

Beyond Surgery

Injury, Healing, and Religion at
an Ethiopian Hospital

ANITA HANNIG

The University of Chicago Press
Chicago and London

CONTENTS

Acknowledgments / ix

Introduction / 1

PART ONE: KIN, SOCIETY, AND RELIGION

ONE / A Malleable World: Injury, Care, and Belonging / 31

Interlude: Yashume / 57

TWO / The Pure and the Pious: Flow, Containment,
and Transgression / 64

PART TWO: FISTULA TREATMENT AND THE INSTITUTION

THREE / Mending the Mothers of Ethiopia: Institutional
Roots, Logic, and Mission / 93

Interlude: Poison / 119

FOUR / Clinical Tracks: Moving through Surgery / 122

PART THREE: BEYOND SURGERY

FIVE / Healing and Reforming: The Making of the
Modern Clinical Subject / 149

Interlude: Conversion / 176

SIX / From Orphan to Apprentice: Crafting Patient
Entrepreneurs at Desta Mender / 179

Conclusion / 205

Notes / 209

References / 227

Index / 237

Introduction

A Story of Loss and Salvation

The image burns itself into the brain easily. A young Ethiopian woman sits in a dilapidated, dimly lit hut on the edge of her village. A stream of urine is running down her shins, soiling her dress and the makeshift bed on which she sleeps. Occasionally, someone stops by to drop off a pot of food. Otherwise the woman is left to her own devices. A failed, obstructed labor had caused her to lose both her baby and control over her excretions. Appalled by her state and disgusted by her smell, her kin, husband, and community were quick to cut all ties with her and banish her out of sight. So there she sits, stinks, and suffers. Until, that is, she discovers the possibility of a surgical intervention that promises to repair her leaking. The woman undergoes the operation, finds that she is cured, and becomes reinstated as a human being.

Obstetric fistula is a maternal childbirth injury that leads to chronic incontinence. Women sustain these injuries as a result of prolonged, obstructed labor, unrelieved by an emergency obstetric intervention, such as a Caesarean section. Approximately one million women suffer from obstetric fistula globally, most of whom live in sub-Saharan Africa. Especially over the past few decades, a particular narrative has been crafted around this injury, and variants of it have been sold to a stunned global audience. Consequently, obstetric fistula has come to be known as a profoundly stigmatizing condition: an affliction poised to break up marital bonds, erode kin relations, melt communal succor, and reduce a young woman—a mere child—to a social outcast. Today, the archetypal fistula sufferer is a young African girl who has been forced into a “child” marriage. She gives birth before she is physically mature, which leads to complications during her pro-

tracted delivery and, ultimately, the onset of her postpartum incontinence. Owing to the ceaseless flow of her excretions and their conspicuous smell, her kin and husband abandon her and relegate her to a hut on the fringes of her community. Eventually, the girl makes her way to an urban fistula center where a surgeon manages to restore her continence, enabling her return to the fold of society.

Despite some variations, examples of this narrative framework can be located across the broad spectrum of media and donor publications, including several award-winning fistula documentaries, the biographies of eminent fistula surgeons, and the world's leading newspapers and radio stations.¹ Celebrities such as Oprah Winfrey and Meryl Streep have picked up the fistula cause and recounted a similar trajectory from abject suffering to surgical salvation, as have some academics and medical practitioners.² In the course of this coverage, respected media outlets like the *New York Times* have branded women with fistula as the "lepers of the 21st century" and "the most wretched people on this planet."³ "Because they are so offensive to be near," writes John Little (2010, 3), biographer of Dr. Catherine Hamlin, cofounder of the first fistula hospital in Ethiopia, "fistula sufferers are invariably divorced by their husbands and banished from their village. Theirs are lives of loneliness and despair, often in some ruined dwelling away from everyone else." Women with fistula are said to face "a fate worse than death" (Winsor 2013), leading some commentators to assert that, in the words of Dutch fistula surgeon Dr. Kees Waaldijk, "To be a woman in Africa . . . is truly a terrible thing."⁴

It is hard to overstate how pervasive the framing of fistula sufferers as despised outcasts of their societies has become, even at the local level. When I visited the office of Intrahealth—a local nongovernmental organization (NGO) partner of the fistula hospital in Ethiopia charged with raising awareness about fistula in rural areas and driving patients to a repair center—I asked the Ethiopian project manager how many women with fistula, on average, turn into social pariahs who are fully deserted by their kin. "One hundred percent," his response came shooting out. "One hundred percent?" I asked. "Yes, the family tries to make a small house for her somewhere," he replied impatiently. "She must sit in this house. She must hide herself."

Against the "cultural" failings that both precipitate and mark women's experiences with fistula, the dominant narrative positions surgical repair as the cool antidote. Women with fistula are widely reported to find both physical and social redemption through surgical repair. Popular accounts portray fistula surgery as a quick and simple "fix"—a technocratic solu-

tion akin to vaccinating children or handing out mosquito nets.⁵ In part, it is the ostensible ease but enormity of impact in a case like fistula—a \$400 surgery that takes no more than two hours, and often much less—that has made pledging money to its cause so palatable for donors. At the fistula hospital, an ailing woman is reported to emerge anew, “like a butterfly from the chrysalis” (Hamlin 2001, 282). Fistula surgery is “life-transforming for everybody who gets it done,” an American fistula surgeon declared in a *New York Times* interview. “It’s astonishing. You take a human being who has been in the abyss of despair and—boom!—you have a transformed woman. She has her life back.”⁶ Therapy for fistula—more so than most global health interventions—has come to be seen as an uncontested good. The one-stop surgical cure for fistula promises to mend body and person all in one technical performance.

Stories are powerful things. In global humanitarian and medical settings, they can decide the difference between who lives and who dies—who gets access to lifesaving treatment, legal recognition, and political rights, and who does not.⁷ Telling an effective story allows individuals and the institutions that serve them to tap into fleeting currents of global funding and attention and pull in vital financial support. All too frequently, however, prevailing narratives take on a life of their own, creating blind spots and resulting in an array of concrete, real-world repercussions.

The narrative that has been forged around obstetric fistula has taken on such ubiquitous—even hegemonic—dimensions. I am not talking about a narrative that floated somewhere up there, in the realms of foreign media, donor, and activist circles, a narrative that Ethiopian women with fistula never came across. If they paid attention, it was everywhere: in the paintings that hung on the walls of the fistula ward in Addis Ababa, in the educational films they watched during their hospital stay, in the assumptions underwriting the classes that broke up their treatment routines, in the plans made for their rehabilitation. The narrative inflected clinical decisions and shaped treatment protocols; influential institutional initiatives followed from it. There were moments when patients came to experience their injuries, relationships, and episodes of care through this narrative framework, borrowing from its language and lexicon. At other times, they strongly resisted such framing and articulated divergent experiences.

