to build operating rooms and procure equipment and supplies; it would have saved us a great deal of time and made us more effective. We did learn that lesson, but only after presiding over the grisly spectacle of young women dying because they were pregnant and poor.” [Farmer 2008:549]

Farmer’s statement particularly highlights the root causality of continued maternal mortality and morbidity: poverty, or social circumstances. Farmer’s words highlight the need to understand the feedback relationship between rights and health, particularly relating to the empowerment of women. Such an approach is especially valuable for the women Farmer treats, who, by being poor, are already marginalized before being swept farther aside by ill health.

A specific aspect of the right to health is a women’s right to reproductive health. Reproductive rights pertain to the ability of a woman to choose when to get pregnant, how many children to have, and to maintain good health throughout her reproductive life (UN High Commissioner for Human Rights 2008:13). Women in general should not be considered mere vessels for procreation, and deserve the right to control their own reproduction (Murray
In today’s world, there are a variety of short- and long-term contraceptive methods available to effectively regulate birth spacing. The use of family planning methods is in fact considered to be a key aspect of a woman’s right to health (UN High Commissioner for Human Rights 2008:13). If members of a given society do not allow a woman to plan her family and do allow her to die or become injured in childbirth, it is a violation of the woman’s right to basic health during her reproductive years (Murray 2008:11). Conversely, by controlling her reproduction, a woman gains ownership of her body. This ownership is a strongly empowering sentiment that fosters agency from being able to assert one’s needs.

*Clarifying the Right to Health*

Because this “health as a human right” concept has been garnering attention in the international community, the Office of the UN High Commissioner for Human Rights and the WHO published Fact Sheet No. 31, on “The Right to Health” in 2008. The comprehensive document outlines what the right to health really means and how it applies to specific vulnerable groups, such as women. The right to health is based on ensuring fundamental livable everyday conditions, such as having safe drinking water and food, along with social requirements like gender equality. Entitlements of the right include “equal and timely access” to maternal, child, and reproductive health. It is important to remember, however, that the right to health is the opportunity to attain good health, rather than be promised good health itself, as the latter cannot be guaranteed by the state (UN High Commissioner for Human Rights 2008:4-5).

To clarify this point, the UN published a more focused report on the “Right of everyone to the enjoyment of the highest attainable standard of physical and mental health” prepared by the Special Rapporteur of the Human Rights Council Anand Grover in August 2011. He
acknowledges the place of access to sexual and reproductive care within a woman’s right to overall health (UN General Assembly 2011:2). In order for women to have this right to health realized, “the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services” must be removed (UN General Assembly 2011:3). Here again we see the emphasis on access to quality care as a necessary component of a woman’s ability to achieve this “highest standard of physical and mental health” (UN General Assembly 2011:1).

Not having access to quality emergency obstetric care, for example, can result in childbirth injuries like obstetric fistula. Besides physical complications, obstetric fistula is also psychologically damaging. Women with fistula often become isolated from their families, living in a small hut in order to not offend their family with their smell. The women may avoid liquids and food, in order to minimize the leaking (personal interview with Aynalem Yigzaw, August 18, 2011), placing their bodies in further danger. Many curl up, do not move about, and waste away, wishing for death (United Nations Population Fund 2008:5). Poor health, as manifested here in the form of fistula, places already vulnerable women to the peripheries of the population, making them ashamed of their condition and entirely dependent on others. This type of injury not only damages women’s bodies, but also degrades their will and spirit.

Consequently, we can view the existence of high maternal mortality and morbidity as a reflection of lacking women’s rights. After closely examining the case of obstetric fistula, we can also acknowledge that having poor reproductive health places women in socially marginalized positions. Such marginalization may include social isolation, chronic disability that keeps a woman from being able to work, or infertility that limits a woman’s ability to contribute to her social group in a very literal sense. Within the framework of seeing health as a human right, it
becomes clear that the relationship between women’s health and women’s rights is actually that they are one and the same. In addressing one side, we affect the other. If this critical equation remains at the forefront of global health policy-making, women’s health-as-a-right and right-to-health have the potential to improve dramatically.
Using The Human Rights Approach As A Tool For Female Empowerment

Acknowledging the causative and circular relationship between inadequate women’s rights and poor health allows us to identify good health as a key factor in empowering women. Therefore, healing can be used to empower women. Empowered women are then able to take charge of their well being, further improving their health and access to care.

Health as the Primary Starting Point

Some women’s rights activists have argued that there are more direct ways to empower women than through health. Economic stimulation via microfinance initiatives or improving women’s property and inheritance rights can foster independence and decision-making power. In some areas of the world, “microfinance has done more to bolster the status of women, and to protect them from abuse, than any laws could accomplish” (Kristof and WuDunn 2009:187). Upon traveling to many impoverished regions globally, Nicolas Kristof and Sheryl WuDunn conclude that the easiest way to decrease maternal mortality is to “put more money in the hands of women” (2009:193-4). In the case of arguing for long-term investments in women’s rights through health, however, perhaps the simplest solution is not the most desirable.

While the above methods have been shown to raise women up in society, focusing on improving women’s health is in fact the most basic and effective way to empower women. Addressing health is primary to further success, whether it be economic or otherwise. In 1954, psychology professor Abraham H. Maslow published his notorious hierarchy of needs. Maslow categorizes most human needs into “basic needs” and “higher needs.” The most basic need is the satisfaction of hunger. Higher needs, for example, include the desire for self-actualization and intellectual curiosity. Maslow theorizes that only once the basic needs are satisfied can higher needs emerge. In a struggling body, the mind is focused on bare survival and immediate (basic)
needs. When the body is supplied well enough, the mind is free to seek the next opportunity (Maslow 1970:15-31). This supports the claim that women’s health must first be addressed or managed before they can begin occupational training or work. As a psychologist, Maslow focused more on the need for psychological health in his writings. If we reject the Cartesian mind-body dualistic view, we can recognize that psychological health is both part of overall health and related to physical health. Regardless, the maintenance of psychological health remains relevant for fistula patients, who may have experienced traumatic social rejection as a result of their condition.

