

B2641

**SOCIAL PROBLEMS OF WOMEN WITH
OBSTETRIC FISTULA IN ETHIOPIA: THE
CASE OF WOMEN TAKING TREATMENT
AT ADDIS ABABA FISTULA HOSPITAL**

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE
STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF ARTS IN DEVELOPMENT
STUDIES (ENVIRONMENT AND DEVELOPMENT)

By- Ruth Ayallew Yimer

Advisor- Ato Yigremew Adal

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF DEVELOPMENT RESEARCH

JULY 2007
ADDIS ABABA

B2641

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF DEVELOPMENT
RESEARCH (IDR)**

Title
**Social Problems of Women with Obstetric Fistula in Ethiopia: The
case of Women Taking Medical Treatment at Addis Ababa Fistula
Hospital.**

BY
Ruth Ayallew Yimer

DEVELOPMENT STUDIES

26256

APPROVED BY THE BOARD OF EXAMINERS:

Dr. Mulugeta Feseha
Institute of Development Research
Director

SIGNATURE

FACULTY CHAIRMAN
Yizremew Addal

[Signature]

ADVISOR
Mulumebet Zenebe

[Signature]

EXTERNAL EXAMINER
Cebachew Yoreph

[Signature]

INTERNAL EXAMINAR

[Signature]

Acknowledgments

First of all, I would like to thank God for without Him, none of this would have come true.

My earnest gratitude shall then go to my advisor Ato Yigremew Adal whose comments and invaluable advice contributed tremendously towards the successful completion of this thesis. Without his constant support and consideration, this thesis would have not been a success.

My special thanks go to the women taking treatment at Addis Ababa Fistula Hospital, the doctors, nurses, other staffs of the hospital, government bodies and non-government bodies for taking their time and providing me with the required information.

I fall short of words to properly thank my husband Yohannes Abera who stood on my side, made all the possible means in arranging the time and shouldering the responsibility of taking care of our daughter and all work in the house throughout my postgraduate studies.

Also deserving my deepest gratitude are my beloved parents, relatives, friends and colleagues for their encouragement and all rounded support. Especially, I would like to forward my heartfelt appreciation to Ato Mesfin Lemma, W/ro Fitawek Abebe, Ato Abenet Abera, W/t Lemlem Abera and W/t Mihret Abera for their unreserved support whenever I needed them.

Last but not least, I would like to thank the Addis Ababa University (School of Graduate Studies) for funding this thesis.

Table of Contents

	Page
Acknowledgements.....	I
Table of contents.....	II
List of tables.....	IV
List of figures.....	V
List of boxes.....	V
Acronyms.....	V
Abstract.....	VI

Chapter One

1. Introduction

1.1 Background of the Study -----	1
1.2. Statement of the Problem -----	3
1.3. Objectives of the Study -----	4
1.4. Significance of the Study -----	5
1.5. Limitation of the Study -----	6
1.6 Organization of the Study-----	7

Chapter Two

2. Methodology

2.1 Description of Addis Ababa Fistula Hospital-----	8
2.2 Data Collection -----	10
2.3 Data Analysis -----	11
2.4 Characteristics of the Respondents -----	11

Chapter Three

3. Literature Review

3.1 What is Obstetric Fistula? -----	13
3.2 Causes of Obstetric Fistula -----	14
3.3 Prevalence of Obstetric Fistula -----	19
3.4 Obstetric Fistula in Ethiopia -----	22
3.5 Social Problems Associated with Obstetric Fistula -----	24
3.5.1 Poverty -----	25
3.5.2 Separation and Problems in Family Life -----	26
3.5.3 Stigmatization and Isolation -----	27

Chapter Four

4. Findings

4.1 Occurrence of the Fistula Problem -----	32
4.2 Social Problems the Women Faced -----	36
4.2.1 Poverty -----	36
4.2.2 Separation and Problems in Family Life-----	38
4.2.3 Stigmatization, Isolation and Loss of Social Support -----	45
4.3 Problems faced when Deciding to get Treatment and Future Plan-- --	51
4.4 Findings from Concerned Officials -----	55
4.4.1 Addis Ababa Fistula Hospital -----	55
4.4.2 Women for Women Foundation -----	59
4.4.4 Federal Ministry of Health -----	60

Chapter Five

5. Summary and Conclusion

5.1 Summary -----	65
5.2 Conclusion -----	67

Bibliography -----	70
---------------------------	----

Annex

List of Tables

	Page
Table 1: Frequency and Percentage Distribution of Informants by their Region -----	12
Table 2: Frequency and Percentage Distribution of Informants by their Age -----	12
Table 3: Prevalence of Obstetric Fistula in Ethiopia -----	23
Table 4: Time the Women went to Clinic after Labor Started -----	32
Table 5: Reason for not going to Clinic as soon as Labor Started -----	33
Table 6: Respondents' Reaction to their Condition -----	33
Table 7: Number of Years without Treatment after Fistula Occurred -----	34
Table 8: knowledge of Why Fistula Occurs and knowledge about someone with Fistula in their Area -----	35
Table 9: Frequency and Percentage Distribution of Informants by their Educational Qualification -----	37
Table 10: Frequency and Percentage Distribution of Informants by Source of Income before and after Onset of the Problem -----	37
Table 11: Delivery at which the Fistula Occurred -----	39
Table 12: Frequency and Percentage Distribution of Informants by Marital Status before and after Onset of the Problem -----	39
Table 13: Husbands' Response when they knew about the Problem -----	40
Table 14: Frequency and Percentage Distribution of Informants by Number of Living Children who were Separated after Onset of the Problem -----	41
Table 15: Frequency and Percentage Distribution of Informants by Number of Living Children who were Married after Onset of the Problem -----	41
Table 16: Informants' Attitude why their Marriage Ended -----	42
Table 17: Women's Parents' and Relatives' Response after Onset of the Problem -----	46

Table 18: Husbands' Parents' and Relatives' Response after Onset of the Problem -----	46
Table 19: Frequency and Percentage Distribution of Informants on Society's Perception about Fistula -----	49
Table 20: Informants' Response about the Type of Stigmatization they encountered -----	51
Table 21: Reason for not Seeking Treatment after the Fistula Occurred ---	52
Table 22: How they knew the Problem could be treated at Addis Ababa Fistula Hospital -----	53
Table 23: Women's' Response about their Future Plan -----	53

List of Figures

Figure 1: The obstetric fistula pathway: Origins and consequences -----	16
Figure 2: Countries from which obstetric vesico-vaginal fistulas have been reported -----	21

List of Boxes

Box 1: -----	36
Box 2: -----	44
Box 3: -----	50

Acronyms

AIDS	-	Acquired Immuno-Deficiency Syndrome
CSA	-	Central Statistical Agency
FMOH	-	Federal Ministry of Health
HSDP	-	Health Sector Development Program
ICRW	-	International Center for Research on Women
NGO	-	Non Governmental Organization
RVF	-	Recto Vaginal Fistula
UNFPA	-	United Nations Population Fund
VVF	-	Vesico Vaginal Fistula
WHO	-	World Health Organization

Abstract

The purpose of this study was to examine the social problems of women with obstetric fistula in Ethiopia, with particular emphasis on women taking treatment at Addis Ababa Fistula Hospital. This purpose necessitated to assess what social problems the women face, the causes for the social problems, the life experience and social relations the women have had since the problem occurred and what changes they expect in their lives after getting the treatment.

To this end, qualitative research method supported by quantitative method was employed. In-depth interview, secondary documents and observation were used to collect data. Thirty seven women who were taking treatment at Addis Ababa Fistula Hospital were purposely picked with the criteria: willingness to take part in the interview, cause of the fistula formation, that is, women with fistula as a result of obstructed labor and number of years without getting treatment, in this case, women who had the problem for one and above years without getting treatment .

The result of the study revealed that consequent to the occurrence of obstetric fistula, the women face different kinds of social problems. They become separated from their husbands; become economic dependents on family or friends; are exposed to verbal and physical harassments; isolate themselves from any kind of social activity and do not expect to lead a normal life again even after they are being cured. The major cause of their social problems, among other things, is lack of awareness in the society about the problem and the desire to have children. The result also revealed that there are no adequate numbers of organizations or centers to help alleviate the social problems of these women. On top of all these, despite effort by the government to expand health centers for women to get immediate maternity care during pregnancy and childbirth, the extent of the current need entail that it cannot be satisfied in a short period of time.

Chapter One: Introduction

1.1 Background of the Study

Health problem is one major problem in developing countries. Ethiopia is not an exception to this fact. Ethiopia's health problems are mostly linked to deficiency in proper nutrition and preventable diseases. Although both men and women suffer from lack of access to resources, inadequate health services, unemployment and many other problems as a result of poverty, women are the most severely affected because they have a lower social status than men due to unequal relationship between men and women in the political, social and economic arenas.

Women are more vulnerable to many health problems associated with early marriage, repeated childbirth, rape, abduction, harmful practices and violence against women. And many health problems are unique to women consequent to their role in child bearing and rearing.

One common women's health problem in developing countries is obstetric fistula. Obstetric fistula plagues thousands of women throughout the developing world but is eradicated in Western Countries at the end of the 19th century when cesarean section became available.

The scope of the obstetric fistula problem in the developing world is largely unknown because the areas where the problem is endemic tend to be hidden behind geographic, political, and cultural barriers that make population surveys difficult or impossible to perform with

any accuracy. However, maternal morbidity from obstructed labor parallels the trends in maternal mortality (Arrowsmith et al, 1996).

According to WHO estimate, obstetric fistula occurs at a rate of 350 fistulas per 100,000 deliveries in developing world. Fistula problem in Ethiopia is also very significant. WHO, estimates that about 150,000 women in Ethiopia have the condition.

Fistulas may be caused due to obstructed labor, pelvic surgery, sexual abuse before reaching physical maturity, malignancy, radiotherapy or a combination of these. But the main cause of fistula in developing world is obstetric fistula. In most third world countries, over 90% of fistulas are of obstetric aetiology (Hilton, 2001). Studies conducted at Addis Ababa Fistula Hospital also reveal that around 96% of the cause of fistula is obstructed labor.

Women who develop fistula are unable to control urine and/or feces and are exposed to other related complications. In addition to their physical injuries, they suffer from social problems. They are abandoned by their husbands, rejected by their communities, suffer from worsening poverty and malnutrition and are forced to lead an isolated life.

On the brighter side of this, the Addis Ababa Fistula Hospital, dedicated exclusively to fistula repair, treats around 1,200 women annually to repair fistulas, free of charge. This figure only represents the number of women who came to Addis Ababa Fistula Hospital to take treatment. The number is estimated to be much higher because it is likely that there are also women who are suffering at their homes without seeking treatment due to various reasons.

This study tries to shed light on the social problems of women with obstetric fistula found at Addis Ababa Fistula Hospital.

1.2. Statement of the Problem

Ethiopia is one of the most underdeveloped countries in the world. Ethiopia is consistently positioned to the bottom of the annual UNDP Human Development Index. The Ethiopian population is impoverished and most of the people lead subsistence living. Most of its people have inadequate healthcare, education and infrastructure. One of the many factors that contribute to its underdevelopment is health problems with a number of causes.

Women's health is one of the major health issues in Ethiopia. Women suffer from health problems and associated social problems that could have been avoided had it not been for insufficient medical services, lack of transport networks, poverty and lack of education. As a result, future life of significant numbers of young women is being ruined, families are fallen apart and the country is losing productive forces due to a problem that could have not occurred.

Women with obstetric fistula suffer from social problems in addition to the physical injury. The social problems include, divorce, abandonment, exclusion from social activities, separation from their families, worsening poverty and unendurable suffering. Because of the offensive odor consequent to the formation of fistula and because the problem is viewed as incurable in traditional local cultures, these women are usually divorced or abandoned by their husbands and are often cast out by their families.

The psycho-social circumstances in which these women find themselves as a result of having sustained obstetric fistula can be even more devastating than the physical injuries themselves (Wall, 2002). Dr. Reginald Hamlin, one of the founders of Addis Ababa Fistula Hospital, describes the horrible situation of women with obstetric fistula by saying,

A fistula victim has nothing in this world. She has lost everything apart from faith and hope and urine soaked clothes. The lepers can marry and they can work inside. The blind can even become lecturers at the university and marry, but not the fistula victims. They have nothing left in this world.