That the contours of the iconic fistula narrative break down on closer inspection is perhaps not too surprising in and of itself. Indeed, the assumptions that sit at its heart—the imagined neglect of the sick in Africa,

the idea of “culture” as a culprit for bodily injury, and the notion of the quick, biomedical fix—don’t hold up too easily to scrutiny. Still, the narrative opens a critical space for scholarly inquiry, that is, how experiences of injury and treatment for fistula play out in a specific ethnographic site, both in connection to the narrative and independently of it. Here, superficial images of cultural pathology and exclusion give way to more complicated systems of value and meaning, and surgical treatment emerges less as a bound moment in time than a much more tortuous, unpredictable process.

In this book, I use the loss-and-salvation narrative that has been constructed around obstetric fistula as a springboard to a more expansive set of concerns. Based on over fourteen months of ethnographic research at two fistula repair and rehabilitation centers in Ethiopia, I take women’s encounters with fistula and their hospitalization as an occasion to delve into deeper reflections on the intimate and collective experience of bodily affliction, the function of hospitals as spaces of both healing and reform, and the equivocal role of biomedicine as a technological imaginary. In the process, I engage with understandings of health, illness, and suffering in relation to work both within and beyond medical anthropology. Several questions motivate this book: How do people engage in meaningful individual and joint pursuits amidst experiences of affliction? How is religious piety sustained in the wake of bodily injury? What are projects of healing if not social projects? And what happens when biomedical treatment fails to have the desired effects and produces only partially healed subjects?

Part of my goal is to document how bodily affliction influences people’s relationships and engagement with various public and private spaces. In revealing the cascading effects of fistula on women’s moral, aesthetic, social, and religious landscapes, the book grapples with themes around purity and contamination, concealment and exposure, and belonging and loss. My core contention is that both processes of injury and projects of healing are entangled in a range of agendas that exceed a focus on the biophysical body. Just as women’s birthing injuries draw in a host of concerns, practices, and actors, so does the project of healing. Therapy for fistula extends well beyond the technocratic event of surgery—itself steeped in a potent set of imaginaries—and comprises a variety of extramedical programs aimed at transforming patients. To reduce fistula treatment to surgery would be to disregard the socially and morally transformative work that medical institutions often undertake in relation to the populations they serve.⁸

Beyond Structural Violence

In his recent book *Humanitarian Reason* (2012), Didier Fassin calls for an anthropology that would combine the fields of critical and culturalist anthropology. "In anthropology," he argues, "the boundary is often drawn between those who challenge the structural violence of the world and those who seek to give an account of the unique ordering of each society: critical anthropology versus culturalist anthropology" (245). He traces these differences to the diverging approaches to ideology of Karl Marx, "who sees ideology as what deforms, disguises, and even inverts reality for us by masking the logics of domination," and that of Clifford Geertz, "who views it as the cultural system by which we make sense . . . of social relations." Seeking a reformulation of this binary, Fassin invites anthropologists to take a position "at the frontiers" by joining the task to "unveil" and "denounce" with the task to "translate" and "offer a grammar of social worlds."

This book tries to inhabit such a position: it takes seriously the structural obstacles and health access problems that affect women who sustain obstetric fistula, but it also shows how a seemingly devastating medical condition can illuminate key cultural logics at the intersection of bodily integrity, care, belonging, piety, and social viability. In revealing how Ethiopian women respond to the event of obstetric fistula in their lives, this book chronicles experiences of human hardship and strife but also innovation and potential.

My rationale for such an approach derives in part from a dissatisfaction with the model of structural violence—if used in isolation. Critical medical anthropologists who employ this or similar analytical frameworks argue that large-scale socioeconomic and political factors force individuals into situations beyond their control that expose them to the destructive effects of illness and mortality (Scheper-Hughes 1992; Singer 1998; Farmer 1999, 2003, 2004; Kim et al. 2002). In their efforts to draw attention to vast global inequities of health access, these scholars tend to paint bodily affliction as both emblematic and generative of social crisis. This tendency is nowhere more apparent than in the literature on HIV/AIDS, an affliction said to "[ravage] every aspect of people's lives" while it "continues its relentless march from one country to another" (Campbell 2003, 4–5). Paul Farmer has dubbed HIV/AIDS "a 'misery-seeking missile'" that has "spread along the paths of least resistance, rapidly becoming a disorder disproportionately striking the poor and vulnerable" (1992, 259).

As valuable as the structural violence approach has been in shifting the

focus away from individual culpability for bodily affliction to unearth systemic inequalities, it has also obscured some things. A narrow focus on structural violence can create the impression that people's mechanisms for dealing with distress and misfortune are rendered entirely obsolete by dominant structural forces—that their lives become bereft of meaning and purpose when they fall ill, faltering under the weight of insufficient health access. "Structural violence is structured and *structuring*," writes Farmer (2004, 315; original emphasis). "It constricts the agency of its victims. It tightens a physical noose around their necks, and this garroting determines the way in which resources—food, medicine, even affection—are allocated and experienced." Linda Green (2004, 319), in response to Farmer's article, asserts along similar lines: "There is accounting to be had for the diminished lives of the impoverished, lives lived at an emotional, intellectual, and spiritual minimum, where general expectations of life are emptied of hope."

In addition to being "overly determinist" (Biehl and Locke 2010, 332),⁹ the problem with the structural violence framework is that it hinges on several universalist bottom lines. First, it rests on the unexamined assumption that illness and mortality are entirely wanting in meaning and must be averted at all cost, so that all may share in the "equitable distribution of the fruits of scientific advancement" (Farmer 2003, 18).¹⁰ Anthropologists have long given us reason to think that there are other available models for conceptualizing human frailty and finitude, one that a bioscientific view of the world has trouble accommodating.¹¹ The second assumption contained in this paradigm is that there is a certain universal quality to suffering that transcends culture. In explicit opposition to the idea of cultural specificity, Farmer (1999) claims that anthropologists have long inflated the significance of cultural difference and unduly exaggerated the agency of those who fall victim to physical misfortune. In fact, in several of his writings, he bristles against what he sees as anthropologists' myopic focus "on atomistic cultural specificities" (2003, 13).

This second point requires elaboration. Here, I find it useful to draw from Joel Robbins's recent insights in conjunction with his notion of "the anthropology of the good" (2013). In a provocative article, Robbins traces the shift in ethnographic focus over the last thirty years from what he calls "savage slot" anthropology to "suffering slot" anthropology. As anthropologists have increasingly moved away from studying people considered radically "other," the discipline has turned much of its attention to "suffering subjects"—individuals who live in pain, poverty, violence, and oppression (448). He argues that this new focus on "empathetic connection

and moral witnessing"—though valuable—has weakened the discipline because through it we have lost sight of what he terms "the cultural point" (453, 447). Invoking an idea of shared humanity, many of these works have placed suffering and violence *beyond* culture, "and hence as realities with universal and in some ways obvious import that do not require cultural interpretation to render them sensible" (454). As a result, anthropology's contribution to illuminating other ways of being has been lessened, and with it the potential to teach us something about our own.