Addressing health then becomes a basic need for people, and women specifically, as health affects every other part of their lives (Murray 2008:12). Professor Lesely Doyal of Bristol University’s Centre for Health and Social Care asserts that for women, the “first and most immediate need is to survive and be physically healthy” (1995:8). A woman with untreated fistula, for example, often cannot work because of her condition. She usually becomes reliant on her family to support her, which can be an immense strain if she is already from an impoverished background. She cannot support her family. When asked about the relationship between women’s rights and women’s health, Aynalem Yigzaw of the IntraHealth International Ethiopia office said he considered women’s health as “an ingredient for other goals” and that gender equity is a “minimum” requirement to be satisfied before anything else (personal interview, August 18, 2011). Even Jeffrey Sachs, Director of the Earth Institute at Columbia University, identifies “improving basic health” as second on his list of Big Five key targets for African development initiatives. Maathai brought his backing into her discussion of the importance of “investments in basic health” (2009:71).
Activating Agency

Since grassroots movements address feelings of hopelessness by fostering agency in individuals, they would be an effective means towards empowering women through addressing global health issues. Ideas of ownership extend specifically to women’s health problems in that health-related decision-making enables agency within female bodies. Dr. Hirut Terefe, Associate Professor of Anthropology and Director of the Institute of Gender Studies at Addis Ababa University, acknowledges the complexity of activating a woman’s agency, however. She says agency relies upon whether or not a woman feels she has the backing to demand certain rights. Many women in Ethiopia do not see receiving obstetric care as a right, because they are taught to bear the pain at home as a natural consequence of being a woman (personal interview, August 22, 2011). Empowerment through involvement and opportunity, then, becomes a critical vehicle for change in giving women the ability to demand rights that have not yet been achieved. Women will not be able to demand care independently without having the context in which they make these demands altered. Murray elaborates, “the conditions of women’s lives must also change so that we women can gain more power over our lives and our health” (2008:15). As a result of such “social change,” women will have a more adequate space within which to exercise their rights by taking charge of their bodies and lives (Murray 2008:15).

Desta Mender (Village of Joy) outside of Addis Ababa, Ethiopia is an excellent illustration of the need to address health issues before other needs for women. Desta Mender is a Hamlin Fistula Hospital-affiliated rehabilitative community for women who have either undergone fistula repair surgery and are recovering, or have irreparable fistulas and must instead learn to live with and manage their condition. Often, the women who remain there cannot return home due to painful pasts and the trauma of harsh fistula-related stigma, or because they will
require regular medical supervision in the future (personal interview with Zuriash Aklilu, August 10, 2011). Upon recovering or learning to manage their condition (particularly in the case of ileal conduits), the women receive job training in different areas. Women may be trained in hospitality services and run Juniper Café, the village restaurant. They also garden in the valley shown in Figure 2, package and sell spices, and cook food for the patients in the main hospital. Eventually a small group of women may leave the village together and jointly start their own business, remaining nearby so as to have continued access to care. It is of the utmost importance for the women to manage their health and recover to a level where they are capable of working before embarking on these small-scale business endeavors. Microfinance or other economic initiatives cannot work for women who do not have their health under control.
Practical Approaches and Applications

How, then, do we address the social and infrastructural issues that place women in socially marginalized positions as a result of poor reproductive health? Generally, there are two unidirectional approaches. One is “top down,” or modifying policies to alter the framework within which these problems occur and eventually improving the everyday experience. The second is “bottom up,” or utilizing grassroots movements to enact local changes that will ideally translate to widespread progress. Though there are clear advantages to each method, each also has its limitations. In practice, it is often a blend of these two approaches that is most successful. One could say the two approaches would “meet in the middle,” covering the distance from federal systems to villagers more swiftly than one alone would.

The Top Down Approach: Policy Changes & Development Assistance

For deeply embedded pervasive infrastructural issues such as inadequate access to emergency obstetric care to change, formal intervention is required. Outlawing child marriage or increasing a woman’s right to abortion, for example, are important legal alterations because they become part of a system that provides citizens (who are informed of the laws) with a backing that enables them to demand concrete, available rights. Legal priorities also provide a template for what public health interventions should strive toward achieving.

The MDGs are an excellent example of the prioritizing power of policymaking. In establishing a list of the top areas for international development improvement, the United Nations identified specific directions for programs, funding, and international attention. The MDGs essentially act as a guideline for what should be the intended focus of international development and global health. Additionally, removing legal barriers relating to family planning and women’s health in general communicates that the opportunity to attain good health is a right.
Legally limiting a woman’s options for sexual and reproductive health can be considered a violation of a woman’s right to health (UN General Assembly 2011:6). In formulating new policies, a government may also be fulfilling a responsibility to keep its people informed.

Maathai partially blames the rapid spread of HIV/AIDS in sub-Saharan Africa, for example, on those in power not having “successfully sensitized a critical mass of the African people” about the disease’s dangers (2009:66). Perhaps official attention can be crucial for information flow within a country and for encouraging citizen mobilization. Besides getting the people involved, prioritizing women’s health and rights in national policymaking ensures that leaders are actively discussing these issues, becoming aware of the current realities. Policy changes also promote personal investment as government members allocate funds for various projects based on political demand while assessing citizens’ needs. Using inside funds, as opposed to agenda-driven foreign aid, mandates thorough deliberation and thought.

The danger of relying too heavily on this approach, however, is an ungrounded expectation that changes in law translate directly to changes in social behavior and local expectations. If the new laws are not enforced, it is unrealistic to expect any immediate changes in the individual and collective expectations of women. Particularly in countries with distinct regional differences, there may be the added problem of conflict between national and customary law. Changes in the national constitution may not translate to changes at the local level because of the persistence of local laws. In order to enforce a law, government officials must demarcate the national constitution as capable of overriding customary law (Smet 2009:152). As alluded to above, the law provides backing for those who are aware of their rights, and willing to demand them. It can take quite some time for word to travel between a capital’s urban people and those
in the rural peripheries. Governments of nations with high illiteracy rates or significant remote populations may need to find alternate ways of informing their citizens of legal changes.

Too often, foreign development assistance focuses on immediate solutions rather than long-term preventive tactics. Such an approach further destabilizes national infrastructure, and places outside interests and priorities ahead of local needs. As an active public figure, Maathai holds aid agencies accountable for their problematic “crisis mentality,” calling instead for “putting a priority on prevention, strengthening health systems, and implementing policies to improve the basic health of Africans” (2009:67). Such an approach would promote resiliency rather than disaster “in the face of preventable yet debilitating diseases” (Maathai 2009:67). Such ideological approaches are also pertinent to the issue of maternal mortality and morbidity, as obstetric fistula is both preventable (with timely access to emergency obstetric care) and inarguably debilitating. Preventing fistula, though, requires investments in infrastructure and building a capable national healthcare system (Maathai 2009:77). Sewing up fistulas is dealing with the crisis; establishing a competent, reliable, comprehensive maternal health care network is certainly a long-term investment.