Despite the severity of social problems faced by women with obstetric fistula, detailed investigation for the understanding of the social impact of this problem and how to deal with it seems to be limited. And the problem seems to have received less attention than it deserves, from a social standpoint.

1.3. Objectives of the Study

General Objective

The general objective of the study is to assess the social problems of women with obstetric fistula in Ethiopia, with particular reference to women taking treatment at Addis Ababa Fistula Hospital.

Specific Objectives

The specific objectives of the study are:

1. To assess the diversity of social problems women with obstetric fistula face,
2. To explore the possible causes of the social problems,

3. To assess the life experience and social relations these women have since the occurrence of the health problem,
4. To assess problems they have faced when deciding to come to Addis Ababa Fistula Hospital,
5. To assess what changes they expect in their lives after taking the treatment, and
6. To investigate what has been done by the government and other concerned organs to ameliorate the problem.

1.4. Significance of the Study

Health problems and associated social problems are one group of factors that hinder development. Obstetric fistula is a problem of under-development (Arrowsmith et al, 2001). It is also known that solving a single problem has a ripple effect. For example, if the social problems of women with obstetric fistula are improved, without a doubt they would be able to support themselves, their family and contribute towards the development of their country.

According to preliminary information gathered from the Addis Ababa Fistula hospital and an observation made at the hospital, many young girls and women are suffering from both physical and social problems and the number of women who are affected by obstetric fistula has been increasing from year to year. The fact that these young girls and women are suffering from a problem that could have been avoided makes the problem worth giving attention. Many researches are undertaken regarding features and obstetric experience of fistula patients with particular attention to the physical injuries. However, it seems rare to find detailed and comparative study which assesses the social problems of women with obstetric fistula in Ethiopia.

This study contributes to knowledge by focusing on the social problems of women suffering from obstetric fistula. It will also provide baseline information to policy makers and health care providers in Ethiopia. The study may encourage other researchers to undertake thorough research on the subject and broaden our understanding of the problem. The research findings could also be used as a reference for other studies that could be conducted in the future.

1.5. Limitation of the Study

Some factors have impeded the research undertaking beginning from data collection to analysis that came out to influence the quality of the research. The data were collected from thirty seven women who were taking treatment at the hospital. Hence, the researcher cannot generalize the findings to the entire country's social problems women with obstetric fistula face. Although the sample was drawn from the whole women taking treatment during the data collection period, study participants do not necessarily represent different ethnic and cultural groups. For example, the women were mostly from Oromiya and Amhara regions. Thus, the researcher was unable to identify possible ethnic and regional variations in women's social problems.

The translation of interviews from Oromifa and Amharic to English was challenging in that some expressions in Oromifa and Amharic are not directly translatable, so the researcher had to look for equivalents. Some respondents felt afraid to talk about their problems and few got so emotional while talking about their problems that they could not express their feelings properly.

1.6. Organization of the Study

The study is organized into five chapters. The first chapter deals with the introduction. The second chapter discusses the methodology applied in the study. The third chapter is for literature review. The fourth part discusses the findings followed by summary and conclusion, which is the last part of the study.

Chapter Two: Methodology

2.1 Description of Addis Ababa Fistula Hospital

The study area is Addis Ababa Fistula Hospital, which is the only hospital in the world dedicated to treatment of women with fistula. In 1959, Dr. Hamlin and her late husband, Reginald, both Gynecologists and Obstetricians, came to Ethiopia to work and to found a school for midwives at the "Princess Tsehai Memorial Hospital". In their work, they found large number of women suffering from childbirth injuries and they quickly became aware of the suffering endured by women with fistulas. Before the doctors came to Addis Ababa, there was no treatment available for fistula victims in Ethiopia (Fistula Foundation, 2004). Reginald and Catherine quickly began to learn everything they could about obstetric fistula. They perfected a surgical technique to mend the injuries, while continuing to treat other obstetric cases.

They started to operate these women in the hospital but there were no enough beds available for the women and the women had no money to pay for their treatment. Because of these problems, the doctors decided to open the Addis Ababa Fistula Hospital. They worked for more than a decade to establish a fistula hospital, even through a period of a military coup when most foreigners fled Ethiopia. Finally, the hospital was opened in 1974.

According to the Hospital, the stated goal of the hospital is "To provide services for those suffering from childbirth and related injuries, and rehabilitate them to the point where they can be integrated back into their society with dignity and a sense of self-worth". Since its operation, the Drs. Hamlin and a team of doctors have cured

thousand of girls suffering from fistulas and given specialized care free of charge. For this incredible work, Dr. Hamlin was nominated in 1999 for the Nobel Peace Prize. Dr. Catherine Hamlin has spent nearly 50 years of her career providing free reconstructive surgery to thousands of young girls and women suffering from fistula caused during difficult childbirths.

The hospital has a large 60 bedded ward and a small 12 bedded ward. The hospital can perform 1,500 surgeries annually to repair fistulas. Operations are on Mondays, Wednesdays and Fridays, with the other days used for sterilisation of theatre and equipment. Fistula Hospital's resident doctors, including co-founder Dr. Catherine Hamlin, are widely considered the world's premier fistula surgeons and enjoy a success rate of greater than 90%. The hospital's unique corps of nurses are also credited with the high success rate at Fistula Hospital.

In 2000, the hospital requested the Ethiopian Government and eventually received a grant of approximately 60 acres of land located eight miles from the hospital. There the hospital built Desta Mender, a village of ten cottages and two common buildings for women who could not return back to their homes because they require continuous medical treatment. Desta Mender was officially opened on 21 January 2003. Currently there are 54 long term patients at Desta Mender.

In close cooperation with the regional health centers, Addis Ababa Fistula Hospital has opened and is in the process of opening five new outreach centers in Mekele, Bahir Dar, Yirgalem, Mettu and Harrar for the treatment of fistula without the need for these women to make a long journey to Addis Ababa. It also has a medical team that travels

throughout rural Ethiopia and operate a medical facility for women with fistulas.

With support from nonprofit foundations and private donors, the hospital has grown into an internationally recognized center for fistula research and has trained doctors from 28 countries to perform the surgery.

2.2 Data Collection

Both primary and secondary data were used in this study. Primary data were collected through structured and semi-structured interviews and personal observation. Secondary data were collected from various documents found in the hospital, books, journals and websites.

During the data collection period, there were 185 patients in the hospital under treatment. Therefore, the sampling frame was the total number of patients found during the data collection period. Taking into consideration the time it may take for the interview and limited convenient time when the women are free from medical examination, 20% of the women were assumed to provide sufficient sample size and allow adequate representation of the women. The required sample (20% of 185 of the women) was purposely selected. The selection criteria were: willingness of the women to participate in the interview, women with fistula as a result of obstructed labor and number of years they spent without getting treatment after the fistula occurred, in this case, women who had the problem without getting treatment for one and above years were selected.

The interview questions were designed keeping in mind the research objective and ethical issues. The questions were designed in such a way that will address the research questions properly and respect the privacy of the respondents. The interview questions were pre-tested. The respondents' informed consent was sought first and they were briefed about the purpose of the study and the confidentiality of their responses.

In-depth interviews were conducted with the selected thirty seven women at the hospital; structured interviews were conducted with senior nurses at the hospital who were willing and had the time; Project Manager and senior nurse of Desta Mender; concerned official from Women for Women Foundation identified to have programs related to the problem and Planning and Program Department- Health Information Processing and Documentation Team Leader from the Ministry of Health. Notes were taken during the interview.

2.3 Data Analysis

Quantitative data collected through interview, from different statistical reports and documents were analyzed using descriptive statistics. Content analysis was applied in analyzing the information collected from interview, observation, and secondary documents.

2.4 Characteristics of the Respondents

Respondents from the hospital were composed of various ethnic groups coming from different parts of the country. Although it was hard to get the exact ethnic and regional composition, it was learnt from the hospital that above 90% of the women in the hospital come

from Oromia region following from Amhara region. Very little number of women come from other parts of the country. As far as the regional composition of the women interviewed is concerned, the Oromia represent 64.86%, the Amhara 27.03% and Somali 8.11%. The number of women and the regions they came from is summarized in Table1.

Table1: Frequency and Percentage Distribution of Informants by their Region

Region	No.	Percentage
Amhara	10	27.03%
Oromiya	24	64.86%
Somali	3	8.11%
Total	37	100

Regarding the age of informants, the majority of the women are under the age category of “16 -20”. The least percentage goes to age category of “26- 30” as depicted in Table 2. This shows that women under the age of 16-20 are more vulnerable to the problem.

Table 2: Frequency and Percentage Distribution of Informants by their Age

Age of Respondents	Total	
	Frequency	%
15	3	8.11
16 – 20	15	40.54
21 – 25	9	24.32
26 – 30	2	5.40
31 – 40	4	10.81
41 – 60	4	10.81
Total	37	100

Chapter Three: Literature Review

3.1 What is Obstetric Fistula?

Fistulas are holes that develop in the tissue that separates the vagina from the bladder and/or rectum (Arrowsmith et al, 2001).

While most fistula cases in developing countries stem from obstetric causes, others result from direct trauma caused by rape or other sexual abuse. At Addis Ababa Fistula Hospital, for example, 91 of 7,200 cases over a six-year period, or about 1.2%, were caused by rape or other sexual abuse. In some areas, harmful traditional practices like female genital cutting also add, either directly or indirectly to the risk of fistula. This practice can directly injure the bladder or urethra and may explain as many as 15% of fistula cases in northern Nigeria (UNFPA, 2004). Whereas, fistulas in the developed world is as a result of pelvic surgery, malignancy, radiotherapy, surgical complication or a combination of these (Wall 1995, Kelly, 1998).

Obstetric fistula is a defect that forms in the vaginal wall communicating with the bladder (vesico-vaginal fistula) or the rectum (recto-vaginal fistula), or both, as a result of obstructed labor beyond the reach of medical help (Mulu, 2004). Labor is considered obstructed when the presenting part of the fetus cannot progress into the birth canal, despite strong uterine contraction (Kelly, 1998).

It occurs when a teenage girl cannot deliver a baby because it is too big for her pelvis. Wall (1995) describes the occurrence as follows:

The fetal head is pushed down hard into the pelvis and impacts against the soft tissues of the pelvis floor, often pinning the bladder base and urethra against the pubic bone. This constant pressure can be exerted for several days without getting competent obstetrical care. Prolonged pressure of this kind cut off the blood supply to the soft tissues in the pelvis, leading to severe internal injuries, and in most cases, the fetus dies. Several days later the dead tissue falls away, creating a massive hole between the bladder and the vagina leading to constant loss of urine. Not infrequently, a similar fistula also develops between the rectum and the vagina, leading to constant loss of stool from the bowl.