In trying to unveil and denounce the socioeconomic and political structures in which affliction is embedded, the structural violence framework unwittingly imposes its own metanarrative of suffering that subsumes all other narratives. In isolation, it does not give us the tools for understanding how illness and injury are experienced in situ or allow us special insight into how such experiences are rendered comprehensible, even meaningful. Suffering becomes something of a "you-know-it-when-you-see-it" variety—people's struggles with bodily affliction are presumed to be more or less the same everywhere. All too frequently, this is where the analysis stops.

In the pages that follow, I show that studying the carefully situated nature of bodily affliction can offer us valuable insights into how subjects are remade in the face of misfortune. As an intrinsic part of individual and collective life, injury is mediated by—rather than divorced from—existing relations to the world and their powers of signification. In recounting women's experiences with fistula in Ethiopia, this study aims to not only unsettle received accounts of victimhood and isolation but also challenge a priori notions of suffering. In managing their impairment, women with fistula draw from an expansive cultural repertoire, evidencing the type of resources that may be mobilized in times of affliction.

At the same time, the book retains some of the usefulness of the structural violence approach as a tool for highlighting the systemic inequalities of health access faced by women who incur obstetric fistula. In most popular representations of fistula, a focus on these larger-scale factors is elided in favor of a more dramatic narrative of cultural pathology, centered on practices such as "early marriage." The iconic fistula narrative locates fistula as a consequence of unenlightened "culture," oppressive patriarchy, and neglectful families, thus depoliticizing and obscuring enormous structural inequities in the domain of maternal health. The structural violence paradigm is a critical instrument for showcasing these constraints. But there is also another story here, one that an exclusive focus on structural violence cannot tell.

Obstetric fistula—a condition that has been almost universally branded as a social death sentence—offers a window into a complex world of malleability and sociability. For example, as the first part of this book demonstrates, local ethical concepts of bodily containment and integrity are relative in that they are being managed spatially and situationally. Owing in part to such elasticity, Ethiopian women who develop fistula during labor find ways to reconfigure existing forms of affiliation, belonging, and affect, particularly in the religious realm and in their dealings with kin and community. Even though women with fistula usually refrain from entering an Orthodox Christian church for fear of defiling sacred ground, they avail themselves of other embodied religious practices such as fasting to maintain their quest for divine grace. Similarly, most women with fistula remain entangled in intricate networks of kin and community obligations that defy their supposed relegation to the margins of society. And while some of their relationships might be changed by fistula, they are rarely dismantled by it.

To be clear, obstetric fistula presents an enormous burden to those who experience it. Many of my research subjects faced divorce and reduced social contact; others entertained suicidal thoughts and felt that their incontinence had once more relegated them to the status of infants. My purpose in this book is not to downplay Ethiopian women's very real struggles with fistula. But even though the condition brings with it considerable social and physical handicaps, the prevailing narrative of exclusion is too simple. Their birthing injuries do not irrevocably flatten women's lives but occasion many of them to draw from cultural resources of various kinds to craft meaningful individual and collective futures. But when we talk about affliction only in terms of fracture and crisis, we isolate actors and events from their wider fields of reality.

This study then also makes a contribution to the burgeoning anthropology of care.¹² In this ethnography, I use the term "care" in the way that Julie Livingston (2005, 197) does to describe "bodily care in the more narrow sense of the palliation that people provide daily to debilitated persons but also in the broader sense of activities that contribute to the well-being of others." The latter may include, for instance, the provision of food, labor, baths, visits, prayers, or holy water. Particularly the first two chapters of the book detail how the advent of obstetric fistula pulls in a whole host of practices of caregiving and intimacy, revealing how women with fistula remain enmeshed in meaningful social and religious relationships of various kinds.

Hospital Ethnography

Just as women remain entangled in the world around them in the course of their injuries, so is the project of healing—with surgery at its core—entrenched in a broad range of religious, political, and moral agendas. This book taps into a growing concern in medical anthropology to produce accounts of affliction that take the hospital as the primary site of ethnographic inquiry. In what follows, I treat the hospital not as an insulated site for the unimpeded, cool exercise of biomedicine, but as a place of entanglement and encounter. In this space, relationships to various human and nonhuman actors are kept up and regenerated, and new forms of interaction and subjectivity emerge. Despite temporal and spatial markers that define the hospital as a liminal space—the impermanence of treatment, external boundaries such as doors and fences, internal rules and codes, new ways of dress and bodily care, and the attempt at physical transformation through surgery—what goes on inside the hospital constantly refracts and gestures to the world outside of it. In this way, the hospital becomes a place that always and already points beyond itself.

Early sociological studies often depicted medical institutions as isolated enclaves whose organizational principles had a totalizing effect on patients and staff, severing them from the outside world and operating according to a unique set of logics (Goffman 1961; Roth 1963). These studies took the liminal space of the hospital for granted. More recent ethnographies have directed our attention to the permeable, porous nature of medical institutions, which—rather than constituting a world apart—are firmly embedded in their surroundings (Anderson 2009; Garcia 2010; Wendland 2010; Livingston 2012; Street 2014). Anderson (2009), for example, eloquently describes colonial hospitals in the Philippines as “lighthouses throwing into sharp relief otherwise obscure features of their setting” (154). In Papua New Guinea, Street (2014) takes the public hospital as a “crucial site of production for the everyday state, a place where people engage with, imagine, and contest forms of state power” (22). Along similar lines, in the introduction to a dedicated journal issue on hospital ethnography, the authors prompt anthropologists to study the hospital as “a domain where the core values and beliefs of a culture come into view” (Van der Geest and Finkler 2004, 1996).

This book builds on and develops these insights through two related contributions. First, it offers a detailed account of how hospitals transform patients’ lives in ways that exceed a focus on the body proper, illustrating

that institutionalization is as much about biomedical care as it is about a whole range of other agendas. Second, the book shows that the hospital is never just a site for the “pure” exercise of scientific rationale. At the fistula hospital, biomedical and religious concerns became infused with each other to the point of being indistinguishable. Medicine came to be seen as a profoundly religious endeavor, and religion inflected surgical treatment each step of the way—for patients and surgeons alike.

The principles that undergirded the fistula hospital’s desire to heal could never quite be disentangled from its impulse to reform. Patients’ treatment stays became projects in social transformation and engineering that sought to shape new kinds of modern subjects. While they awaited or recovered from surgery, fistula patients underwent intensive moral and behavioral education and economic training. Once they returned home, women were expected to become ambassadors of model health and hygiene practices in their communities. Training programs did not always go over smoothly, though. An array of ideological orientations collided at the hospital, replicating frictions evident in the country as a whole: tensions between urban and rural Ethiopia, ethnomedical and biomedical concepts of healing, and Protestant and Orthodox Christianity.