If a top-down approach is to be successful especially with regard to women’s health and rights, increasing the presence of women in leadership is a necessary change that must occur. Women are generally privy to the issues specifically facing their gender group. Having women in office can help raise concerns such as access to quality reproductive care higher on the political agenda. A more powerful female perspective would keep women’s health at the forefront of policy-makers’ minds as well as help implement more pragmatic solutions. Women can use any differences in leadership style to their advantage and to expand diversity of priorities rather than trying to fit into what is usually the male-dominated field of politics.
Maathai, while a supporter of grassroots initiatives, also held a position in the Kenyan government. Her actions reveal that she acknowledges the importance of having motivated, compassionate people in the federal government who can carve out space to include social programs. While promoting the presence of female leadership in the political sphere, however, we must not neglect that “organizational paradigms and systems themselves need to change” as well (Murray 2008:218). Mere participation in a previously male-designed and dominated system is a start, but will not be sufficient.

Psychologist Edward Whitmont argued that as women’s movements grow, “such feminist values as nurturing the earth, respecting the cycles of the earth, and expressing a love and concern for the generations that follow” are the powerful foci for relevant change (Murray 2008:219). How an organization functions rather than the work it does is a defining feature. Activist Marilyn Waring believed that feminist approaches tend to be “transparent, community-based, collaborative, diverse, respectful, and valuing of individual people” (Murray 2008:221). These values are critical to addressing women’s issues by mobilizing the women themselves and appreciating collective action, while maintaining focus on each individual woman’s right to health.

The Bottom Up Approach: Grassroots Initiatives

Grassroots initiatives are advantageous in different ways than are top-down approaches. Local solutions are often most pragmatic, direct, and efficient. Initiatives that start on a smaller scale can be flexible and more easily tailored to immediate needs. They also promote community and individual ownership of the issue, and more importantly, of the solution.
It is primarily important to determine what constitutes an effective grassroots movement before promoting them. “Grassroots” necessitates that “ordinary people [are] regarded as the main body of an organization's membership” (Oxford Dictionaries). Pertaining more to the issues of women’s rights and women’s health, groups of non-governmental workers gathered outside the bounds of the 1995 United Nations Conference on Women to identify key factors that shape a successful, locally-rooted approach to problem-solving: “commitment to operating in terms of sincerely held principles; respect for women’s ways of knowing; new kinds of leadership, advocacy, and political empowerment” (Murray 2008:222). It is time to solve problems through emphasis on sensible, realistic solutions. Local solutions by definition require local manpower, further sensitizing the necessary “critical mass” Maathai identifies (2009:66).

Grassroots approaches also address debilitating sentiments of disempowerment or hopelessness by spurring community members to action. Maathai, 2004 Nobel Peace Prize winner, discusses at length the temptation to disconnect and become discouraged in the face of seemingly insurmountable problems. Maathai actually identifies disempowerment “through a lack of self-confidence, apathy, fear, or an inability to take charge of one’s own life” as an under-recognized issue (2009:129). It can be difficult for disempowered people to believe in the possibility for positive change, feeling instead that it would be easier to leave responsibility for change to others. She discusses at length the importance of a focus on “reclamation” by helping community members “recognize the utility and value” of provided services (2009:129;288;69). Maathai believes that grassroots movements are ultimately what will move the “social machine” (2009:129) and counter these feelings, empowering communities. Anne Firth Murray echoes the sentiment, believing that progress occurs only when individuals are empowered (2008:219).
Especially vocal supporters of grassroots movements in the international health and development sphere include prominent figures like Paul Farmer, Nicholas Kristof and Sheryl WuDunn, Maathai, and Anne Firth Murray. While Farmer is known for generally casting aside the global health policymakers’ preoccupation with sustainability, his *accompagnateurs* model keeps solutions local and maintainable. *Accompagnateurs* are community health workers who assist neighbors with AIDS, tuberculosis, or who are otherwise sick by encouraging adherence to treatment regimens and providing emotional support. In areas where healthcare facilities or trained specialists are few and far between, *accompagnateurs* help create a web of service that connects the patient to provider services in a low-cost way (Partners in Health 2009).

Nicholas Kristof supports people who are proactive. In the book he co-authored with his wife Sheryl WuDunn, *Half the Sky*, Kristof highlights women who have first taken action to create change in their own communities. He informs his readership about women who start schools and loan programs on a small scale, and lists a number of organizations supporting women to stand behind at the end of the book (2009:255-8).

Maathai is herself an example of the power of grassroots initiatives as founder of the Green Belt Movement, based in Kenya. She started the tree-planting program to halt soil erosion and reverse the effects of environmental degradation, and ended up promoting peace and empowering women through marking them as “stewards of the natural environment” (Green Belt Movement 2006). In her book *The Challenge for Africa*, she repeatedly discusses the required investment of the people in order to change something, by seeing the problem, having hope, and following through with determination (2009:129-159).

Finally, Murray was once jaded by the seeming lack of resources available for programs supporting women worldwide. To fill this void and place opportunity back in women’s hands,
she started the Global Fund for Women, which has since provided over 4,200 grants to individuals and groups around the world who are promoting the status of women (Global Fund for Women 2010).

The Last 10 Kilometers (L10K) project, started in 2007 and funded by the Bill & Melinda Gates Foundation, aims to involve communities in alleviating problems relating to maternal health in Ethiopia. Hibret Alemu, technical director at L10K, says the project was launched as a response to the federal Health Extension Worker (HEW) program started in 2003. HEW are government employees stationed at health posts in rural areas who travel throughout communities to educate villagers and encourage health-seeking behavior. While this program has great potential for connecting rural citizens to available health services, it has fallen short because Ethiopian citizens were not aware. To counter this, L10K started two initiatives based on the idea of community involvement: the Community Health Promoters (CHP) and Participatory Community Quality Improvement (PCQI).