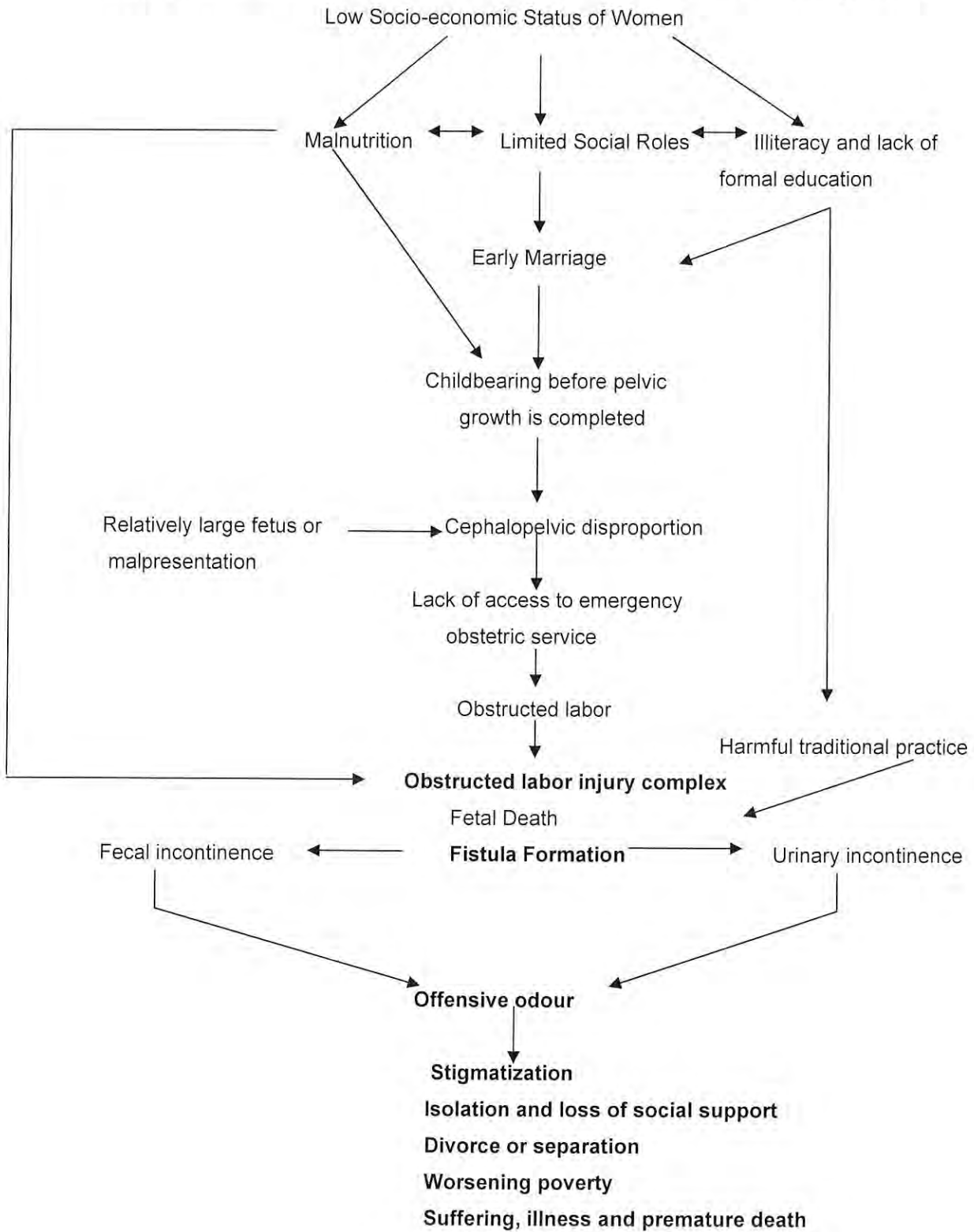
In addition to permanent incontinence of urine or feces or both, women with obstetric fistula may suffer from infections and sores due to the incontinence, as well as nerve damage due to the prolonged labour, resulting in foot drop, a condition where patients walk with a serious limp, dragging one foot and using a stick for support (Hilton, 2001).

3.2 Causes of Obstetric Fistula

WHO reckons that poverty, malnutrition, hard physical work, no education, too few health centers, long distances, no transportation, early marriage, circumcision of young girls and discrimination of women are all factors that have something to do with obstetric fistulas. UNFPA's report on recent needs assessments completed in 21 countries underscored the fact that marginalization due to gender and socio-economic inequality lies at the root of the condition. The assessments found that poor, young, illiterate women from remote areas are disproportionately affected more by obstetric fistula.

The assessment also forwarded examples from some African countries such as Ethiopia, where early marriage is common; Mali, where 85% of women in rural areas live at least 30 kilometers away from the nearest hospital; Kenya where women are required to obtain permission from husbands or other relatives before seeking care, thus delaying their ability to access emergency obstetric care; Uganda where 60% of women deliver at home, partly as a result of cultural beliefs dictating that women should prove their fidelity and womanhood by delivering at home and notable gaps in access to information and services to both prevent and treat the condition in most parts of the countries under consideration. Figure 1 depicts origins and consequences of obstetric fistula.

Figure 1: The obstetric fistula pathway: Origins and consequences



Source: Worldwide Fistula Fund, 2004

Rahmat (2001) classifies the causes of obstetric fistula as direct and indirect. The *direct* cause is unrelieved obstructed labor. He explains that in situations where there are health facilities and where pregnancy has been monitored during the course of at least six months before the onset of labor, the likelihood of obstructed labor is minimized. Other direct causes of obstetric fistula include accidental surgical injury related to pregnancy, and crude attempts at induced abortion. The *indirect* causes of obstetric fistula are multiple and affect poor, uneducated and young women living in rural areas. The *indirect* causes are:

A. Poverty and Gender Discrimination- result in under- nourishment and poor physical development, particularly of girls. In most communities girls marry at an early age and get pregnant before the pelvis is fully developed. This increases the risk of obstructed labor and ultimately obstetric fistula or maternal death.

B. Lack of Education- results in poor intake of antenatal services and where the services are available, girls are unaware of the importance of utilizing the service. Lack of education coupled with low status of young wives, these women are likely to be stopped from uptake of antenatal care by their own timidity, or by their husbands, their family, their community or even the traditional birth attendants. In this case, high-risk pregnancies are not identified in time.

C. Culture and Tradition- high percentage of rural childbirth takes place at home due to culture or traditions. Problems occur when complications arise and there is an absence of attendants qualified to identify complications and seek medical help in time.

D. Access to Service- many women in rural areas do not have access to medical services due to poor availability of primary health care, lack of obstetric care, physical isolation or lack of transport. Thousands of women die from complications of pregnancy and childbirth in developing world.

In a similar way, WHO puts pervasive poverty to be a root cause of obstetric fistula while emphasizing the fact that the immediate causes are obstructed labor and lack of prompt access to emergency obstetric care. WHO also reckons that women who suffer from obstetric fistula tend to be impoverished; traditional practice of early marriage contributes to a risk of obstructed labor and fistula. Example mentioned is in parts of Sub-Saharan Africa and South Asia, where obstetric fistula is most common, women often marry as young as ten years of age and become pregnant immediately thereafter, before their pelvises are fully developed for childbearing. In a similar token, in Ethiopia and Nigeria, over 25% of fistula patients become pregnant before the age of 15, and over 50% had become pregnant before the age of 18.

In addition, WHO illustrates that the low status of women, particularly young women just after marriage, plays a fundamental part in fistula development. Some women are denied access to care, or actually harmed, due to cultural beliefs and traditional practices; harmful traditional practices such as female genital cutting or mutilation increase the likelihood of gynecological and obstetric complications, including prolonged labor and fistula. Although there are few reliable statistics available, these practices may increase the likelihood of such complications by up to seven times and may explain as many as 155 of fistula cases in some parts of Africa.

This is further strengthened by Wall, 1995, who emphasized that the major contributing factor is lack of adequate midwifery services and proper obstetrical care to deal with labor complications. He further explains that, VVF in Africa are the result of “Obstructed labor and obstructed transportation.” This situation is reflected in the maternal mortality statistics throughout Africa, which continues to have the highest maternal mortality rates in the world where the risk is 1 in 15. He also cited that the following are also contributing factors:

- Poor maternal nutrition and anemia making pregnant women more susceptible to injury and to poor wound healing when injury occurs
- A burden of endemic parasitic disease further complicates a woman’s abilities to handle pregnancy and its risks
- Traditional mutilating practices, such as “female circumcision” in some parts of Africa such as Somalia and Sudan provide additional risk factors for fistula formation
- Traditional gynecologic and obstetric treatment involving cutting inside the vagina in other parts for example in Northern Nigeria can also lead to fistula formation

3.3 Prevalence of Obstetric Fistula

Obstetric complications are as old as human birth (Arrowsmith et al, 1996). The issue of vesico-vaginal fistula dates back to the ancient Egyptian times, when it was observed in the mummy of Queen Henhenit of the XIth Dynasty (2050 BC) who seems to have suffered from a large vesico-vaginal fistula (Rahmat,2001).

Research writings cite that prior to the middle of the 19th century, obstetric fistula was generally regarded as an incurable and hopeless

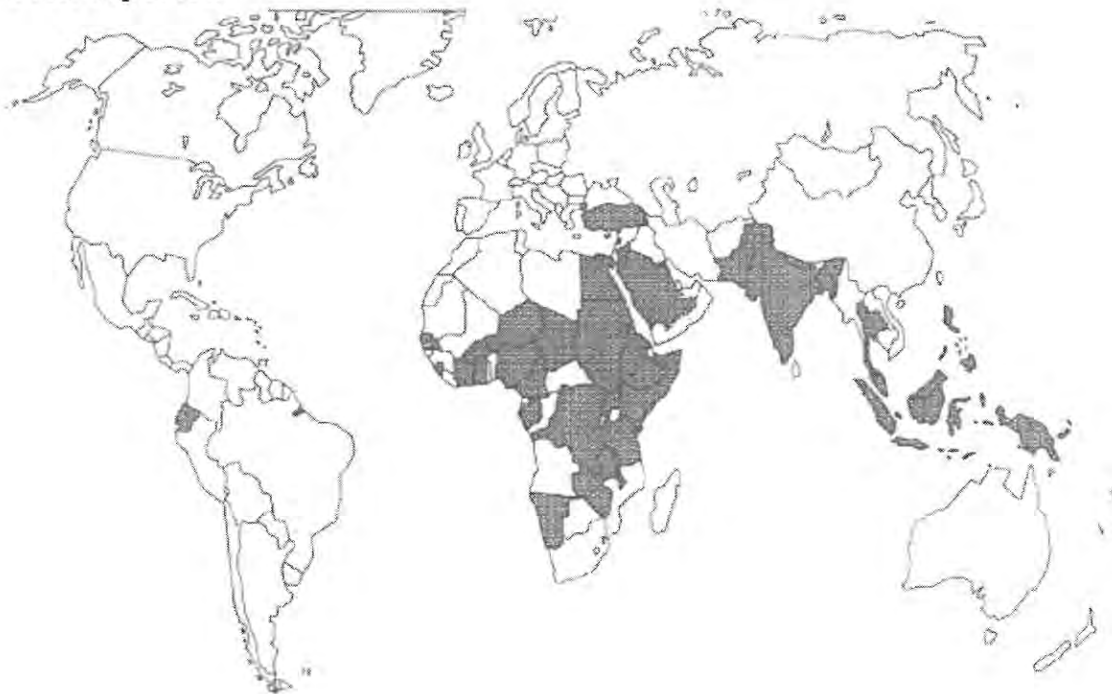
condition and was a problem in much of what are now the developed countries including the United States and Europe. However, advances in scientific obstetrics and the development of comprehensive system of pregnancy care since the end of the 19th century have made obstetric fistula almost unknown in developed countries today. In the industrialized world, this condition is uncommon: many gynecologists will go through their entire careers and never see a vesico-vaginal fistula (Wall, 1995). Currently, only a few non-obstetric fistula cases are reported from developed countries and almost all of these are iatrogenic following gynecological surgery or radiotherapy (Mulu, 1997).

However, obstetric fistula is a common health problem in developing nations and in most cases result from prolonged obstructed labor. Obstetric fistula disables millions of women and girls in developing countries, primarily in sub-Saharan Africa and South Asia (United Nations, 2005). Various studies indicate that the prevalence of obstetric fistula reaches epidemic proportion in some parts of Asia and Sub-Saharan Africa and a similar high prevalence of obstetric fistula has been reported from Nigeria, Chad and Sudan (Mulu, 1997). Obstetric fistula is the single greatest problem of maternal morbidity in West Africa (Wall, 1995). Actual incidence/prevalence rates from community-based studies are difficult to come by because the condition is under reported due to stigma associated with it. However, in many parts of Africa, especially in the more remote rural areas, it is one of the commonest distressing conditions (Kabir et al, 2003).

The UNFPA estimates the world population of fistula sufferers at more than two million and that there are 100,000 new fistula cases each year but the international capacity to treat fistula remains at only 6,500 per year, although almost no population-based surveys on

fistula have yet been undertaken and data remains scarce. In sub-Saharan Africa the incidence of obstetric fistula has been estimated to be about 124 cases per 100,000 deliveries in rural areas, compared with virtually no case in major cities (WHO, 1998). The map presented below shows regions thought to have the highest numbers of fistulas-Sub-Saharan Africa, South Asia, parts of the Near East and North Africa, whereas, the prevalence is actually assumed to be greater than this map indicates.