Relatedly, when it came to fistula treatment in Ethiopia, religion and medicine did not occupy separate, compartmentalized domains. Neither patients nor surgeons saw biomedicine as a sanitized, detached realm that could escape divine influence. Even the project surgery—which has been dubbed “biomedicine’s most distinctive and technologically intensive means of treating bodies” (Prentice 2013, 6)—took on a markedly religious quality at fistula facilities in Ethiopia. For expatriate surgeons, Protestantism offered an ideological basis for the venture of surgery, which came to symbolize a kind of (biblical) rebirth. The Protestant convictions of the founders of the hospital imbued treatment for fistula with strong soteriological undertones, an idea that lives on even in more secularist renderings of fistula surgery today. From the start, God was seen to stand behind the work of the hospital, overseeing every suture.

Like surgeons, Orthodox Christian fistula patients experienced and gave order to their hospital stay through various religious registers. In Amharic, the verb “to heal” (*adane*) means both “to cure” and “to save.”¹³ Similarly, the term for medicine (*medhanít*) and for Savior (*medhanê*) stem from the same root, suggesting that healing has long been understood in both a medical and a religious idiom and that physical and spiritual healing go hand in hand. In a world where patients shuttle back and forth between churches and clinics to find healing, medicine and religion are tightly

intertwined. To illustrate, many patients viewed access to hospital doctors' knowledge as restricted not merely because it rested on a complex body of scientific "facts," but because God had sanctioned such knowledge. At times, patients' medical treatment interfered with their religious convictions, such as when they voiced the desire to make up for religiously prescribed fasting days they had lost at the hospital. The ethnographic material then also allows me to bring medical anthropology together with the anthropology of religion.¹⁴

That biomedical interventions do not operate in a vacuum should be plain by now. This book takes the example of fistula therapy in Ethiopia to unravel how precisely these kinds of interventions inhabit and are shaped by their surroundings. The rest of the introduction lays down the essential groundwork for this project.

Hamlin Fistula Hospitals

The subject of this ethnography is a set of privately run hospitals specializing in obstetric fistula repair and rehabilitation in Ethiopia. Amidst a tumultuous regime change that put an end to the Haile Selassie era (1930–1974) and ushered in nearly two decades of Socialist rule, Dr. Catherine Hamlin (from Australia) and her late husband Reginald (from New Zealand) founded the first of these hospitals in Addis Ababa, Ethiopia's capital, in May 1975. The Addis Ababa Fistula Hospital was the first dedicated institution for fistula repair in the world. Since then, Hamlin Fistula Ethiopia, as their charitable organization came to be called, has established five fistula repair centers in larger regional towns across the country, a rehabilitation and training center near the capital, and a small midwifery college.

From its inception, the Hamlins' work with fistula patients has been funded by a combination of governmental, institutional, and private donations. As a result of decades of fundraising, the hospital has a broad foreign donor base today. Among its largest contributors are USAID (the United States Agency for International Development), Ethiopiaid (a UK-based fundraising organization for Ethiopia), AusAID (the Australian Agency for International Development), UNFPA (the United Nations Population Fund), World Vision, the Norwegian Lutheran Mission, and Rotary International. Across eight countries—the United Kingdom, United States, Australia, the Netherlands, Sweden, Germany, New Zealand, and Japan—international partners have set up fistula trusts that raise money for the institution, often in churches, and get together in knitting circles to produce the signature patchwork shawls patients wear during their stay at a treat-

ment facility in Ethiopia. Together, these trusts and the Ethiopian Fistula Welfare and Research Trust form Hamlin Fistula Ethiopia, a single overarching nongovernmental organization that manages the hospital's financial affairs.

Since the beginning of fistula repair in Ethiopia, some patients whose bladder injuries could not be fully mended have been hired as nurse assistants (or "nurse aides") and trained to perform essential nursing duties in the ward and operating theaters. The recruitment of uncured patients initially served as a way to solve the hospital's urgent nursing shortages and was later continued as a "best practice," in large part because it enabled chronic patients to keep receiving medical attention. The hospital was particularly concerned about the small number of patients who had received urostomy bags to manage their incontinence; it was thought that they had to remain tethered to the institution to manage these devices. At first, most urostomy patients were employed at the Addis Ababa Fistula Hospital. When the hospital's demand for nursing staff was met—and before any of the regional fistula centers had been built—it founded Desta Mender ("Joy Village"), a rehabilitation and training center for urostomy patients outside the capital.

Starting in 2005, the hospital opened five satellite centers for fistula repair in locations across Ethiopia: Bahir Dar—the primary site of my research—was to provide coverage for the northwestern Amhara region, Mek'ele the northeastern Tigray region, Harar the east of Ethiopia, and Yirga Alem the vast area south of Addis Ababa. In 2010, the latest center was inaugurated in Metu, located in the western part of Ethiopia near Jimma. During the time of my research that same year, expatriates occupied many of the leading administrative and some of the top surgical positions. Today, Hamlin Fistula Ethiopia is almost exclusively run by Ethiopian staff.

Obstetric Fistula as a Medical Condition

In biomedical parlance, a urogenital fistula refers to "an abnormal passage or communication between two pelvic organs, such as between the vagina and bladder (vesicovaginal), or vagina and rectum (rectovaginal)" (Broughton 2010, 12). Across the global south, over 90 percent of these injuries are of obstetric origin, that is, they are the result of prolonged, obstructed childbirth (12). While urogenital fistulas (or fistulae) are rare in resource-rich countries today—where they tend to have iatrogenic causes due to radiation therapy or surgical interventions—they affect an estimated

one million women in the global south (Adler et al. 2013).¹⁵ In Ethiopia, estimates place the incidence of obstetric fistula at around 1.62 per 1,000 women of reproductive age (Muleta et al. 2007).

An obstetric fistula—a fistula developed during labor—describes a hole in a woman’s bladder and/or rectum wall that leaves her trickling urine and/or feces through her vagina. The sustained force of protracted labor unrelieved by an obstetric intervention, such as a C-section, causes the fetus to exert pressure on the mother’s pelvic tissue, leading to ischemic necrosis, the death of tissue resulting from a loss of blood supply. The compromised tissue eventually gives way and leaves behind a fistula. In nearly all cases, the baby does not survive the multiday ordeal of labor: it is estimated that over 85 percent of all obstetric fistula cases result in stillbirths (Ahmed and Holtz 2007). Fistula may be accompanied by other ailments as well, such as foot drop, bladder and kidney infections, limb contracture, secondary infertility, or excoriation from the skin’s constant exposure to urine or feces.