CHPs are individuals selected *by the community* who act as a link between the community and the HEW. Each CHP represents about 25-30 households, is trained by the HEW, and communicates key health messages to families, focusing on those with pregnant mothers or young children. Most importantly, the CHP keeps track of pregnant mothers, helping ensure they get prenatal care, and discusses the possibility of giving birth at the health center rather than at home. They specifically aim to address the first two major delays in obtaining care during delivery: seeking care during labor, and reaching the health center during labor. While there have been notable improvements in the number of antenatal visits (40 to 68 percent over the course of two years), facility delivery increased more slowly from 6 percent in 2008 to 11 percent in 2010.
The PCQI program focuses on the next step after the CHPs have created demand for health services. People often do not find the services at the health centers very enticing—the midwives may not be gentle, the women are exposed and sharing a room with others during childbirth, or they may even be uncomfortable with the providers wearing latex gloves. Figure 4 shows a picture of the maternity ward in a health center in Debre Markos, Ethiopia. PCQI rallies the community to conceive of small changes that could make a big difference. In the pilot program there are two models: one where seed money was provided, and one where there was not. While changes have been seen under both scenarios, motivation does seem to be increased when there are allocated funds. Some enacted solutions include: coming up with an emergency transport plan for women in labor, repairing roads, or building a living room near the health center for the HEW so that he or she will be more likely to stay and help. While these initiatives are funded by outside sources, the ultimate goal is not to abrogate the role of federal health services, but to find ways to close the gap between the community and the government (personal interview, August 17, 2011).

Another strong example of utilizing community involvement to create lasting change is the work of Dr. Deogratias Niyizonkiza, founder of Village Health Works. He opened a clinic in his homeland, Burundi, to provide people with basic services and raise them back up after the country’s debilitating civil war ended in 2005. He “started from scratch” in a rural village where there was nothing, and found that community members were immediately willing to help. They built bricks while Dr. Niyizonkiza traveled, raising further funds. Two years later in 2007, the clinic opened, and many people came on the first day. Dr. Niyizonkiza noticed that of the people who sought care, “most of them are women who come in here, with their children.” After seeing
the changes created in the community when the clinic opened, Dr. Niyizonkiza concluded, “where there’s health, there’s hope” (2010).

One drawback to grassroots initiatives, however, is that it may be harder to expand small-scale success to a national level. Securing funds in early stages can prove challenging. It may also be difficult to specifically secure government funding until the program has proven to be effective. How do people convince funders and policy-makers (whether local, national, or outside) that their approach is valid and worthwhile without results? The need for evidence-based practices, while a good idea in terms of ensuring quality for large-scale interventions, can be an obstacle to the larger success of grassroots initiatives.

Meeting In The Middle: Combining The Grassroots and Top Down Approaches

Realistically, a blend of both approaches would likely be most comprehensive and effective. Such a combination would avoid the circular situation in which policy-making requires a strong evidence base, while larger-scale grassroots initiatives require funding from outside sources. In deciding how to approach problems, we can consider where taxpayers would commit their money: in the hands of community members who are privy to their problems, or in the hands of officials who mean well for the people they represent? It is unlikely that people would unanimously decide on one avenue. This hypothetical difference of opinion highlights the importance of having problems like high maternal mortality approached from a variety of angles, and of appreciating different methods of problem solving.

In 2003, the Ethiopian government launched a new initiative called the Health Extension Worker (HEW) program, aimed at bringing health resources to members of the rural population. HEW are stationed at health posts, and travel into villages and educate community members
about health seeking behavior. They refer patients to health centers, and provide very basic treatment. Importantly, they also keep track of pregnant women in the villages and encourage them to seek prenatal care and give birth in facilities. They also may accompany women who are in labor, as they are trained to identify warning signs of a dangerous delivery. HEW are intended to be a point of access to the health system for rural citizens (Bilal 2011:434,440; person interview with Hibret Alemu August). HEW are not only a way for rural people to access government services, but also a way to access the often hard-to-reach rural population. HEW can help ensure that fewer people “fall through the cracks,” never getting the care they need. The HEW program uses federal funding and organization to connect with people in remote areas. One shortcoming of the program was citizens’ unawareness of these improved health services, which was supplemented by the L10K program, a grassroots movement described previously.

In a way, Dr. Catherine Hamlin’s success is also an example of this dual approach. When she and her late husband learned more about the high prevalence of fistula in Ethiopia, they pushed the hospital administration to provide beds and allow them to perform reparative surgeries. She garnered support for her work from the Ethiopian government, becoming closely allied with Emperor Haile Selassie. As the Drs. Hamlin became determined to open a fistula-only hospital, they gained international recognition, and attracted important attention to the injustice of maternal morbidity manifested in the continued presence of obstetric fistula. Viewing this path to success in hindsight marks the necessity of doing small deeds to combat big problems, while pursuing loftier goals and aligning oneself with important decision-makers.

Dr. Catherine Hamlin also accomplished her goal to open a Hamlin College of Midwives in 2007, which graduated its first class in 2010. The College recruits girls from rural areas to come study in Addis Ababa free of cost for three years, and asks for a commitment from them to
work six years in their hometown after graduation. They are even encouraged to form alliances with traditional birth attendants, often considered by formally trained personnel to engage in dangerous practices. Such an approach promotes gradual change based on mutual respect rather than creating blatant conflict between different practitioners. The Ethiopian Department of Education approves the College’s curriculum, and monitors its progress. The College, in turn, helps increase the number of trained midwives working in rural areas on the frontline of the fight against continued maternal mortality and morbidity (personal interview with Dean of the College Jacqueline Bernhard, August 10, 2011). The institutionalized mechanism of ensuring improvements in rural population health is a good example of the “meeting in the middle” of the two directional approaches.

**Improved Women’s Health as the Way Forward**

One way to approach the necessary advancement of women’s health is by way of the economic argument. Former secretary general of the United Nations, Kofi Annan, has said that, “there is no tool more effective for development than the empowerment of women” (United Nations News Centre 2005). It is true, for example, that healthier women give birth to healthier babies. There has been increasing interest on the developmental origins of disease, or studying how conditions in the womb and during early childhood influence lifetime health (Paul 2010:172). Providing women with better pre-natal care and implementing maternal and child health programs, then, ensures a healthier future for entire communities. Women invest more readily in their families– USAID recognizes that “a woman multiplies the impact of an investment made in her future by extending benefits to the world around her, creating a better life for her family and building a strong community” (2012). Women are also generally more
Insightful in grasping the impact of services, such as having a functioning health center nearby (Niyizonkiza 2010). Individuals may also operate from this perspective. Yenaw Fentie, maternal health officer at the health center in Dejen, Ethiopia, explains how a reluctant husband can agree to provide care for his wife: when females are empowered, they are taught that they are equal with male partners. If a woman needs money for a referral or wants to give birth at the health center, she can discuss it with her partner. The husband may realize that if she does not receive care, she may die, also leaving him childless (personal interview, August 16, 2011).