Figure 2: Countries from which obstetric vesico-vaginal fistulas have been reported



Source: WHO, 1991.

According to Rahmat (2001), the prevalence of VVF seems to be high in areas where poverty is high, especially amongst women; prevalence of education is low or in some non-existent for girls/women and maternal mortality rates are high. Obstetric fistulas are most prevalent in poverty-stricken rural areas (Wall, 1995).

3.4 Obstetric Fistula in Ethiopia

Ethiopia has an estimated population of 63.5 million, of which more than 85.1 percent live in rural areas spread across an area of about 1.25 million square kilometers (CSA, 2006). The annual birth per 100 women between the ages of 15 and 19 years of age is currently at 15.2 (Addis Ababa Fistula Hospital Annual Report, 2001-2002). There are a mere 20% of women receiving antenatal care; deliveries by skilled assistants is only 8 % (CSA, 2006). WHO's figure shows maternal mortality of 1,400 per hundred live births. This statistics excludes women with fistula as few of these women will have a live birth. Ethiopia tops the list of the Reproductive Risk Index at 72.3 points out of a possible 100, meaning that women in Ethiopia are 99% more likely to die in pregnancy or childbirth than in western countries (UNFPA, 2004). So it is no wonder that there are large numbers of women with obstetric fistula in Ethiopia. Combined with an increasing population with inadequate health coverage, the problem is bound to be pervasive.

WHO estimates that in Ethiopia, there are 8,000 to 9,000 women who suffer an obstetric fistula each year. At present, only about 1,400 women are able to go to the Fistula Hospital for treatment. What happens to the others seems to be unanswered. According to the 2005 Ethiopian Demographic and Health Survey results, 1% of interviewed Ethiopian women who have ever had a birth reported experiencing obstetric fistula; older women (age 40 and above) and very young women (age 15-19) are slightly more likely to report the condition. Women residing in urban areas and women residing in Amhara, Oromiya and SNNP regions are also relatively more likely to have experienced obstetric fistula. Table 3 presents the result of those who

reported suffering from obstetric fistula by background characteristics.

Table 3: Prevalence of Obstetric Fistula in Ethiopia

Background Characteristic	% Experienced Obstetric Fistula	Number
Age		
15-19	2.0	443
20-24	0.9	1,533
25-29	0.6	2,190
30-34	0.6	1,698
35-39	1.1	1,559
40-44	1.6	1,154
45-49	1.9	1,125
Residence		
Urban	1.4	1,228
Rural	0.8	8,474
Region		
Tigray	1.6	634
Affar	1.0	105
Amhara	0.5	2,562
Oromiya	1.2	3,467
Somali	0.0	381
Benishangul-Gumuz	0.6	94
SNNP	1.5	2,054
Gambela	1.1	33
Harrari	0.1	23
Addis Ababa	1.0	307
Dire Dawa	1.0	42
Education		
No Education	1.0	7,635
Primary	1.3	1,453
Secondary and Higher	1.0	614
Total	1.0	9,703

Source: Ethiopian Demographic and Health Survey, CSA 2005.

3.5 Social Problems Associated with Obstetric Fistula

According to the free encyclopedia definition, social issues are matters that can be explained only by factors outside individuals' control and immediate social environment. They usually concern more than a single individual and affect many individuals in a society. Common social issues include poverty, violence, injustice, suppression, discrimination, crimes and usually revolve around conflicting viewpoints and tension between people who take different stances.

From the review of different literature, the researcher came to understand that the concept of social problem cannot be generalized to apply to all kinds of situations. One problem considered being a social problem for one society or community may not be considered as a social problem for another society. It all depends on the specific situation and condition under consideration. In this respect, this research dealt with social problems that are assumed to apply to women with obstetric fistula.

Women with obstetric fistula face social problems in addition to the physical injury they endure. The urinary incontinence that is produced by a fistula causes these women to become social outcasts. They also suffer from profound psychological trauma resulting from their utter loss of status and dignity. Different writings agree that although physicians tend to think in terms of clinically definable injuries, much of the suffering that fistula patients endure is as a result of social consequences of their condition. They suffer from lifetime burden of suffering that this condition presents at a young age. Although it is difficult to generalize the type of social problems women with obstetric fistula face due to different social context in which these injuries occur, there are recurring patterns that allow for some

general observations to be made regarding the social problems they face. The social problems could be in relation to:

3.5.1 Poverty

According to UNFPA, poverty is the main social risk factor because it is associated with illiteracy, malnutrition and because poverty reduces women's chances of getting timely obstetric care.

Study conducted at Murtala Mohammed Specialist Hospital, Nigeria (Kabir et al, 2003) shows that of the 120 patients considered, 94(78.3%) were illiterate. This finding agrees with similar studies conducted at Aminu Kano Teaching Hospital, Nigeria where of the 191 patients under consideration, the majority were illiterates, engaged in menial jobs; and of the 1,210 cases analyzed in Addis Ababa Fistula hospital by Mulu (2004) illiteracy was common amongst the patients and the analysis also found that women who owned property of value were less likely to be divorced or abandoned by their husbands.

Since fistula formation is more common in young women who are likely to be illiterate and from impoverished rural areas, the injuries are most likely to affect these women who are already among the most vulnerable members in the society. Economically they cannot work because they cannot stay in public and will not be employed, thus the patients become economic burden to others (Kabir et al, 2003).

3.5.2 Separation and Problems in Family Life

In most societies where fistulas are still prevalent, a woman's role in life is defined in terms of marriage, childbearing and the family life that results (Wall, 1995). Both men and women depend on their children for farm labor and as the only hope they have for security in old age. Large families are source of pride and since the social and economic lives of these societies are still dominated by ties of kinship, not having children is a disaster in many respects. Researches undertaken in different countries reveal that the fetal mortality in obstructed labor is above 90% and the majority of these births occur at first delivery, making these women childless. Many writings also reveal that even after successful fistula repair, many women are unable to have children again.

Researches have shown that childlessness is one of the major reasons for divorce and women are blamed for being childless. Women who could not have children do not have respect in the society and they are abandoned by their husbands.

Although obstructed labor is common as a complication of a first pregnancy, it can occur in any pregnancy if the baby is too large, presents wrong or other complications arise (Wall, 2002). What happens to the living children when their mother's life is ruined this way is also other indirect consequence of fistula formation which seems to have been unexplored.

In many rural societies, women are responsible to perform heavy manual labor such as tending the fields, carrying water and firewood; in addition to taking care of children and preparing food for the

family. Foot drop and associated pelvis injuries may make performance of these tasks impossible which affect the family negatively. Then these otherwise productive women become burdens to their family and the society at large.

The combination of all the above factors often lead to a gradual disintegration of the marriage over time which then ends up with complete cut off of the relationship. The existing data shows that large numbers of fistula victims are divorced or separated. For example, in a study undertaken at Aminu Kano Teaching Hospital, Nigeria, of the 191 patients coming for repair, 67.1% were divorced or separated from their spouses because of the fistula. Mulu (1997) documented similar findings where, of the 1,210 cases analyzed in Addis Ababa Fistula Hospital, 530 were divorced by their husbands following development of the fistula.

Small number of patients (about 3% of those treated) are so badly damaged in childbirth that they cannot be cured. These patients are fitted with an external bag for their urine and they need continuing medical care. These women are forced by their situation to live isolated from their family.

3.5.3 Stigmatization and Isolation

Stigmatization and discrimination due to different kinds of health problems are prevalent in the world.

Stigma is generally accepted to be an “attribute that is deeply discrediting” that reduces the bearer “from a whole and usual person

to a tainted, discounted one” (ICRW, 2002). As per the National Aids Council’s description (2001),

Stigmatization often leads to discrimination, which refers to any form of distinction, exclusion, or restriction affecting a person by virtue of a personal characteristic. Stigma is most frequently associated with diseases that have severe, disfiguring, incurable, and progressive outcomes, especially when modes of transmission are perceived to be under the control of individual behavior. It is common in diseases that are perceived to result from the transgression of social norms, such as socially unsanctioned sexual activity.

Types of stigmatization and discrimination could be gossip, verbal/physical harassment and avoidance/isolation (MOH, 2004). Many researches cite that the causes for the stigmatization are attitudes, beliefs and culture of a given society and lack of awareness about the cause and ways of transmission of the disease.

For example, according to Herek (1999), HIV related stigmatization refers to all unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS, as well as toward the significant others, loved ones, close associates, social groups and communities associated with infected individuals.

Stigma is not unique to HIV/AIDS (ICRW, 2002). Women with obstetric fistula also face stigmatization and discrimination in their societies. This stigmatization increases feelings of social isolation and depression and lessens their chances of getting the care and treatment they need. The uncontrollable trickle of urine and/or feces makes these women hygienically problematic and physically offensive.

Dr. Hamlin in her book writes, “the young woman is often shunned by her husband, and sent back home to her parents. The women are then shunned by their families. The father says, ‘let us build a house for her to live in, a little room somewhere on our family plot.’ So they put her into a little shed, and there she will stay for the rest of her life, unless she can be cured. She is ruined, a beautiful girl... with no hope of being cured.”

Because of the nature of the injury, a fistula patient simply cannot maintain normal hygiene, no matter how hard she tries. This fact has an enormous impact on all aspects of her life. The girl is initially kept hidden, subsequently, she finds it difficult to maintain decent standards of hygiene because water for washing is generally scarce; destitution follows.

Kelly (1998) says, “when I suggested to one patient who was blind, that we might deal with her eye problems first, she pleaded ‘cure my fistula first; if I am blind people will come and sit with me and talk to me, but no one will come near me when I am wet and I smell.’”

Study conducted at Murtala Mohammed Specialist Hospital, Nigeria (Kabir et al, 2003) shows that of the 120 patients considered, up to half of the patients were bitter about the condition they found themselves in, 53% suffered from societal negative reaction and a third were psychologically depressed.

According to Wall (2002), because of the social stigma attached to their condition, fistula victims have often been subjected to major psychosocial trauma. He writes about a song he encountered on his trip to Northern Nigeria. The “praise song” is performed by a group of

Nigerian fistula patients as a vehicle for building group identity as part of a “sisterhood of suffering”. He describes the song in the following manner:

The song is entitled Fitsari ‘Dan Duniya, which may be loosely translated as “Urine, the Oppressor of the World.” The song is performed by a large group of incontinent women who had developed VVF as a result of prolonged obstructed labor. These women live together in a special hostel for fistula patients on the ground of Evangel Hospital in the city of Jos, in Plateau State, Nigeria. The song was written by a fistula victim. The women in VVF hostel have adopted the song as their anthem. Performing it helps them develop the sense of community and group solidarity that is critical for their rehabilitation and for the psychosocial healing.

The leader of the song calls out the verses and the congregants respond, loudly and enthusiastically. The lines of dancers form in the aisles and weave through the congregation. The song goes like this:

*Urine, the Oppressor of the world. Urine, who has forced me from
my home*

*We went out looking to be healed, but they said we were all
whores*

This sickness “caught me”, when I was only a young girl

I sat confined at home until I heard the good news

I said, “My word, mother! Give me the money”

*I will go to Jankwano in Jos! I will go down there and see the
new Europeans!*

By this time tomorrow I will have arrived in the operating theatre

I will remain there at Dr. Karshima’s place

Doctor Karshima I thank you! May God bless you!

*You have sewn up the leaking women
My husband threw me out because I was leaking
If the sickness “catches you” they’ll carry you out and throw you
away too.*

Arrowsmith et al (2001) write what he came to know through his personal communication with Professor Abbo Hassan Abbo, professor of Obstetrics and Gynaecology at the University of Khartoum in the Sudan, telling him a powerfully poignant story of a group of Somali women with fistulas who, in despair, chained themselves together and jumped off the dock in Mogadishu in a mass suicide because their suffering had become unendurable.