Prior to the institutionalization of birthing, obstetric fistula was not uncommon in Europe and the United States (Zacharin 1988). Starting in the seventeenth century, European doctors first attempted to close obstetric fistulas, employing sutures made of swan quills, gold wire, and lead. Though not the first American surgeon to successfully close a vesicovaginal fistula, Dr. Marion Sims has been credited with pioneering an effective, replicable surgical technique for repairing obstetric fistula cases. Between 1845 and 1858, Sims conducted medical experiments on enslaved black women suffering from obstetric fistula in antebellum Alabama, subjecting one of them to thirty unanesthetized surgeries before pronouncing her “cured” (Ivy 2013). Since these ominous beginnings, fistula repair has continued to undergo innovations and refinements. Yet, an aspect of experimentation remains part and parcel of the project of surgery, with most fistula surgeons developing their own set of surgical techniques and methods of convalescence for the patients under their care.¹⁶ Expatriate fistula surgeons began treating obstetric fistula cases in Africa around the 1950s, soon followed by a growing cadre of African surgeons. Today, there are specialized fistula repair facilities in over thirty countries, most of them in sub-Saharan Africa.¹⁷

Fistula surgeries are usually postponed until three months after the fateful labor—the affected tissues are much too fragile to withstand an operation at first. Surgeons also want to allow for the possibility that a fistula might close by itself, which does happen occasionally. The majority of fistula cases are said to be curable through surgery. Some studies place the

success rate for first-time fistula repair as high as 80 to 95 percent.¹⁸ Other studies cite slightly more conservative estimates, putting the proportion of women continent after their first repair at 75 percent. In fact, the authors of the latter study assert that “negative outcomes are not frequently reported in the literature. We believe this is due to a strong bias towards positive outcome reports” (Maulet, Keita, and Macq 2013, 532). With each surgical attempt, the likelihood of success decreases sharply—if a patient doesn’t regain her continence after the first surgery, her chances for a cure plummet with each consecutive try. In Ethiopia, patients with irreparable injuries have several surgical choices for managing their incontinence through a form of urinary diversion (see chapter 6). Most of them choose an ileal conduit operation, which requires them to wear a urostomy bag for the rest of their lives.

Treatment for fistula presents a variety of medical challenges. According to Dr. Roger Jamison, onetime medical director of the Addis Ababa Fistula Hospital, 80 percent of patients are diagnosed with multidrug-resistant bacteria in their bladder, exposing them to an array of infections and inflammations. They routinely suffer from urinary tract infections and face a heightened risk of succumbing to renal failure. Some patients arrive so weakened and anemic from having reduced their food intake that they must receive blood transfusions and be fed a special diet rich in proteins to regain their weight before surgeons will attempt an operation. Others suffer from muscle atrophy and bedsores as a result of being bedridden for prolonged periods of time. Then there are patients who are afflicted with various postlabor disabilities. Since they must be mobile for the recovery process to avoid the formation of blood clots, these patients are required to undergo several rounds of physiotherapy at the hospital to relearn how to walk prior to their surgery, usually with the help of a walker or a walking stick. Finally, many patients not only suffer from obstetric fistula but also from other maladies that interfere with their treatment, including diabetes, tuberculosis, or HIV/AIDS.

Fistula surgery comes with its own set of challenges. The first is closing the hole in the patient’s bladder and sometimes rectal wall. In Bahir Dar, approximately 15 percent of all fistula patients were diagnosed with a “double fistula”—a fistula in the rectum as well as the bladder. Surgeons usually attended to the rectal injury first. Larger holes were of course much harder to repair than smaller ones as so much of the tissue had been destroyed. If a woman had lived with a fistula for a long time, there was usually some degree of scarring around the bladder or urethra that further

complicated the repair. Very rarely would a patient present with a traumatic fistula, which was a result of rape in most cases, but could also be caused by a gunshot wound or contact with a sharp object. One time a patient came in after she had tried to abort her baby with a pencil, accidentally giving herself a fistula—the surgeon found the pencil during the operation.

Yet, even a successful repair does not necessarily result in a patient's regaining of her continence. Aside from closing the hole itself, the challenge of fistula surgery is to rebuild all of a patient's continence mechanisms. For some, their fistula might be closed following surgery, but they still suffer from residual urinary incontinence.¹⁹ Most cases of residual incontinence are caused by what is known as stress incontinence—although the fistula itself is sealed and urine flows through the intended passage again, the muscles around the bladder and urethra are so weakened that patients encounter problems with urine retention. When they laugh, cough, jump, or carry heavy loads, postoperative patients may still experience involuntary leaking. It was long difficult to obtain this kind of information, as hospitals did not have the resources to conduct follow-up studies. But ever since some patients received financial incentives to return to their operating center for checkups, it has become even clearer that fistula repair is not the quick panacea it has often been made out to be. A rare follow-up study conducted by the Bahir Dar Fistula Center found that 31 percent of those who had been discharged as "cured" had developed residual urinary incontinence; in another 9 percent the repair had broken down.²⁰ A similar study, conducted at the Addis Ababa Fistula Hospital, found that about 33 percent of all patients still suffered from known residual urinary incontinence after their surgery.²¹

In his time as a fistula surgeon, Dr. Daniel Radford, director and chief surgeon at the Bahir Dar Fistula Center, developed a technique that seemed to reduce the incidence of residual urinary incontinence through the construction of a "sling" from the patient's ischiocavernosus muscle, which is placed under the urethra. He estimated that this operation cut postsurgical residual incontinence in half. Still, the long-term outcomes of the technique remain unknown, in part because the Bahir Dar center, like others of its kind, has limited means of following up with patients once they are discharged.

The potentially chronic nature of obstetric fistula underscores the fact that fistula is larger than a moment of crisis. It would be a mistake to envision the trajectories of patients in a linear manner that moves from affliction to therapy to cure. That linearity occludes the indeterminacy of surgi-

cal outcomes as well as the logistical complexities of patients' efforts to seek treatment. Besides, focusing on surgical repair as the moment of salvation discounts women's abilities to navigate unsuccessful operations.

Health Infrastructure

To situate the incidence of obstetric fistula in Ethiopia, it is useful to get a brief sense of the country's health infrastructure currently and historically as well as of conventions around childbirth more broadly. According to the latest Ethiopian Demographic and Health Survey, approximately 4 percent of laboring mothers in rural Ethiopia deliver in clinics or hospitals, compared to 50 percent in urban areas (CSA 2012, 126).²² All others give birth at home. Fistula patients I interviewed during my research confirmed that delivering at home remains the norm in the countryside: most of them regarded a trip to the clinic or hospital as a last resort measure reserved for serious complications. Patients explained that they feared the costs associated with giving birth in an institution (when birthing at home was free), that they lived too far from any major health facilities, that finding transportation to these facilities was costly, and that they felt wary of the low quality of the clinics in their area.²³ In Ethiopia, many rural health facilities are burdened by chronic shortages of high-level personnel, drugs, ambulances, electricity, and water. The vast majority are ill-equipped to handle obstetric complications.