Human rights advocate Anne Firth Murray condemns the economic argument, believing it to be outdated and not the ideal way to go about promoting women’s rights (2008:11). While the economic development perspective perhaps is not the most productive way to view problem-solving, such an approach will undoubtedly prove useful when pitching ideas for interventions to investors, or rallying support among certain stakeholders. Perhaps it is still useful for creating stir about the issue among parties who are not yet receptive to the human rights perspective, but can understand and relate to the economic perspective.

The economic benefits should be used as a (valid) outcome, however, rather than the primary motive for improving women’s health. Above all, incidence of obstetric fistula and maternal mortality are human rights issues. The mobilization for justice should be the driving force in a world with increasing socioeconomic and health disparities. We need to recalibrate our focus onto the absolute value of human life rather than trying to justify our economic or political arguments. The human rights perspective also provides a continued foundation for a discussion of women’s issues without it being problem focused. It is useful to examine fistula as a case study to explore the relationship between health and rights, but we need to expand the platform from there to remain focused on ideology rather than a single issue. Approaching women’s
health issues from a human rights perspective is highly valuable because it draws on the sentiment of “common humanity” (Murray 2008:15), potentially tying closer together an already economically globalized world with empathy as the currency. Fortunately, the option to create change and pursue equality in maternal health is a choice that can be made.
Conclusion

Maternal mortality and morbidity can be contextualized within the field of global health using an anthropological lens. When the social causes of childbirth injuries are examined, it becomes clear that the persistence of injuries like obstetric fistula can be seen as a consequence of systemic ills. Obstetric fistula is a debilitating physical disease with psychological manifestations that pushes affected women towards social peripheries. By viewing health as a human right, and reproductive health as a woman’s right, we can identify good health as the primary point of empowerment for women. Programs aimed at improving women’s health and increasing females’ agency over their own bodies are best implemented along a middle path between top down and grassroots approaches. Tapping into the sentiment of a “common humanity” offers hope for justice in health in the future, particularly in the current global health climate of the MDGs and Campaign to End Fistula.

Obstetric fistula is a mere case study for the equating of women’s health with women’s rights. The conclusions from this case study allow for a framework to address a variety of maternal health problems. In our globalized world, perhaps it is time for an emphasis on connectedness and unity to combat global health disparities in maternal healthcare access. Taking on global citizenship requires a sense of duty to the marginalized, which is made easier by the understanding that health is largely circumstantial; it is a result of social factors as much as biological disarrays. The time is ripe for addressing inequalities in healthcare and decreasing disparities in access to basic services such as emergency obstetric care.
Addendum: Reflections On My Background Research Trip in Ethiopia’s Amhara Region

Preparing for An Academic Adventure

I first learned about obstetric fistula when I was fourteen years old, from a documentary I watched with my mother called *A Walk to Beautiful* about Dr. Catherine Hamlin’s work treating women with this condition in Ethiopia. Like many people that I talk to about fistula today eight years later, I had not heard of this childbirth injury at the time. After admittedly forgetting about the issue for a few years, the documentary resurfaced in my mind during my freshman year of college and I had trouble getting it out of my head. As my interests in anthropology and medicine converged around women’s health issues, I began to see the incidence of obstetric fistula as a representation of everything that I thought was wrong with societies that do not consider maternal health a priority.

As I began to consider various ideas for my senior thesis, I realized that I could make the inkling of a dream to meet Dr. Hamlin and learn about her amazing work firsthand, which I had been harboring for so many years, come true. I managed to convince a few professors that it was of the utmost importance for me to go – fortunately, as experienced researchers reviewing my application, they saw what I would get out of this trip more than I realized at that time.

If we seek evidence of an intensely globalized and interconnected world, the planning of my Ethiopia trip would be the smoking gun. Despite not knowing anyone in Ethiopia, I managed to e-mail and call colleagues-of-friends-of-friends and lock down the details of a two-week long trip to the capital, Addis Ababa, and throughout the surrounding Amhara region. I would be visiting health centers in Debre Markos, Bahir Dar, and Dejen. I would also meet with people who work at IntraHealth International, Africa Humanitarian Action, L10K, a Hamlin fistula-affiliated clinic and rehabilitative camp, and Dr. Hamlin herself. I should write an ode to the internet.
Though I was thrilled to have put together my first mini foray into anthropological fieldwork, as the date of my departure approached, I became more and more anxious. I was travelling alone for the first time. As a young, white woman. Why was I being allowed to do this? Was this still a good idea? Whom could I turn to if I were to get into trouble there? Questions swirled through my awake and sleeping mind. My mother reminded me that the trip was only two weeks long, and to treat everything I saw as if it were some sort of large social experiment. The best advice I received, though, was from a doctor I had somehow found who had done work in Ethiopia herself. “Be bold, be brave!” she told me. Those words became my mantra in times of discouragement.

_Landing on Ethiopia’s Green Hills_

I arrived in Addis Ababa on a morning in mid-August during the end of the rainy season. I quickly became confused by the contradiction of lush greenery, incredible amounts of rainwater, and apparent lack of material wealth around me. In one moment I would be admiring the bright green hills and the next studying the precise way women would tie incredibly heavy loads onto their backs. A roll of cloth around the waist to cushion the load, and a string tied across the shoulders to steady the weight. Hands clasped behind their backs, digging in with mostly bare feet.

A journal entry reflected my preoccupation, “So beautiful! So much rain and fog and lush greenery, and mud… and people hard at work carrying the heaviest things on their backs.” When it started to rain, as it did often and heavily during that rainy season, people would be caught wherever they happened to be. Dirt roads would run into rivers, and paved ones seemed to slide off slopes, cracking from the eroded supports beneath them. I was surprised by how incongruent
the manmade edifices appeared, how weak they were, caught in this powerful force of nature. I also could not help watching the endlessly flowing water as a wasted resource, revealing how unused I was to this temporal natural abundance. On the other hand, the fields being tilled by wooden, ancient-looking farming “machinery” were depleted-looking and rocky. I witnessed deforestation—eucalyptus trees originally from Australia being piled like giant toothpicks between the hills. Such sights made me aware of the need for Wangari Maathai’s Green Belt Movement reforestation plan.