Chapter Four: Findings

This chapter deals with the analysis and findings of the gathered data. The second part deals with the interview result that was collected from women in Addis Ababa Fistula Hospital, NGO working in the area and government bodies.

4.1 Occurrence of the Fistula Problem

Table 4: Time the Women went to Clinic after Labor Started

Time Went to Clinic	Frequency of Respondents	%
Immediately	1	2.70
After two Days	5	13.51
After three Days	4	10.82
After four Days	7	18.92
Did not Go	20	54.05
Total	37	100

The above table shows that more than half (54.05%) of the women did not go to clinic to deliver. Of the women who went to clinic, the majority went after four days of labor. Only one respondent went to clinic as soon as labor started. It can be concluded that most of the women had been in labor from 2-4 days without getting medical help.

Table 5: Reason for not Going to Clinic as soon as Labor Started

Reason	Frequency of Respondents	%
Lack of money	6	16.22
Unavailability of medical service near where they live	14	37.84
Wanted to deliver at home	5	13.51
Wanted to go to clinic but their husbands or relatives did not want them to go to hospital because of cultural taboo or tradition of the locality	12	32.43
Other reason	-	-
Total	37	100

Unavailability of medical service near where they live is the major reason for not going to clinic when their labor started. Culture and tradition of the locality to deliver at home is another reason for not seeking medical help, representing 32.43% of the respondents.

Table 6: Respondents' Reaction to their Condition

Reaction	Frequency of Respondents	%
Bitter	18	48.65
Resigned to Fate	9	24.32
Depressed	10	27.03
Total	37	100

More than forty five percent (48.65%) of the respondents were bitter to find out their problem. Significant number of them also responded that they were depressed to see the problem happen to them.

Most of the women under study had the problem for many years and have suffered from physical and social problems all those years without getting treatment due to various reasons.

Table 7: Number of Years without Treatment after Fistula Occurred

Number of Years	Frequency of Respondents	%
1 - 2	11	29.73
3 - 4	14	37.84
5 - 6	6	16.22
7 - 8	2	5.40
9 - 10	2	5.40
Above 10	2	5.40
Total	37	100

As the above table shows, the majority of the women, 37.84%, lived with the problem for 3 – 4 years without getting any treatment and 29.73% of them lived with the problem for 1 -2 years. Twelve of the respondents have lived with the problem for 5 and above years, of which 2 women had lived with the problem for more than ten years.

Table 8: Knowledge of why Fistula Occurs and knowledge about Someone with Fistula in their Area

Item	Response	
	Frequency	%
1. Did you have any idea why obstetric fistula occurs?		
A. Yes	1	2.70
B. No	36	97.30
Total	37	100
2. Did you know someone with obstetric fistula in your area?		
A. Yes	6	16.22
B. No	31	83.78
Total	37	100

The above table clearly puts in view that almost all of the women (97.30%), did not have idea why fistula occurs. In the same way, when asked if they know anyone in their area with the problem, most of the respondents, (83.78), responded that they do not know any woman in their area with the problem. From this it could be questioned how these women did not come across a woman with the problem or have been cured, while there are thousands of women who are cured in many rural parts of the country. This also implies that there is lack of information and communication among the rural society regarding the problem.

4.2 Social Problems the Women Faced

4.2.1 Poverty

The finding of this research reveals that largest numbers of the women interviewed are illiterate. All of them do farming for their living with a little income to cover for their daily lives. Even some are dependent on their family incomes. Facing family and social rejection and unable to make a living by themselves, many of the women have lived for years without any financial or social support and many have fallen into extreme poverty.

Box 1

After the fistula occurred, my husband was supporting me and waited for me for a year .After waiting for a year, he once came to me and told me that he cannot live with me with such a problem and is tired of waiting for such a long time hoping that I will be healed. He told me that he wants to marry another girl and to have a child. Then I was obliged to go to my relatives' house as I have no parent. I went to my aunt who lives near where I used to live. She has five children and is so poor that she even does not have enough earning to sustain her family. I became a burden to her family. I sometimes do not eat any food because I feel ashamed to eat without doing any kind of work. I was afraid to go out of the house so do not help her when she works in her farm. To make things worse, I also feel so tired and sick so could not help her in doing things to be done inside the house. I spent three years in such a situation before knowing that my problem could be healed.

Table 9: Frequency and Percentage Distribution of Informants by their Educational Qualification

Level of Education	Total	
	Frequency	%
Illiterate	32	86.49
Read and Write	1	2.70
Primary(1-6)	4	10.81
Junior and Secondary	-	-
Total	37	100

When analyzing the above table according to the level of education of informants, it can be clearly seen that the majority belonged to the 'Illiterate' category with a total percentage of 86.49%. On the contrary, the least percentage goes to 'Read and Write' category by constituting only 2.7%. There are also some women who attended primary education.

Table 10: Frequency and Percentage Distribution of Informants by Source of Income before and after Onset of the Problem

Source of Income	Before Onset of the Problem		After Onset of the Problem	
	Frequency of Respondents	%	Frequency of Respondents	%
Family Dependent	1	2.70	17	45.95
Dependent on Friends and Neighbors	-	-	10	27.03
Farming	33	89.19	9	24.32
Farming and Trade(sell of fuel wood, traditional alcoholic drinks, etc)	3	8.11	-	-
Trade(sell of fuel wood, traditional alcoholic drinks, etc)	-	-	-	-
Self Employed	-	-	1	2.70
Total	37	100	37	100

As Table 10 shows, before onset of the problem, the majority, (89.19%) of the women's source of income was farming. The next highest group is women who were engaged in farming and trade before the problem, the percentage being 8.11%. On the contrary, only one respondent was dependent on family before the problem. Nevertheless, after onset of the problem, the majority of the women, 45.95%, were dependent on family. On the other hand, 27.03% of them who had no parents were dependent on friends and neighbors. And only one woman was self employed. Farming, which was the main source of income for them, was reduced to only 24.32% after onset of the problem. This implies that most of the women have become dependent without any income after the problem.

4.2.2 Separation and Problems in Family Life

In most societies of Ethiopia, people are ambitious to have children. The society considers having children as a major means of increasing labor force, old age security and ensuring lineage continuity. Inability to have children due to various reasons deprives the family of these advantages of having children. This also causes loneliness, loss of respect, lack of support in old age, polygamous marriage and family breakdown.

Women with obstetric fistula lose their child in addition to the formation of fistula. In the sample of women taken from the hospital, the outcome of the delivery was still birth for all of the respondents and the fistula occurred at their first delivery for the majority of the respondents. Table 11 shows the delivery at which the fistula occurred.

Table 11: Delivery at which the Fistula Occurred

Delivery	Frequency of Respondents	%
First	30	81.08
Second	1	2.70
Third	1	2.70
Fourth and above	5	13.52
Total	37	100

According to the above table, for the majority, 81.08 % of the informants, the fistula occurred at first delivery followed by their fourth and above deliveries, which is the case for 13.52% of the respondents. On the contrary, the least percentage goes to “second and third” delivery categories by constituting only 2.7 %. This implies that for the majority of the women, the fistula occurred at their first delivery.

Consequent to the occurrence of the problem, the majority of the respondents have separated from their husbands. These women have lost their marriage at an early age and have lost the pleasure of being a mother in their first deliveries.

Table 12: Frequency and Percentage Distribution of Informants by Marital Status Before and After Onset of the Problem

Marital Status	Before Onset of the Problem	%	After Onset of the Problem	%
Single	-	-	-	-
Married	36	97.30	9	24.32
Separated	-	-	26	70.27
Widowed	1	2.70	2	5.41
Total	37	100	37	100

When looking at their marital status before and after the fistula occurred as depicted in table 12, all of the respondents, with the exception of one respondent, were married before onset of the fistula. However, the majority of the women, 70.27% of them, were separated after the onset of the problem. In contrary, only few respondents, 24.32%, were married after onset of the problem.

Table 13: Husbands' Response when they knew about the Problem

Response	Frequency	%
Were supportive and willing to help and accept them with the problem	9	25.72
Were supportive and willing to be with them but the women refused so were forced to be separated	3	8.57
Left them as soon as they found out the problem	11	31.43
Left them after waiting for some time	3	8.57
Wanted to be with them but their parents forced them to leave them and marry another girl	6	17.14
Wanted to be with them but couldn't stand the pressure from the society and were forced to go away from them	3	8.57
Total	35	100

As can be seen from the above table, most of the women's husbands have left the women as soon as the husbands knew about the problem. And 17.14% of the husbands were forced by their parents to leave their wives and marry another girl. It also shows that society's

negative attitude and influence is one reason for leaving their wives. On the contrary, it shows that there are also husbands who were supportive and stayed married with the women's problems, which is the case for 25.72% of the respondents.

Table 14: Frequency and Percentage Distribution of Informants by Number of Living Children who were Separated after Onset of the Problem

Age of Informants	No. of Informants	Women having Children	% of no. of Informants	% of Women having Children
15	3		11.54	-
16 - 20	15	2	57.69	40.00
21 - 25	6	3	23.08	60.00
26 - 30	2	-	7.69	-
31 - 40	-	-	-	-
41 - 60	-	-	-	-
Total	26	5	100	100

Table 15: Frequency and Percentage Distribution of Informants by Number of Living Children who were Married after Onset of the Problem

Age of Informants	No. of Informants	Women having Children	% of no. of Informants	% of Women having Children
15	-	-	-	-
16 - 20	2	-	22.22	-
21 - 25	2	2	22.22	28.57
26 - 30	-	-	-	-
31 - 40	1	1	11.11	14.29
41 - 60	4	4	44.45	57.14
Total	9	7	100	100

In analyzing the situation of the women who were separated after the problem, the majorities are under the age group 16 – 20 and only five of them have children. On the contrary, of the nine women who were married after the problem, most of them have children ranging from 1 – 12 while only two of the women do not have children. The majority of the married women after the onset of the problem belong to age group of 41 – 60, which is 44.45%. This indicates that women with children tend to stay married after the problem than women without children. This corresponds with many researches and literature about one of the reasons for divorce, childlessness due to various reasons. It also shows that older women are likely to stay married after the problem than younger ones.

Table 16: Informants’ Attitude why their Marriage Ended

Response	Frequency	%
Their husbands could not tolerate the smell	5	19.23
They lost their child	9	34.62
Their husbands were willing to accept them but were forced by their family or could not tolerate the pressure from the society	9	34.62
Their husbands were willing but the women did not want to stay with them with the problem	3	11.53
Total	26	100

The table shows that the losses of their child and parents’ and society’s influence are the major reasons for their separation, which was 34.62% of the informants’ response for both cases.

In most rural parts of Ethiopia, marriage is concluded between young men and women. Especially women get married at an early age. In their marriage, women are responsible for work in the house related to preparing food for the family, fetching water and fuel, harvesting crops and raising children. Women with obstetric fistula may face difficulty in doing their day to day work as a result of other complications created. One woman said:

After to the problem occurred, I could not move my legs properly. I want to do some light work in the house but could not because of my leg .I also feel some pain when I want to lift heavy things or try to work for long hours. I could not take care of my two younger children properly so my oldest daughter is obliged to miss class to stay at home and take care of them and all the house work. She also tells me that when she goes to school, her classmates embarrass her by asking her what happened to me.

Box 2

I noticed something terrible that changed my life forever. I noticed that urine was coming down my legs without my control. I couldn't believe my eyes and wanted to wait and see what was happening. I wanted to hide it from my family but couldn't hide it. It was my mother who knew about it first. She was sorry for me and we cried together. Soon all the family members knew about it. I isolated myself from any social activity except with my family. I used to weep the whole day and stay in the house for days without going out of the house.

When my husband came to visit me, he noticed the problem and asked me what happened to me. I was very afraid to tell him. He soon realized what was happening. He was very sorry for me at first and used to come and visit me. As time went on, neighbors and my husband's parents knew about it. My parents became ashamed of being with people around because they started saying different things about me. My husband waited for me for a year and after a year he once came to me and told me that he cannot live with me with such a problem and is tired of waiting for such a long time hoping that I will be healed. He told me that he wants to marry another girl and to have a child. He did not come back again. My mother heard from someone that he has married another girl. I was in deep sorrow for days for losing my marriage because of this. I hated myself for being a burden to my family at this age without any hope of being healed. My mother was very depressed because of me and stays with me at home as much as she could. Her friends stopped coming to our house and she had no social life.