Thirty-nine-year-old Tangut from West Gojjam, who incurred fistula during her sixth delivery, described the health infrastructure in her home area: "There is one clinic in our *woreda* [district], but the staff are not skillful or professional. When I was four months pregnant, I went to that clinic and they told me that I was just fat. Only after I gave them a urine sample did they believe me that I was pregnant." Instead of assisting laboring mothers with their deliveries, other patients claimed, clinics could only refer them elsewhere, so they preferred staying at home. "Clinic staff are not professional; they are not good at assisting women during birth. They only give them injections and pills, and then they refer them to the hospital," forty-five-year-old Hodiye from the South Gondar zone remarked. Yet others shared stories of visiting their district clinic during labor just to discover that there was nobody there.

Staff in rural health facilities are usually not qualified to carry out a C-section.²⁴ According to Dr. Radford, in 2010 there were but four hospitals in the entire Amhara region (for a population of seventeen million people)—staffed with nine obstetricians total—that could perform

a C-section. Even the sizable district hospital in the town of Mota, a few hours' drive from Bahir Dar, did not have a single OB/GYN on staff in 2010 and was dependent on flying in foreign volunteer doctors on three-month rotations to execute these surgeries. Prior to this program—which was funded by Dr. Radford's personal charity—any laboring woman who had taken the journey from her home to the hospital could not be assisted once she arrived, except by referral to Bahir Dar. The hospital in Mota came up frequently in fistula patients' testimonies as being notorious for incompetent treatment. As Misgana, a nurse aide in Bahir Dar who was taken to Mota hospital during her labor and received no assistance there, told me, "I really hate to think about Mota hospital at all. I even saw some others with fistula who came from Mota hospital during my work here. My problem was not enough for them."

In addition to institutional inadequacy, patients conceded feeling reticent to deliver in clinics where they aren't allowed to squat or sit during labor but are compelled to give birth while lying down—at times with their legs in stirrups—and while surrounded by teams of mainly male clinicians. As Warren (2010) notes, "Important traditions and customs around birth are not recognized by health care providers" (103), further dissuading Ethiopian mothers from delivering outside the home. Warren argues that women tend to feel alienated in clinical settings where they are unable to uphold familiar practices: the privacy of the mother during the birthing event, ceremonies to protect the mother and newborn from harmful entities, access to special foods, and the presence of trusted relatives (101–2; see also Hannig 2014). "Until these socio-cultural aspects . . . are incorporated into the care provided at the health facilities," she concludes, "we will continue to see women giving birth at home" (103).

That relatively few rural Ethiopian women deliver in clinical settings today also has to do with a lack of historical precedent. In the Amhara region where I conducted most of my research, it has long been common for local midwives (*auwalaj*) to assist mothers during labor or for female kin or a neighbor to assume the role of midwife. The midwives I met became involved in midwifery by accident and drew on their personal experience of having helped countless mothers give birth over the years. As one midwife from Quarrit related, "My mother had a lot of children and when I was a child, it was too late for me to call a midwife when my mother was in labor. So I helped her when she delivered. After that, my neighbors and friends started to call me when they were having a child." The role of the midwife is generally noninterventionist: she might massage the laboring women's abdomen with butter to loosen it or offer her a linseed drink

to speed up the labor.²⁵ Otherwise, she will simply encourage the mother, wait for the labor to progress on its own, and receive the child. Women typically perform their midwifery work on the side and receive little or no remuneration for it.²⁶ Through their work as midwives, the women I met hoped to receive social recognition and secure divine favors.

The lack of historical precedent for institutional births is also owed to the fact that national health services were established in Ethiopia comparatively recently. It was not until 1952 that the Ethiopian government began to develop a network of basic biomedical services, most of which were concentrated in urban areas and—at least initially—staffed by foreign physicians (Kassie and Kloos 1993, 135). The country's first medical school opened in 1966 to begin training Ethiopian doctors. Under the reign of Emperor Haile Selassie (1930–1974), the bulk of the country's health budget—and some of his personal money—went into urban hospital construction, almost exclusively in the capital.²⁷ It was in part through the construction of modern hospitals, which became showpieces for foreign diplomats and catered to urban elites, that Haile Selassie sought to justify his role as visionary monarch and Ethiopia's position as an independent African nation that had escaped colonialization (Clapham 1969). The countryside, by contrast, had to make do with preventive health services centered on teams of health officers, sanitarians, and community nurses, which were to staff rural health centers and health stations. The role of these teams—particularly the community nurses—consisted not of institutionalizing deliveries but of attending and “correcting” births at home (Weis 2015).

Despite the construction of more rural health facilities and a revised commitment to primary care in the countryside during the Socialist Derg era (1974–1991), the urban bias in the provision of health services persisted and continues to persist today. In 1988–1989, about 62 percent of medical doctors and 46 percent of nurses worked in the country's capital, which accounted for only 4.6 percent of the population (Kassie and Kloos 1993, 143). Fast-forward to 2009, and 46 percent of physicians and 28 percent of nurses were stationed in Addis Ababa, home to still roughly 4 percent of the country's population (AHWO 2010, 27). Today, some Ethiopian physicians elect to go into private practice rather than poorly paid government work, or they leave the country following their medical training for more lucrative work abroad, such as in Botswana or South Africa. In spite of ongoing efforts at decentralization and the expansion of medical training institutions by the EPRDF (Ethiopian People's Revolutionary Democratic Front) since 1991, rural areas remain underserved by current health services, even though they compose about 85 percent of the

population. The EPRDF has revived some of the benchmark policies of the Haile Selassie era, including a rural health system that is primarily run by health officers and a cadre of lower-level auxiliaries, so-called health extension workers, tasked with providing preventive health education and basic health services (Weis 2015). One difference is that the Ministry of Health is now pushing health extension workers to encourage mothers to deliver at a health facility rather than at home, representing a shift away from previous imperial policies.

Yet, it would be misguided to frame hot-button issues like obstetric fistula in terms of a generalized call to institutionalize all deliveries. Even if all births were moved into biomedical facilities, women would still encounter unreliable or insufficient services there. According to estimates by the Addis Ababa Fistula Hospital, at least 11 percent of all fistulas in Ethiopia are caused by doctor malpractice, mainly by attempted C-sections that pierce the laboring woman's bladder. During our interviews, these patients would tell me with a conviction that was only matched by their indignation, "A doctor killed my bladder." As Abbaynish, a nurse aide at the Bahir Dar Fistula Center, noted when pondering solutions to reduce the prevalence of fistula, "People say it is safe to give birth in a hospital or a clinic, but women are getting fistula even in these places now. These women, they went to hospitals and clinics to give birth, but after their delivery they got fistula, too." Rather than relocating all births to clinical settings, women in labor require reliable access to quality emergency obstetric care in cases of distress. Presently, such access remains elusive to most rural (and some urban) Ethiopians.