After visiting the Hamlin Fistula Hospital and Desta Mender (Village of Joy) rehabilitative community that day, I experienced my first real feeling of culture shock. I had feverish chills, no appetite, and no will to do anything but sleep in a mosquito-infested room that I had no actual desire to sleep in. But I felt guilty, and found my mind checking myself: what are you complaining about, being here in a solid building while there are so many people outside getting soaked by the rain and mud? I began to trivialize any of my own experiences in comparison to those of the people I had seen walking on the side of the road earlier that day.

The next day I suffered instead from distrust. My ride had been scheduled to pick me up at 7am, or 1am in Ethiopia time, since the sun as the signal of the day’s beginning had already been up for one hour. Over an hour later I sat at the hotel in a panic, thinking that since I had already paid for my travel I must have been ripped off and I would be stuck here with no way to continue with my plans. Finally, a small van pulled up with three passengers inside: the man who had picked me up at the airport the previous day, a driver, and a girl who looked about my age with skin lighter than any Ethiopian I had seen so far. She was introduced to me as Fasika, and I could not properly remember her name until I saw it written down. She handed me a cell phone that was to be mine for the next two weeks, and told me she was twenty-three years old and
studying computer science at Addis Ababa University. She would be my translator and guide during my stay. And so began our survey of health clinics in the Amhara region.

A Van With A View

My eyes remained fixed out the window during our first long drive. I watched the land pass me by, the endless bumpy paved roads turning into dirt ones, the people walking on the side of the road keeping goats in line with sticks greatly outnumbering any traveling vehicles. What did it mean for my first vantage point into the lives of Ethiopian people to be from a car window?

During the long drives, and at night in our bedroom, I would ask Fasika about things I had seen or learned during the day. I was also curious about her life, particularly since we were both students of the same age. Fortunately, she was very willing to provide me with as much information as possible and was an invaluable resource. Fasika and I talked about student life and especially about the differences between an American and an Ethiopian education. In Addis Ababa, boys and girls would never be allowed to live in the same building in university dormitories, let alone on the same floor. She said there is “too much harassment.” When I prompted, “they say things when you walk by?” She laughed and responded, “oh saying things? No, I wish that’s all they did,” and left it at that.

Fasika also told me about the different regions of Ethiopia. I was struck by the extreme differences between them. Fasika told me that the Amhara people fear someone from Oromo, for example, becoming president, because he or she could legally change the national language from Amharic to Oromo. She said that people outside of the Amhara region are reluctant to learn Amharic, because they do not consider it to be the national language but rather the language of
the Amhara people. Becoming aware of these distrustful feelings between ethnic groups made
me realize how complicated implementing nation-wide programs could be.

An Amateur Fieldworker’s Foray Into Interviewing

Once the first drive ended, I finally met maternal health officers, doctors, and a recovered
fistula patient. Each new person I met received me well. I found it difficult to explain what I was
doing there: I am a university student learning about women’s health in Ethiopia, became the
start of my standard introduction. Regardless, many people assumed I was working for USAID.

The first few people I met with told me about the federal HEW program launched in
2003, described previously. I was excited to hear about this relatively new project that brings
health services to Ethiopia’s most remote corners. The facilities that HEW refer patients to,
however, are still severely lacking. The health clinic in Dejen (a town less than 150 miles
northwest of Addis Ababa), for example, only had two beds to accommodate women in labor. I
was told that if more than two women arrived, they would have to wait their turn. I found this
scenario difficult to imagine, and began to understand why so many Ethiopian women prefer to
give birth at home rather than in a facility. Additionally, I learned that because of their close
contact with communities, HEW are often used as an avenue for a variety of different programs
by third parties who can provide necessary resources and training. While such use makes sense,
it may leave the HEW burdened by everyone else’s agendas.

At the IntraHealth International offices in Addis Ababa, I talked to Aynalem Yigzaw. He
told me about the Fistula Care project, started in 2006, that his office manages. The main
program goals are to educate the community on fistula prevention, screen for fistula, provide pre-
surgery rehabilitation, and support for reintegration post-treatment. I found Mr. Yigzaw’s
identification of challenges ahead particularly valuable. He mentioned the need to address misconceptions people have about the causes and treatment of obstetric fistula, including the belief that it is caused by a curse and cannot be cured if God dictated it. One of the weaknesses of the program is the exclusive focus on identifying fistula, which results in turning away women who are incontinent for other reasons such as uterine prolapse. This rejection may cause some women to have poor associations with seeking healthcare outside the home, and make them unlikely to approach healthcare providers in the future. Mr. Yigzaw also touched on the high turnover of staff at the health facilities, and the questionable sustainability of the program’s Pre-Repair Units (PRU). Finally, he identified lack of adequate transport as a significant barrier to accessing care for fistula patients. Transporting women from rural areas is not considered to be cost-effective.

In Debre Markos, a Prevention of Mother to Child Transmission (PMTCT) training session was coincidentally being held where I was staying. The training was for health sector workers, specifically nurses, midwives, or health officers, and is sponsored by USAID, John Snow International, The International Federation for Housing and Planning, and the Ministry of Health. I learned about WHO clinical staging of HIV, and how to use a partograph. The latter was particularly useful, as it was interesting to see this relatively simple tool that many advocate for use in identifying dangerous deliveries. I was able to sit in on two sessions, and at the end of the second, spoke with the workshop leader. He told me that there has been noticeable progress in terms of decreased refusal for HIV testing and providing more mothers with ARV prophylaxis during childbirth. The main problem, he told me, was the lack of antenatal care and care during delivery, not a lack of knowledge of the spread of HIV.
By chance, I was able to meet with Jamal Kassaw, Deputy Director of Programs at EngenderHealth Ethiopia. I saw a sign for the organization at the top of a mall complex, and decided to go see if I could find someone to talk to, “be bold, be brave!” ringing in my ears. The organization provides technical assistance to other parties, including the Ethiopian government. I was interested to learn that EngenderHealth has a few different programs aimed at involving men in discussions of gender-based violence and family planning. They know that decision-making usually lies with the man in many Ethiopian families. As a response, EngenderHealth has male discussion forums and promotes vasectomy, to involve males in family planning. They also support partners like Intrahealth International, who are the lead implementers of the fistula program in Ethiopia, as discussed above.

The program I most enjoyed learning about was the Last 10 Kilometers program, or L10K. Hibret Alemu, the Technical Director, described their programs to me in great detail, complete with data on progress since implementation in 2008. The program focuses on harnessing the power of community engagement to close the gap between the government and community members. By supporting links between community-elected volunteers and government HEW, there has been a significant increase in antenatal care, and slight improvement in number of facility deliveries. The program uses non-financial motives, like recognition, to encourage these volunteers. Mr. Alemu also observed that women who are elected as these Community Health Providers (CHP) take their job very seriously, which is encouraging for further improvements in linking women to healthcare during reproductive years.