My mother became sick and died suddenly without getting medical assistance. That was the time my life became worse. I wanted to kill myself but was afraid to do it. To make things worse, my father died soon after my mother's death. I remember neighbors who came to our house to comfort us used to gossip about me by saying, "She is the reason why both of them died. She has brought bad luck to the family."

My sisters got married and went to their husbands far from where we live. I started living with my brothers. One day my elder brother came home and told me that a close friend of him has told him that he knew a woman with the same problem but was cured after taking treatment at Addis Ababa Fistula Hospital. My brother brought me to Addis Ababa Fistula Hospital and now I am taking the treatment.

4.2.3 Stigmatization, Isolation and Loss of Social Support

Women with obstetric fistula are considered to be unfit to live with the rest of the family, so they are forced to lead an isolated life. Worse than the physical isolation is the social isolation in which these women are considered unfit to participate in any social activity or religious activities. Even worse, in many traditional cultures, where women's status and self-worth may depend almost entirely on marriage and childbearing, difficult labor and inability to have a child is seen as a punishment from God for infidelity or other sins. One of the women stated;

People in my area say to me “egna yemanawkew beshita keyet new yeyazesh. Yanchi degmo yeteleye new. Lijish motobish anchi degmo shintishin beyemengedu tishegniyalesh. . Min hatiyat bitiseri new yihe hulu neger yederesebish?” meaning, “you have a problem that we all do not know. Yours is even worse because you have lost your child and leak urine. What wrong have you done?”

The respondents' response indicates that most of the stigmatization comes from their husband's parents and relatives. On the contrary, the women's parents are supportive and willing to help their daughters with the problem, with few exceptions where they isolate and let them know that they can not live with them with the problem.

Table 17: Women's Parents' and Relatives' Response after Onset of the Problem

Response	Frequency	%
Were supportive and willing to help and accept them with the problem	18	48.65
Were very supportive and insisted that they shouldn't go to their husbands with the problem even if the husbands are willing to accept them	3	8.11
Family members are ashamed of them and did not show them good face	10	27.03
No parent or close relative	6	16.21
Total	37	100

The table shows that most of the women's parents and relatives, 48.65%, were supportive and willing to help and accept them with their problems. On the contrary, 27.03% of them were ashamed of their daughters and did not show them good faces. Some of them have even forced their daughters to leave their house.

Table 18: Husbands' Parents' and Relatives' Response after Onset of the Problem

Response	Frequency	%
Were sympathetic and willing to help and accept them with the problem and advised their son not to abandon them	11	29.73
Did not want to see her after the problem	15	40.54
Forced their sons to abandon them and marry another girl	6	16.22
Has no parent or close relative	3	8.11
Have not seen them since their husbands died	2	5.40
Total	37	100

As presented in the table above, most of the husband's parents and relatives were not supportive and willing to accept them with the problem. 40.54% of the husbands' parents did not want to see them after the problem occurred. In addition, 16.22% of the husbands' parents have forced their sons to abandon their wives and marry another girl. On the contrary, 29.73% percent of the parents were supportive and willing to accept them with the problem. The above two tables imply that the women's parents and relatives accept the women's problems and are willing to help and accept them with the problem than husband's parents and relatives. One woman, unable to control her expression of sadness stated that:

My husband was really sorry for me and wanted to be with me and help me in everything. But his mother comes to our house and tells him to leave me and marry another girl. She says, "kesua lela set lij yelele meseleh inde? Lela tenegna yehonech konjo mist ametalihalew. Isua lijim tiweldilhalech. Ante bicha yichin tilehat na" meaning, "Do you think that she is the only girl here? I will bring you a beautiful and healthy girl. She will also give you a child. You just leave this girl and come to me." Her constant advice to leave me made him change his mind and one morning he told me that I should go to my mother's house. I was forced to go to my parent's house and live there with no hope of being healed and being normal again.

The women under consideration all have explained that they have separated themselves from any kind of social activity. They say that they have no courage to meet with people with such a problem. None of them said that they have social life as before. They do not go to

market places; do not go to their neighbors' house; they do not participate in religious activities or any kind of social activity. They claim that society's lack of awareness had negative consequences on their lives hence even if they can lead their lives and help themselves by doing what they can do, they are obliged to lead an isolated life and wasting their precious time sitting idle .On the other hand, two of the respondents responded that they try to tolerate what the society thinks and says about their problems and lead their lives as much as they can.

One of the women who has been separated said that she does not even go out of the house when people are around. They help their parents in doing some kind work which could be performed in the house. One woman was crying when she says this:

“My mother is sick and stays at home. My younger sister used to help her but now she got married and lives far from where my mother lives. She used to be helped by her close friend and neighbors. When I came to my mothers' house after my husband left me, I used to wear trouser and go to market place, go to fetch water and do all the house work. However, when I go to market place or fetch water, I hear people gossiping about me saying” Look at that girl! She leaks urine and because of her smell her husband has left her. How could she dare to be in front of people with her urine?” And some friends of mine who used to go with me to fetch water began to hide themselves when they see me because they were also mocked because of me. Then I couldn't tolerate their gossip and verbal harassment so decided to stay at home. Now my mother's health is going worse and I could not help her enough. A close friend of mine helps us in doing things that are done outside the house.”

Table 19: Frequency and Percentage Distribution of Informants on Society's Perception about Fistula

Response	Frequency	%
Obstetric fistula is sent by God as punishment for wrong doing	12	32.43
Bad women will have obstetric fistula	10	27.03
Any woman with obstructed labor may have obstetric fistula	8	21.62
Have no idea	7	18.92
Total	37	100

Respondents' view about what the society knows about fistula shows that the society lacks awareness about fistula. Table 19 shows that the majority of the respondents believed that the society thinks about obstetric fistula as a punishment from God. Also significant number of respondents, 27.03%, believe that the society think that bad women will have obstetric fistula. There are also respondents who believe that people in their society have no idea about obstetric fistula, which represents 18.92% of the respondents. On the contrary, only eight women believe that the society from where they come knows that obstetric fistula could be caused to women who have obstructed labor.

Box 3

After going through a terrible time during my labor and losing my child, another problem came to my life. This problem was something which I have never, ever heard of before in my life. I felt wet and I did not guess it was my urine. My urine started to come out without my control. I thought to myself, what on earth is happening to me? What did I do to deserve this? I felt so mixed up. I thought of running away and disappear, but where? At the beginning, I tried to hide what was happening to me but not for long and no way of hiding.

My husband learnt about it and he was very fast to tell me that he does not want to see me anymore. The girls and friends I knew did not want to get near me. The stigma was too much for me to handle. I had no where to go. Everybody felt like I was a curse, and I felt the same. The only person who was willing to take me was my sister. She was a married woman and had her own family. She was living fairly peacefully before I arrived at her place. After being a guest at my sister's place a little while, my sister's husband who was meant to be my brother in law, told my sister to get rid of me. He told my sister to get rid of her smelly and stinking sister. The quarrel in the family began all because of my presence in their house. He started beating me and my sister just for simple things. He used to harass me by forwarding ugly words to me. I felt so hopeless. One day, I went out of the house without telling my sister and started to go but did not know where I was going.

I traveled for two days without eating and arrived at a small village. There I met with a man who works at the nearby kebele. I told him what happened to me. He told me about Addis Ababa Fistula Hospital and collected money from the local people for my transportation. I supposed it was a relief for the people who knew me that I go far away from them.

I started my journey to the big city of Addis Ababa. I abstained myself from even a glass of water to be safe for a possible embarrassment I may cause during my journey. The Doctors and all the staff at the Hospital are very nice people. I felt very much at home. Specially after watching the girls who were having the same problem like mine, my spirit started to heal. And now I am eagerly waiting for my treatment and hope to be healed even though I have no idea about what kind of life is awaiting me after being cured.

Table 20: Frequency and Percentage Distribution of Informants' Response about the Type of Stigmatization they encountered

Response	Frequency	%
Gossip	3	8.11
Verbal Harassment	10	27.03
Physical Harassment	4	10.81
Avoidance/Isolation	13	35.13
Combination of the above	4	10.81
No Stigmatization	3	8.11
Total	37	100

Table 20 shows that the majority of the respondents, (35.13%), were avoided/isolated. Significant numbers of women, (27.03%), have responded that they faced verbal harassment due to their problem. There also few who faced physical harassment. On the contrary, insignificant number of women, only three, responded that they faced no stigmatization. This clearly shows that women with obstetric fistula are stigmatized.

4.3 Problems faced when deciding to get Treatment and Future Plan

The women under study have gone through many difficulties before knowing that their problem could be treated and in deciding to come to Addis Ababa after they knew about Addis Ababa Fistula Hospital.

Table 21: Reason for not Seeking Treatment after the Fistula Occurred

Reason	Frequency of Respondents	%
Lack of Money after they knew that it could be Treated	13	35.14
Didn't know the problem could be treated	20	54.05
Afraid the treatment could cause other complications	4	10.81
Total	37	100

The major reason why the women did not seek treatment after the fistula occurred is because they did not know the problem could be treated. The second reason for not seeking treatment is lack of money. Fear of other complication is also a contributing factor for not seeking treatment which is the case for 10.81% of the respondents. One respondent said:

When I heard that my problem could be treated at Addis Ababa Fistula Hospital, I was eager to get healed. But my mother said to me "If you go to Addis Ababa, the doctor will open your stomach and you will die." My father even did not like the idea so advised me not to think about going to Addis Ababa. But I decided myself and told to my parents that I may try and if it fails, die, than be alive in such a terrible situation. Then I sold a cow I used to own and made my long journey to Addis Ababa Fistula Hospital.

**Table 22: How they knew that the Problem could be treated at A.A
Fistula Hospital**

Response	Frequency	%
They knew about A.A from the clinic when they went there to deliver	17	45.95
People in their locality informed them	5	13.51
People working in NGOs came to their village and informed them	6	16.22
People from their kebele came to visit their village and informed them	9	24.32
Total	37	100

Table 22 shows that People from their kebeles are playing a major role in informing the women that their problem could be treated. In the same way, 16.22% of the respondents claimed that they were informed by people working in NGOs who came to their village. On the contrary, only 13.51% of the women knew about the treatment from people in their locality which seems to be very insignificant compared to the number of women treated at Addis Ababa Fistula Hospital every year. This may indicate that women going to their homes after getting treatment or their parents do not talk about it.

Table 23: Women's' Response about their Future Plan

Response	Frequency	%
Go home and live with their children	5	13.51
Hope to start a new life again and have a child	2	5.41
Do not want to go to their husbands even if their husbands want to	2	5.41
Do not want a married life again, want to go to school and get a job	15	40.54
Do not want to live in their previous place	8	21.62
Do not want to go to their home place again and want to live in Addis Ababa	3	8.10
Are told by the doctor that they should live in Desta Mender	2	5.41
Total	37	100

Table 23 shows that the majority of the women do not expect their lives to be as before. 40.54% plan not to have a married life again because of what happened to them. There are also a lot of them who do not want to live with their relatives and even some do not want to go to their homes.

Of the two women who cannot be cured and so are required to start living in Desta Mender, one is a sixteen year old young girl. She was told about her situation and is preparing to go home and inform her situation to her parents. Her husband has left her as soon as the problem and she started living with her parents. She doesn't understand the seriousness of the situation she is in. She wants to go home, tell her situation to her parents and if they agree to accept the fact that she is going to be with the problem for the rest of her life, she doesn't want to live here. It may take time for her to accept the problem and decide to be here.

The other woman is 42 years old and has four children. She says the doctor has told her that her situation is more serious and the problem has damaged her kidney and if she doesn't get proper treatment soon, her kidney will be completely damaged. She was confused at that time and did not know what to decide. At the day of the interview, she was going to leave for her home the next day to tell her situation to her family. She was crying hard when she was talking about it. She says she will discuss the matter with her husband and children and decide what to do next. Although the occurrence of complete damage is rare, few women are unable to be cured and need close medical help for the rest of their lives. Such women are obliged to be separated from their parents, family, leave everything they had and lead their lives here in Desta Mender. There may also be other women who did not have the

chance to come to Addis Ababa to get the treatment and die without knowing that they could live with a medical help.