Amhara

I conducted the majority of the research for this study in the northwestern Amhara region of Ethiopia, located on the country's northern and central highland plateau. According to a 2007 census, the region is home to a population of about seventeen million people, of whom 87 percent live in rural areas and are overwhelmingly subsistence farmers (CSA 2008). Roughly 92 percent of the region's residents identify as members of the Amhara ethnic group whose primary language is Amharic, a Semitic language that evolved from the liturgical Ge'ez.²⁸ Today, the Amhara region is divided into eleven administrative zones, among them North and South Gondar, East and West Gojjam, and North and East Wollo. Bahir Dar, the regional capital located on the southern banks of Lake Tana, constitutes its own special zone.

The religious landscape of the region is predominantly Orthodox Christian. In 2007, Orthodox Christians made up approximately 82.5 percent, Muslims 17.2 percent, and Protestants 0.2 percent of religious adherents in the Amhara region (CSA 2008).²⁹ This distribution roughly matches the religious orientations of the patients I met at the Bahir Dar Fistula Center and is the reason why this book focuses primarily on Ethiopian Orthodox Christianity (rather than Islam)—most of my interlocutors at the center were Orthodox Christians and a much smaller minority Muslims. In concentrating on Ethiopian Orthodoxy and its complex relationship to Protestant Christianity, I don't mean to efface the importance of Islam in the region of course (consult Haustein and Østebø 2011 for a useful analysis). But I do think there is something to be gained from zeroing in so intently on Orthodox Christianity, which played a dominant role in the lives of my research subjects at the fistula center.

The Bahir Dar Fistula Center

Founded in 2005, the Bahir Dar Fistula Center sits on the property of the town's much larger public hospital, Felege Hiywet, and occupies several buildings in the rear close to the shore of Lake Tana. The German government constructed Felege Hiywet in the 1950s to serve a patient population of about twenty thousand people, which has, since then, exploded to around seven million. During the time of my research in 2010, the referral hospital was undergoing some restructuring at the hands of the Clinton Health Access Initiative, which set out to update its systems of governance and operation. Prior to this initiative, an Ethiopian surgeon at Felege Hiywet told me, "You cannot compare this hospital to anything but hell."

Indeed, the contrast between the two institutions could not have been starker. Walking through the grounds of the public hospital to reach the fistula center felt like traversing two different worlds in rapid succession. From the early morning hours, patients and visitors lined up outside the hospital's main gate, pressing against the steel bars and bargaining with the guards for admittance. Once inside, they took their place amidst the dense cluster that enveloped the reception building. Roughly half of those who were admitted as inpatients and who had been lucky to secure their own cot were wheeled into hallways or courtyards and pathways between buildings, surrounded by squatting circles of family members. Overstretched doctors and nurses hurried between sparsely furnished examination rooms, attempting to negotiate the frequent power cuts and shortages of pharmaceuticals that paralyzed operational routines. The poorly lit,

packed corridors inside the hospital gave off a pungent olfactory mixture of bodily excrement and disinfectant. If you stuck around too long, the stench of ammonia drifting in from the bathrooms could force tears to your eyes.

On turning a corner after the maternity ward, you came upon a wholly different scene. The fistula center was a quiet, orderly world unto itself. The rectangular ward was immaculately clean, suffused with sunlight, and framed by landscaped flowerbeds. Once you entered, you passed the bathrooms, showers, and an examination room on the left, and a classroom and an office on the right. The hallway opened up onto a ward of forty-five beds in four rows facing each other, divided down the middle by a low wall. Events in the ward were overseen by the nurses' station on the front left. Crossing the length of the ward, you arrived at the doors to the operating theater where fistula surgery was performed three times a week. Adjacent to the ward, a smaller building housed the kitchen, laundry facilities, and patient archives and clothes storage. On the other side of a tiny stream spanned by a wooden footbridge lay the residential compound for nurse aides and visiting surgeons, where I rented a room during my research.

Fistula patients came to this center from across the Amhara region (and beyond), either privately—usually in the company of a husband, brother, or father—or with the help of local NGO partners that gathered rural patients in collection centers and drove them to Bahir Dar. Male kin who accompanied a patient were typically asked to leave her behind and return



2. The fistula ward in Bahir Dar.

home, a rule that most—but not all—obeyed. Some fathers, husbands, or brothers tried to linger unobtrusively, spending the night outside the ward wrapped in thick cotton shawls, sharing food with the guards, and waiting out the period of a patient's recovery.

A patient who had been admitted checked her clothes at the door and received a set of hospital gowns, a knitted patchwork wrap to drape over her gown, a two-liter plastic water bottle, and rubber shoes (if she came barefoot). Her clothes were put into a bag and whatever small possessions she had—maybe a few Ethiopian birr or the bar of soap she was given—she tied around her neck or to her gown. She then received a shower by one of the nurse aides, was assigned to a bed, and served her first meal. Ordinarily, she would be scheduled for an operation at the end of her first week, unless she was unable to walk and had to undergo physiotherapy first. Most patients cycled through the clinical space of the Bahir Dar center relatively quickly. In 2010, the average stay from admittance to release was eighteen days—short, compared to the thirty-two-day average at the Addis Ababa Fistula Hospital. Complicated operative cases remained at the center much longer, of course, or were transferred to Addis Ababa.

What did a typical day in the life of a patient at the Bahir Dar Fistula Center look like? She would wake up around 6 a.m., wash herself, eat breakfast (tea and bread on most days), and undergo morning ward rounds around 8:30 a.m. She would watch as a small contingent of medical personnel moved from bed to bed with a cart of patient files and made its way to where she lay.³⁰ One of the doctors would ask her how she was doing, check her chart, lift up her blanket, and inquire if anything was wrong. If she wasn't scheduled for surgery that morning or was already recovering from the procedure, she would attend the center's classes, which began around 9:30 a.m. Classes were interrupted by a short tea break and would go right until lunch, consisting of *injera* or macaroni and some kind of sauce. On Tuesdays and Thursdays she would return to the classroom after lunch for a movie. Unless she was being examined in preparation for her surgery the next day, she had the rest of the afternoon off. During her down time, she might socialize with other patients on logs and benches outside the ward, braid another patient's hair, knit, receive a phone call, talk to the visiting anthropologist, or meet with a visiting relative. She might also try to domesticate the clinical space of the ward by picking up a mop to clean the floor, grinding coffee for the kitchen, or washing her clothes. Dinner was served early, around 4:30 p.m., as the kitchen staff left work at 5 p.m. On most days she would be in bed by 7 or 8 p.m., with a night nurse and a couple of nurse aides keeping an eye on her while she slept.