I was impressed with how much the people I talked to are doing to improve the situation of women in their own country. It is easy to read UN reports of dismal statistics on maternal mortality ratios and childbirth injuries and become discouraged. It is better to go see who cares
enough about these numbers to work everyday to implement successful programs that help women have better access to care during pregnancy. There are a variety of groups equally invested, with new ideas and implementation practices. They are even addressing maternal health from various points, which is highly valuable and necessary to chip away at problems of access to emergency obstetric care. Each person I met with offered me new information and opened the door to more and more questions.

While the issues in maternal health can seem bottomless and I sometimes wondered how anything gets accomplished, I am bolstered by the creativity and drive I encountered. There are many ideas about how to get things done, and people are trying their best. Perhaps we can get somewhere after all.

*The Hamlin Approach*

I also learned more about the biology of fistula from the medical director at the Bahir Dar Hamlin Fistula Outreach Center. Dr. Bitew Abebe thoroughly explained what kinds of damage could occur during labor and the various surgical methods used in fistula repair. I learned about the dye tests done to assess leakage, the obstacles to successfully repairing a fistula, how the fistula’s location dictates treatment protocol, and about diversion surgeries. During destructive labor, not only could a fistula develop, but entire organs like the bladder could be significantly damaged as well. Dr. Abebe described how a bladder could shrink down to as small as 30 cubic centimeters.

His mini lecture on the medical management of obstetric fistula reminded me of the interconnectedness of the human body and how nothing exists in isolation from other parts. I did notice, however, that it was difficult to discuss the more social aspects of fistula with Dr. Abebe.
I suppose this is not entirely unexpected, since he is trained to approach problems from a highly medicalized point of view.

I still find it difficult to believe that I was able to speak with Dr. Catherine Hamlin in person. I had known her as a giant in humanitarian work for a few years and was shocked to finally find myself in her company, in Ethiopia of all places. Seeing her walk into the room to meet me was surreal— I stumbled over my praises of her work and my admiration for her commitment to the women who need her most. I expected her to be slightly aloof, jaded and tired from so much fundraising and advocacy work. I was nervous to be taking up her time. In extreme contrast to these unfounded expectations, Dr. Hamlin was attentive and generous. She spoke freely with me about her work, and treated me as if I were directly important to her cause. As someone who has been in Ethiopia for so long and has been able to observe long-term progress and changes, Dr. Hamlin is an incredible resource. She believes in teaching compassion in healthcare. Dr. Hamlin acknowledges that sometimes health center workers can be quite rude, and teaches her students of midwifery that even simple interventions, like holding someone’s hand during labor, can be extremely effective. At the end of our meeting, I gave Dr. Hamlin a small replica of Philadelphia’s famed Liberty Bell. I was kicking myself for bringing such a small token for this role model of mine, but handed it over anyway. Dr. Hamlin was surprisingly pleased, and asked me to open the box for her, which I did. She picked up the bell and gave it a ring, exclaiming something like, “it even makes a sound, how lovely!” I smiled, and told myself to try to emulate this ability to accommodate people and make them feel welcome and never insignificant.

Nearly as surreal as talking to Dr. Hamlin was interviewing a patient with a repaired fistula. I talked to the young woman, Kelemnesh, and her mother in the health center in Debre
Markos. She was quite petite, with a high, thin voice. I spoke with her through her mother (who was loquacious) and my translator. As I sat on the edge of her bed, a crowd of nurses and doctors began to gather around me. The other patients in the ward also listened in, observing this unusual sight of a foreigner talking to a young woman who had just given birth. Kelemnesh and her mother told me their story, starting with Kelemnesh’s first pregnancy at age 14.

She had labored for eight days before being carried by stretcher for one day and then travelling by car to arrive at this clinic. She went through a destructive delivery, leaving with a fistula and referral slip. She had to return to her village to collect money for her transport, because bus security would not let her on due to the smell from her leaking. Her relatives lent her money and grain to sell. Her mother insisted that Kelemnesh’s husband divorce her, because Kelemnesh was sick and unable to run a household for him. Kelemnesh said he was 40 years old– the mother laughed and said he was maybe 25. He did not want to leave her, and also gave some money for her transport to Addis Ababa for surgery. When she got to the hospital, she waited for 15 days for a free bed.

Her surgery went well, and Kelemnesh was able to return home, but not before receiving family planning counseling. She had asked the surgeons for a tubal ligation, but they suggested she wait six years to get pregnant instead. Kelemnesh took Depo shots for seven years. Upon missing one shot, she became pregnant, and came to the clinic before delivery as instructed by hospital staff. She had a cesarean section, got her tubes tied, and has a healthy baby boy– and she is my age.

She was very grateful for the services provided to her, and I am happy she is doing so well now and has a healthy baby. However, I am still saddened by her trauma and the fact that her options for reproduction are over because of her experiences. Talking with her really drove
home the point that health is largely circumstantial, and that anyone could have ended up like her had they been born in her situation. At the end of our conversation, Kelmness’s mother kept thanking the doctors, the nurses, and God for the health of her daughter. She even thanked me. I hurriedly corrected her, saying that I was just a student and I had not done anything. She insisted that she thanks the students, too. In that moment I vowed to do something in my life deserving of her gratitude.

Informal Encounters

Throughout my trip, my keen observation of my surroundings rarely wavered. While learning from people I met with, I continued to gaze out of the car window on drives and watch people I passed on the streets. I interacted with people in informal ways, experiencing snapshots of everyday life. These observations and experiences helped shape my perception of Ethiopia in a different way. I noticed that Ethiopians generally have soft handshakes, nothing like the strong American grips I am used to. I noticed I was taller than most women there. I studied the hand written records and data sheets posted inside the offices in clinics. I never stopped watching the women and girls carrying sacks of grain, full baskets, containers of water, bundles of sticks, anything and everything on their backs. All the accounts of girls having to perform hard labor at an early age were true– I imagined the nutrients in their bodies being put towards keeping them from getting weighed down instead of helping them grow tall.