This entails that there is much to be done regarding women who have completed their treatment and are ready to start a new life. After their physical problem is solved, it seems that their social problems are far to be addressed.

4.4 Findings from Concerned Officials

4.4.1 Addis Ababa Fistula Hospital

According to the information gathered from concerned individuals in the hospital, the scope of services of the hospital includes fistula treatment, prevention and education programs for all patients of the hospital. The hospital has a holistic approach of satisfying the physical, social and psychological needs of the women coming from different parts of the country.

It was learnt from the hospital that the problem of obstetric fistula in Ethiopia is increasing from year to year. The number of women coming to the hospital is increasing and they are treating patients more than what they project in their plans. As part of the global effort to end fistula launched by the UNFPA, efforts are underway to identify the incidence of fistula in Ethiopia. Example of an effort in this regard is the research commenced nationwide regarding the magnitude of obstetric fistula in Ethiopia and integration of fistula patients in community, which will help in identifying what can be done to help the treated and untreated fistula patients.

The increase in the number of fistula patients coming to the hospital indicates that there is still gap in the availability of health facilities in rural areas. Increase in population is also another reason for the continuous increase. Also contributing for the increased number of patients is that women from very remote parts of the country who lived for years without knowing that they could be treated are now informed by different means about the hospital and come to get the treatment. One mechanism is that the ministry of health has employed health extension workers that go door to door and teach them basic health education whereby, the health workers inform them about it when they know what their problem is. NGOs working in remote areas are also creating awareness among rural women .The hospital also has medical teams that travel throughout rural Ethiopia.

The officials revealed that the increase in their number has necessitated the opening of other branch clinics at different parts of the country, in coordination with regional health centers. Currently, there are five fistula clinics at Metu, Yirgalem, Harrar, Mekele and Bahir Dar giving fistula treatment services to women coming from the locality. It is also planned to have more fistula clinics to enable women get the treatment near to where they live because they will not need to make the long, costly and humiliating journey to Addis Ababa, until such time that women are able to get delivery services near them so that the fistula may not occur.

Discussing about the social problems of women with obstetric fistula, all claimed that the social suffering these women endure is as serious as the physical damage they have. The women come and tell the doctors and nurses about their social problems and it can be noticed that these women have suffered both from the physical injury and the

social discrimination. The women ask them for how long they are going to stay here and when they are expected to leave. They come reduced to conditions of extreme poverty by their injuries and social isolation after going through hard time in their life and relationship with others. Some patients find it difficult to recover from their depression and could not eat properly and make their body ready for the treatment.

After passing through all these problems, they develop psychiatric problems. The officials also said that although little detailed research has been done on this issue, results of preliminary surveys suggest that depression, anxiety and other forms of mental health dysfunction are widespread among women with obstetric fistula. It was learnt that there are occasions where these women who have had obstetric fistula will never be able to have children and in many instances, cannot have sexual intercourse.

When the women first come here, almost all of them are malnourished, with other complications and their body is so weak to pass through the surgical treatment so they are obliged to go to their home and come again when they are physically fit for the treatment or stay here until they are ready. The women have no money to go home and come back again so will stay here for three or more months, they are young girls and they miss their parents and see everything with doubt.

Regarding their efforts to ameliorate the social problems of these women, Prior to surgery and during recovery, patients attend literacy and safe motherhood classes; they are taught knitting and are given the necessary material to do it while they stay here for a long period of

time during treatment; they also attend an awareness program to make them know about their rights, dangers of childhood marriage and that they have to go to school. The hospital also has envisages to create awareness through the outreach services and the centers that are opened and expected to be opened as these centers are relatively near to the rural women. There are also efforts to create awareness among the society about the problem through radio programs aired in cooperation with other NGOs.

It was also noted that the hospital can only give the women some money for transportation and a new cloth when they are ready to go back home but has nothing to give them to enable them rehabilitate themselves and it has no means of knowing in what situation the women are after they have left the hospital. The hospital is taking former fistula patients for training for the outreach centers but can not accommodate all former patients to train and hire them. Currently, there are twenty former fistula patients who are taking training to be recruited in the outreach centers.

As per the information gathered from Desta Mender, currently there are fifty four women who are living in the village. The village has the capacity of providing accommodation for 100 women and there are ten self-contained cottages each accommodating ten patients. A supervisor lives on-site and there is adequate staffing.

Talking about the situation of the women, he said that at first it would be very difficult to socialize themselves with the people living there until they accept it that this is going to be their home. All the staff knows about their problems and handles them very considerately.

They are very sensitive and need special care which they get in the village. Some of them have complete damage on their legs and should use walking aid or wheelchair. They are all separated from their parents and loved ones and only some are able to go to their home place to visit their relatives because of the need for close medical check up they require.

Most of the patients are able, and want to do some light work. They attend school on the village ground and make handicraft. Some work on farms, grow vegetables, care for livestock or maintain the village compound. The agricultural and handicraft products are used for the hospital and the village. All of the hospital's nursing aides and several other members of the staff are former patients who require long-term care.

Discussing about the challenges the hospital faces, it was noted that financing the hospital's ongoing operations and its efforts to expand is a continuing challenge. The budget comes from donations with the cost of treating each patient for about \$350; total running costs are \$450,000 per year. The overwhelming demand for fistula repair also presents a major challenge for the hospital. Beds are constantly full, and there is not enough room to house women waiting for operations.

4.4.2 Women for Women Foundation

Women for Women Foundation works closely with the hospital with regards to the social needs of the women. According to the information gathered from the organization, it accepts women coming from different parts of the country to Addis Ababa Fistula Hospital until the hospital could accept them for treatment and stay there until

they finish their treatment because they can not stay at the hospital due to unavailability of free bed for them.

During their stay at the organization, they are provided with meal, cloths and all accommodations free of charge. There will be 25-30 women at a time, on average. The number of women to be accepted depends on availability of free bed in the hospital. The organization also follows up the regular treatment of the women and takes them to the hospital on their appointment. During their stay there, they are given an opportunity to attend daily basic literacy classes to enable them read and write.

The organization has recently started a new project for fourteen women who have finished the treatment but do not want to go to their home due to various reasons. These women are under 10 month training on dry food preparation and plastic bag production. The organization is now giving them some pocket money but plans to enable them acquire basic skill in the mentioned works and enable them involve themselves in income-generating activities and be independent.

4.4.3 Federal Ministry of Health

The gathered information from the Federal Ministry of Health indicates that there is a very high unmet health care need in rural Ethiopia that needs to be addressed through rapid expansion of primary health care services. Geographical distance from a health facility and socio economic factors are the major obstacles for the population to get health services. Expansion in terms of improving

physical availability of essential health services is believed to reduce distance between facilities and users.

The major reproductive health problems faced by the young population in the country are gender inequality, early marriage, female genital cutting, unwanted pregnancy, closely spaced pregnancy, unsafe abortion, and sexually transmitted infections including HIV/AIDS. Poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality ratio in the world, which is 871/100,000 live births(Federal Ministry of Health, 2004).

The overall potential health service coverage in 1996 is estimated at 64.02%. However, this varies substantially among the regions depending on their topographic and demographic characteristics. However, the trend over time shows that there is a steady increase both in coverage and utilization. The potential health service coverage has increased from 45% to 57% and then 64.02% during 1997, 2002 and 2004 respectively. The per capita health service utilization that was 27% until 2000 has increased to 36% in 2004(Health Sector Strategic Plan, 2005/06- 2009/10). However, coverage in terms of health workers remains poor. The existing number of health workers and health worker to population ratio for 2003/4, the physician to population ratio is much lower than the WHO minimum standard of one physician for 10,000 people.

As a result of recent policy measures taken by the Government, the Federal Ministry of Health and the Regional Health Bureaus are made to function more on policy matters and technical support, while the woreda health offices have been made to play the pivotal roles of

managing and coordinating the operation of the primary health care services at the woreda levels. The Ministry has been implementing Health Sector Development Programme (HSDP) since 1997/8. The first phase of HSDP was completed in 2002 and the second phase was completed in June 2005. Currently, the third phase of HSDP covering a period of five year i.e. July 2005 to June 2010 is now in its second year implementation. Important steps have been taken in the decentralization of the health care system. The ultimate goal of the third phase of HSDP is to improve the health status of the Ethiopian people through provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population. Regarding maternal health, the general goal is to improve maternal health with a specific objective of increasing deliveries attended by skilled attendants from 9% to 32%; to reduce the prevalence of teenage pregnancy from 20% to 5%.

In order to meet these targets, the number of government health centers has increased from 243 in 1996/97 to 412 in 2001/02 (70 % increase at the end of HSDP-I) and subsequently to 519 in EFY 1996. The number of health posts increased from 76 in 1996/97 to 1,193 in 2001/02 and subsequently to 2,899 in 2003/04. The construction has surpassed the target for 2002/03 and 2003/04 of Phase II HSDP by 15 health centers and 621 health posts. Moreover, the number of hospitals has increased from 87 in 1996/97 to 110 in 2000/01 and then to 126 in 2003/04. Proportion of deliveries assisted by trained health workers declined to 9.45%; and postnatal care attendance increased to 15.84% (from 3.5% in 1989). Although the construction of additional facilities and rehabilitation was a major component of HSDP II, recent reviews of the implementation of HSDP II raised concerns over the speed of the expansion. Despite major efforts in this regard, majority of the population still remains uncovered by primary

health care services and the trend will continue if the present pace of implementation is maintained.

The main priority for the 1998 Ethiopian fiscal year has been on the training and deployment of Health Extension Workers with the main objective of improving access and equity to preventive essential health interventions provided at kebele and household levels with focus on sustained preventive health actions and increased health awareness. It is planned and partially implemented to train and assign two female health extension workers to a health post providing outreach services to households in their respective rural kebeles. The training will last for one year that covers sixteen training health extension packages (nutrition, personal hygiene, adolescent reproductive health, disease prevention and control and health education extension package etc). The health extension workers are salaried by the government and their service is part of the health system. The plan is to train 25,000 females that meet the requirements of health professionals over the coming five years and place them in 13,000 rural kebeles.

Pilot implementation was launched in 5 regions in 2002/03 and encouraging results were seen in terms of community's acceptance and demand for services provided. Improvements were seen in construction and utilization of latrines, utilization rate of contraceptives and vaccination services in areas where the programme has been implemented so far. Regarding maternal and adolescent health services, priority was given to the provision of safe motherhood services to cater for normal pregnancies, deliveries and referral centers for high-risk pregnancies; post abortion care; addressing the sexual and reproductive needs of adolescents; encouraging paternal involvement and discouraging harmful

traditional practices; appropriate nutrition education to mothers and children and provision of family planning services.

Chapter Five: Summary and Conclusion

5.1 Summary

The study tried to examine the social problems of women with obstetric fistula in Ethiopia by taking 37 women taking treatment at the Addis Ababa Fistula Hospital as a sample. Factors contributing to the social problems the women face as well as those working to reverse the situation was carefully analyzed, starting from the cause of the problem, the prevailing social problems and efforts being carried out to struggle against it.

The majority of the informants (40.54%) are young women under the age of 16-20 most of whom delivered their babies at home without getting the proper medical help. According to the informants, the main reason why they did not go to clinic as soon as their labor started is because of unavailability of medical service near where they live.

For 81.08% of the respondents, the fistula occurred at their first deliveries. The majority of them had no idea why fistula occurs or knew no one with obstetric fistula in their area. The majority (37.84%) of the respondents have suffered from the problem for 3-4 years without getting treatment. Significant numbers of the informants (43.24%) were bitter to realize their problem. The reason most of them gave for not seeking treatment after the problem occurred is because they did not know that the problem could be treated.

Majority of the informants (86.49%) are illiterate, and 10.81% of the informants attended primary education. It is only 2.7% of the respondents who can read and write. Most of them were engaged in farming for their living and appear to live in scanty earning. Stigma and fear of people forced them to be dependent on their families after onset of the problem.

After onset of the problem, 70.27% of the women were separated from their husbands. 31.43% responded that their husbands left them as soon as they found out their problems. Large number (34.62%) of them disclosed that the main reason for the end of their marriage is the loss of their child while 34.62% responded that their marriage ended because of their husbands were persuaded by their parents and people around them to leave their wives.

Greater number of the informants (35.13%) revealed that they faced avoidance/isolation from the society consequent to their problem. Verbal harassment is also a serious problem the respondents faced, which is the case for 27.03% of the respondents. When asked about their attitude towards the awareness of the society about the problem, 32.43% responded that the society believes obstetric fistula to be sent by God as a punishment for wrong doing. The responses of the women revealed that their parents and relatives are more supportive and sympathetic than their husbands' parents and relatives.

About forty percent (40.54%) of the respondents do not want to have a married life again. They prefer to go to school and have something to do for their living. Also significant numbers (21.62%) of them do not want to live in their previous places after finishing their treatment. There are also few women (5.41%) who are going to start living in Desta Mender for the rest of their lives because of their situation.

Addis Ababa Fistula Hospital and Women for Women Foundation are trying to address the social problems of women with obstetric fistula coming to Addis Ababa for treatment. The organizations agree that the social consequence of the fistula problems is more serious than the physical injury and that after the fistula is fixed it takes time to be able to rehabilitate these women in to their previous social status. They also agree that the social problems of these women are far to be solved with the existing capacity of these organizations and requires coordinated effort among various stakeholders.

Despite good intentions on the part of the government, the problem is so overwhelming that little change can be expected anytime soon. The government acknowledges the gap in the provision of maternal health services in Ethiopia. To this end, efforts are being made to expand health centers in remote rural areas and to cerate awareness among rural women about prenatal and antenatal health services.

5.2 Conclusion

Despite its devastating impact on the lives of girls and women, the social problems of women with obstetric fistula seems to receive less attention in Ethiopia. It has remained to be a hidden condition because it affects the most marginalized members of the population and because of lack of awareness about the condition in the society.

The social problems women with obstetric fistula face are unable to be responded by health services only. It requires coordinated efforts of different stakeholders. Deeply embedded cultural and social values continue to form barriers to women with obstetric fistula from being able to get the necessary treatment they require and continue their livelihood as much as they could.

The prevention of obstetric fistula in Ethiopia is not attainable within a short period of time. This will require improvement in maternity service, the development of transportation networks, the eradication of illiteracy, the provision of health education to the victim population and the improvement in living standards of the society at large.

Until such time that the country could achieve the prevention of obstetric fistula women who are already affected and are likely to be victims should not be deprived of the necessary attention regarding their social problems. These young girls and women tend to live with their fear and stigmatization in silence and isolation. These women have become economic dependents because of the stigmatization and unacceptability in their society. Even worse, once the physical problems are solved, they cannot lead their normal life making them life long victims of the problem. In addition, there are also women living with untreated fistula and suffering the consequent pain and degradation whose exact number are not known supported by studies.

Efforts being made in creating awareness to the society to reduce stigmatization of people affected with HIV/AIDS or Leprosy seems to rarely apply to women with obstetric fistula in Ethiopia. And it seems rare to find organizations or NGO's working in the area despite the large number of NGO's working in areas of HIV/AIDS or other gender issues. This poses a question of why this problem is not given enough attention.

Failure in taking proper measures to rehabilitate and reintegrate the victims gives the effect of the problem a chance to widen its impact towards the families and society of the victims. As a result, the families of women with obstetric fistula are caught in this cycle of

poverty and stigmatization. Programs for women with obstetric fistula need to incorporate education, literacy training, the development of social network, and the provision of skills with which to earn an adequate livelihood, if the psychological, social and economic problems these women face are to be overcome.

The efforts of government bodies, NGOs and other organizations trying to ameliorate the social problems of women with obstetric fistula will be ineffective unless the society changes its perception about obstetric fistula. The majority of obstetric fistula victims feel that society does not have the right attitude towards them. As long as there is lack of awareness, even those who have been cured will not be able to sustain their lives by engaging themselves in any productive activity. The direct and indirect costs of obstetric fistula in terms of medical treatment and opportunity cost of disrupted family, social life and income forgone mainly from stigmatization, keep on adding pressure on the efforts that are being taken to achieve sustainable development.

Catherine Hamlin (2002). *The Hospital by the River*. Pan Macmillan, Australia. URL: <http://www.fistulafoundation.org>

Central Statistics Agency (2006). *Ethiopia Demographic and Health Survey 2005*. Central Statistical Agency, Addis Ababa.

Federal Ministry of Health (2004). *Accelerated Expansion of Primary Health Care Coverage in Ethiopia*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa.

Federal Ministry of Health (2003). *Adolescent Reproductive Health Extension Package*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa.

Federal Ministry of Health (2004). *AIDS in Ethiopia*. Disease Prevention and Control Department. 5th Edition, Ministry of Health.

Federal Ministry of Health (2005). *Health Sector Strategic Plan (HSDP-III) 2005/6-2009/10*, Ministry of Health.

Fistula Foundation (2004). URL: <http://www.fistulafoundation.org>

Gaetan Bephage (1997). *Social Science and Healthcare*. Mobsy International, London.

- Herek G. (1999). *HIV related Stigma and Knowledge in the United States: Prevalence and Trends*. *American Journal of Public Health*, 1991-1999
- Hilton Paul (2001). *Vesico-vaginal Fistula: New Perspectives*. *Journal of Obstetrics and Gynecology*, Vol.13, 513-520
- International Center for Research on Women (2002). *Addressing HIV-Related Stigma and Resulting Discrimination in Africa: A Three-Country Study in Ethiopia, Tanzania and Zambia*. International Center for Research on Women (ICRW) .Information Bulletin, USA.
- Kabir M., Illiyasu Z., Abubakar I. S. and Umar U. I. (2003). *Medico-social Problems of Patients with Vesico-vaginal Fistula in Murtala Mohammed Specialist Hospital, Kano*. Sokoto and Annals of African Medicine Society, Nigeria.
- Kelly J. (1998). *Vesico-vaginal and Recto-vaginal Fistulae*. *Journal of Obstetrics and Gynaecology*. Vol.8, No.3, 249-251
- Mulu Muleta (1997). *Obstetric Fistula: A Retrospective Study of 1210 Cases at the Addis Ababa Fistula Hospital*. *Journal of Obstetrics and Gynaecology*.Vol.17, NO.1, 68-70
- Mulu Muleta (2004). *Socio-demographic Profile and Obstetric Experience of Fistula Patients at the Addis Ababa Fistula Hospital*. *Ethiopian Medical Journal*.Vol.42, 9-16

Rahmat Hassan Mohammed (2001). *Vesico Vaginal Fistula. A Problem of Under-development*. Foundation for Women's Health, Research and Development, Nigeria.

Raza M. Khan, Nabeela Raza, Mohammed Jehanzaib and Ruqia Sultana (2004). *Vesico-vaginal Fistula: An Experience of 30 Cases at Ayub Teaching Hospital*. Ayub Medical College and Teaching Hospital, Abbott Abad.

United Nations (2005). *Journal of Midwifery and Women's Health*. Vol. 50

United Nations Population Fund (2004). *Campaign to End Fistula*. URL: <http://www.unfpa.org/fistula/index.htm>, UNFPA.

United Nations Population Fund (2003). *Fistula Campaign News*. Issue No. 1, UNFPA.

Wall L.L. (2002). Fitsaro "Dan Duniwa: an African (Hausa) Praise-song about Vesicovaginal Fistulas. *Journal of Obstetrics and Gynaecology*. Vol.100, 1328-1332

Wall L.L. (1995). *Obstetric Fistula: Hope for a New Beginning*. The International Urogynecology Journal. Vol.6, 292-295

World Health Organization (2006). *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*. Department of Making Pregnancy Safer. Geneva.

World Health Organization (1998). *The Prevention and Treatment of Obstetric Fistulae: A report of a Technical Working Group*. Geneva.

Wikipedia, Encyclopedia. URL: [http://en.wikipedia.org/wiki/social issues](http://en.wikipedia.org/wiki/social_issues).

Appendix

Interview Questions

1. Interview Questions for Women taking Treatment at Addis Ababa Fistula Hospital

I. General Information

1. Age
2. Marital Status (Single, Married, Divorced, Widowed, Separated)
3. Previous Address (Region, City, Wereda)
4. Educational Level
 - A. Illiterate
 - B. Read and Write
 - C. Primary (1-6)
 - D. Junior and Secondary (7-12)
 - E. Above 12th Grade, specify
5. Do you have children?
6. If yes, how many children do you have?
7. What did you do for your living before you came here?
8. What was your monthly income at that time?
9. Did you own any property?
10. If yes, what property did you own?

II. Fistula Problem

11. When did the fistula problem first occur?
12. How did it occur?
13. Did it occur at your first delivery?
14. If not, at which delivery did it occur?

15. How soon did you go to a health institution after your labor started?

16. Why didn't you go to clinic or hospital as soon as your labor started?

(Choose all that apply)

A. Lack of money

B. Unavailability of medical service near to where you live

C. Wanted to deliver at home

D. Your husband or relatives didn't want you to go to the hospital

E. Because of cultural taboo

F. Other(specify)

17. Did you have any knowledge about why obstetric fistula occurs?

18. Have you ever known someone with obstetric fistula in your area?

19. What was your reaction when you knew about your problem?

20. After the fistula occurred, how long did you wait without getting medical treatment?

21. Why didn't you seek medical treatment as soon as the fistula problem occurred?

22. Were you married at that time?

23. What was your husbands' response when he knew about the problem?

24. What were your parents' and relatives' response?

25. What about your husband's parents and relatives?

26. What problems did you face in your marriage after the problem occurred?

27. Was it difficult for you to perform your day to day duties at home after the fistula occurred?

28. If yes, how did you manage it?

29. What problems did you face in the society and relationship with others?

30. What was the attitude of people living in the society where you came from about obstetric fistula?

31. What are their attitudes/ knowledge about the cause of the problem?
32. What type of stigmatization did you encounter?
33. Is the child who was born when the fistula occurred alive?
34. If he/she is not alive, did you face any problem at your home or in the society related to his/her death?
35. If you have other children what problems did your children face in the society, family and school consequent to your health problem?
36. How did you know that the problem could be treated?
37. How did you know about Addis Ababa Fistula Hospital?
38. What problems did you face when you decided to come to A.A?
39. With whom did you come here?
40. While you are here for a medical treatment, who is taking care of the children and duties in the house?
41. What is your future plan?

2. Interview Questions for Government Officials and NGOs

1. How do you see the problem of obstetric fistula in Ethiopia?
2. Is the number of women with obstetric fistula in Ethiopia known?
3. If known, what is the number of women with obstetric fistula in Ethiopia?
4. What is your view about the social problems these women face in addition to the physical injury?
5. What do you think is the cause for the occurrence of the social problems?
6. How serious do you think is the social problem of women with obstetric fistula?

7. In which part of the country do you think the social problems prevail most?
8. What is your organization doing regarding women with obstetric fistula in Ethiopia?
9. In which part of the country is your organization working with women with obstetric fistula?
10. What actions or programs does your organization have to ameliorate the social problems?
11. What projects are there to support the victims at Addis Ababa Fistula Hospital and Desta Mender?
12. What major challenges have you faced in your interventions?
13. What do you think should be done to eradicate the social problems of women with obstetric fistula?

3. Interview Questions for Officials at Addis Ababa Fistula Hospital

1. How do you see the problem of obstetric fistula in Ethiopia?
2. Is the number of women with obstetric fistula in Ethiopia known?
3. If known, what is the number of women with obstetric fistula in Ethiopia?
4. In which part of the country do you think the social problems prevail most?
5. How many women does your hospital treat each year?
6. From which part of the country do these women come most?
10. Is the number of women coming to the hospital and clinics increasing or decreasing from year to year?
11. If increasing or decreasing, what do you think is the reason?