I learned about the Ethiopian Orthodox church. I was turned away from visiting a church because I was Catholic. To me, this was confusing– why was I being discouraged from learning about this religion when I was so interested? I gathered that strict compliance is more important than teaching outsiders about the Orthodox religion. But then I met a group of roughly seven
year-old girls in the yard of a different church. One girl shyly approached me, and soon enough a small crowd of children had gathered, asking me questions and stroking my hair and the skin on my arms. They asked me if I was white because Mary came down to kiss me. They asked if they would look like me if they came to my country. They showed me a tattered picture of Jesus. I looked down at the white man on the paper in my hands. No wonder, I thought to myself.

The last time I had been told I was not permitted to wear a specific garment was when I had to wear a school uniform in high school. I was told that I was not allowed to wear pants to visit a church. For the first time, I felt the need to blend in. I took to walking around Addis Ababa with a headscarf on, tired of hearing the shouted *faranj*! (white person) that followed me down the streets.

*A Researcher With Two Left Feet*

As this was my first fieldwork experience, and first time interviewing people abroad, I had many questions crop up regarding the ethics of my research, of my photography, of questioning people for what? Just for my senior thesis. Would that be a valid enough motive for people to give up their time to speak with me? Without substantial professional backing, I was anxious about how comfortable I could feel playing my first role as a researcher abroad. On the plane ride over, I approached the interview process with excitement, writing, “I am going to meet a variety of people, and will surely learn at least something from all of them. How could I not?” I now recognize that this is a valuable frame of mind: to want to learn and absorb, rather than project or judge. I also reminded myself early on to learn to manage the “ups and downs” of doing research in a new place.
Traveling with a translator also made me notice patterns of linguistic accommodation of the researcher. In Dejen, for example, the maternal health officer insisted upon speaking in English, though he did not have an expansive vocabulary that covered his field of work. When he fumbled for words, I suggested that we could use the translator, greedy for a more eloquent picture. In retrospect, it seems to me that using English may have been a point of pride for the health officer I spoke with. The leader of the PMTCT course also began instructing the class in English. Once my translator and I realized what he was doing, we insisted that he continue the course in Amharic. I was surprised by how many people were willing to speak to me in my own language and accommodate my limitations. Even on the street, I smiled as people shouted the one or two words they knew in English at me, assuming by the color of my skin that English was precisely the language I would understand: Hi! Welcome! I love you! My name is! I admired people’s forwardness when they happened upon me—after all, I was the sheepish one who came here without bothering to learn more Amharic before my arrival.

Being in the role of researcher for such a short time also kept me at a distance from understanding how women live everyday in the towns I visited. Focusing on a single problem or disease, and moving from place to place, does not allow for an experience of the conditions that make women vulnerable to what I was studying: fistula. I understood the theoretical *why*, but not the literal *how*. While a survey trip like mine could not provide such answers, the value of fieldwork lies in primary documentation and attaining a level of situational understanding.

*The Befuddlement of Departure*

My time in Ethiopia was one of learning, observing, seeing, reading, writing, and coming to my own conclusions in a concentrated exploratory process. I tried to push myself to challenge
my assumptions as I shaped my views and built my argument for this paper. At times they were simple realizations that have formed the backbone of my current outlook on women’s health, “I just think it’s unfair,” I wrote. “If I were born here, I would be in the exact same predicament, I would be in the same hopeless situation… The lack of the individual’s responsibility (control?) for his or her own initial circumstances is remarkable, and that arbitrariness is what dictates unfairness.” Some claims, though, were more grandiose: “this should be stopped out of human sympathy for human life and the value of that life.”

Associate Professor of Anthropology and Director of the Institute of Gender Studies, Hirut Terefe, forced me to question my understandings of agency. She brought to my attention that women do not have agency unless they have the backing to demand certain rights. If women do not see obstetric care as a right, they will not have the agency to require it.

I also continued the debate in my head on my opinion of foreign aid, and its helpfulness or harmfulness. I was often caught between admiration for the work done with donor money and the thought that this was pulling responsibility away from the federal government. The Hamlin College of Midwifery, on the other hand, complies with Department of Education requirements while being funded from the outside. The dean of the College, Jacqueline Bernhard, says they “aim for sustainability,” by having only two non-national permanent staff members. The midwives trained there are undoubtedly helpful to the communities in which they practice.

Overall, I left Ethiopia more confused than I had been upon my arrival. I think about how the center in Bahir Dar used to have a backlog of patients and now is catching up so that a woman has to wait less than a year to get fistula repair surgery. Does this shift mean that attention can move towards prevention rather than treatment? Hearing Dr. Catherine Hamlin herself admit that she feels badly sometimes for simply sewing these women up was certainly
disarming. She then observed that maybe it was the Ministry’s fault, for not paying the doctors more to retain them. Finally, why was it so difficult to find out about problems with reintegration after treatment? What kinds of things are offered in Desta Mender and no other place that make women so unwilling to leave? I try to use these questions that tumble around my mind as I continue to learn as motivation, rather than allow them to discourage me. Questions, after all, are the basis of research and my (so far academic) pursuit of justice in health.
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Table 1: Comparing adolescent fertility rate, percent of births in presence of skilled attendant, and maternal mortality ratio between countries in sub-Saharan Africa. Note: Only countries for which all three statistics was available were included. Data used is from 2001-2006. Source: WHO Core Health Indicators, World health statistics 2008

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<th>Country</th>
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<th>Percent of Births In Presence of Skilled Attendant</th>
<th>Maternal Mortality Ratio</th>
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<td>880</td>
</tr>
</tbody>
</table>

Source: World Health Organization. Core Health Indicators. World health statistics 2008. [Has recently been combined with the WHO Statistical Information System http://www.who.int/whosis/].
Figures

Figure 1: Biological and social causes and outcomes of obstetric fistula

- **Biological**
  - Poverty
  - Malnutrition
  - Prolonged obstructed labor
  - Underdeveloped pelvis
  - Nerve damage
  - Infection
  - Depression
  - Chronic incontinence

- **Social**
  - Lack of access to emergency obstetric care
  - Early marriage
  - Expectation to bear pain at home
  - Economic hardship
  - Abandonment
  - Social isolation
Figure 2: Hand-drawn poster of the Millennium Development Goals hanging in the Dejen Health Center, Dejen, Ethiopia. Photograph taken on August 16, 2011.
Figure 3: Desta Mender (Village of Joy), a rehabilitative community for patients treated at the Hamlin Fistula Hospital, outside of Addis Ababa, Ethiopia. Photograph taken on August 10, 2011 by the author.
Figure 4: The maternity ward in Debre Markos health center, Debre Markos, Ethiopia. Photograph taken on August 16, 2011 by the author.