When she first arrived, a patient received a bed in the preoperative row of the ward. Following her operation, she was placed in a small group of recovery beds near the operating theater and then moved once again to the beds reserved for postoperative patients. Pregnant women who had previously undergone fistula treatment and had returned to the center to give birth occupied another section of the fistula ward, as did those suffering from various postlabor disabilities who were scheduled for physiotherapy. Expectant mothers were advised to come to the center at the end of their eighth month; they usually remained there for another couple of weeks after giving birth. The C-section they required was not performed at the fistula center itself but in the adjacent maternity ward of Felege Hiywet Hospital.

If a patient who had undergone surgery for fistula was found to be continent after her catheter was removed, arrangements were made for her return home. If the center had the proper fabric on hand, the woman received a new dress to wear, made by one of the center's tailors. If not, she would wear the dress she came in. Before the center's driver gave her a ride to the Bahir Dar bus station, one of the nurses took her aside for an exit conversation. She was told that she should stay away from heavy lifting or other strenuous manual labor for a while, lest the suture break open. The nurse also advised her to avoid intercourse for three months and, if possible, use contraception for nine months to a year following her operation. Finally, the nurse informed her that she must seek out a C-section for her next birth—preferably at a fistula center, as staff there would be familiar with her previous condition.

Of course, this ideal-typical version of events is not how things went always, or even mostly—it is meant to provide you with a working knowledge of daily patient routines and procedures, which the chapters of this book will fill in, complicate, and render specific.

On the Ward and Beyond

In addition to preliminary research in the summers of 2008 and 2009, I spent the year of 2010 conducting fieldwork on obstetric fistula in Ethiopia. The core focus of this work was to study the personal histories, bodily practices, and quotidian clinical lives of fistula patients at the Bahir Dar Fistula Center and at Desta Mender, the rehabilitation and training center for chronic fistula patients near Addis Ababa. I devoted the first nine months to research in Bahir Dar, living at the nurse aides' compound inside the hospital grounds. For the remainder of the year I packed up and moved to Desta Mender, where I stayed in one of the vacant patient houses on site.

At the Bahir Dar center, I tried to insert myself into the daily routine of the institution without getting in anybody's way and—with the help of local female research assistants—privately interviewed individual fistula patients, groups of patients, and nursing staff. In the mornings, I frequently attended and recorded patient education classes; in the afternoons, I held interviews. Every few weeks, I invited patients to participate in small group discussions on topics such as marriage, childhood, and motherhood in Amhara society. These discussions were always lively and well attended. As I describe in more detail in chapter 4, I made a decision early on that I wasn't going to try to inhabit the viewpoint of surgeons at the fistula center: as a result, I only attended a few surgeries and never observed gynecological intake exams.

On weekends and during major religious festivities, the nursing staff and I often took part in Ethiopian Orthodox Church services at various neighborhood churches. Whenever possible, I also accompanied Solomon, the fistula center's health officer, on out-of-town visits, including to the district hospital in the town of Mota, government-run clinics outside of Bahir Dar, and rural community outreach meetings about fistula. Occasionally, I would go on brief sojourns to the capital, where I did research at the Institute for Ethiopian Studies at Addis Ababa University, stocked up on supplies, and checked in with the medical director of the Addis Ababa Fistula Hospital, Dr. Jamison. Otherwise, the fistula center was—so to say—my “village.”

Initially, my research design had involved following several women back to their homes after discharge to document the start of their “new” lives. I did so only once. Part of the problem was the difficulty of tracking down rural women who had no physical address or phone number, and finding transportation there. When my research assistant and I visited Yashume, whose story is featured in the first interlude, we had to elaborately quiz our way to her home. Even then, it seemed tricky to show up out of the blue and hope for more than a cursory visit.

More importantly, however, my conception of the stakes of my study changed a few months into my stay. My original understanding of the project had been firmly rooted in the type of editorial crisis narratives I sketched earlier: I expected to meet young women—heavily stigmatized and deserted—who were finding reprieve through surgical interventions. As it turned out, the women I encountered during my research were never the social pariahs I had presumed them to be, casting doubt on the very idea of an enigmatic “return.” While forms of prejudice toward fistula sufferers existed and sometimes drove them to acts of despair, not once in my

yearlong fieldwork did I come across a patient who had been forsaken by her kin and put outside the village. Perhaps such extreme cases of social banishment occurred somewhere; perhaps some women had faced this kind of treatment. But even if they did exist, these cases were nowhere near representative of the experiences of the women I met during my research.

These findings struck me as significant and prompted me to direct my attention to the larger narrative framework that has been erected around obstetric fistula. Alongside my ongoing work with patients, my focus shifted toward the fistula hospital as a place that was authorizing this narrative and allowed its day-to-day programming to be guided by its suggestive potential. As a result, I became increasingly attuned to the discursive production of fistula—and some of its stigma—by the institution.

These concerns extended into my subsequent research at Desta Mender, where I spent my days attending patient classes, observing livelihood activities designed to groom residents for a life “outside,” and interviewing staff members and—eventually—patients. The three months I spent there overlapped with an important change to the strategic vision of the village, from a permanent “safe haven” for women with urostomy bags to a training center from which they would eventually depart to start their own businesses. Residents were not happy with this shift. Their daily acts of resistance against these unwanted changes included an initial boycott of my research (on which more in chapter 6). In retrospect, I could have easily spent a year at Desta Mender alone to cut through the complex dynamics of this medico-social space.

There are some limitations to conducting ethnographic fieldwork primarily inside an institutional space. In order to reconstruct the course of patients’ histories and trajectories with fistula, I had to rely for the most part on biographic interviews that conveyed women’s own recollections of these events. This required a leap of faith on my part, especially when it came to dealing with differences between reporting and action. Yet, I thought it essential to document patients’ interpretations of their experiences with fistula as they shared them with me, even if I had to assume that some of their memories had been clouded by the passing of time or feelings of hopelessness or were part of their desire to establish themselves as a certain kind of subject.³¹ In fact, my status as someone perceived to be tied to the foreign power structures of the hospital could have led patients to dramatize certain aspects of their accounts. As Malara (n.d.) points out, in many areas of social life in Ethiopia—such as mediation in family disputes, soliciting the intervention of a more powerful person, or invoking the assistance of saints—need is greatly emphasized through statements

that underscore the misery of the petitioner, setting up the proper affective and material disposition to move the other to action. Though I always told patients that nothing they said in the interviews would in any way affect the medical treatment they received, it is possible that some of these dynamics played themselves out in our conversations. But since the world outside the hospital constantly converged on this institutional space in ways that were hard to overlook, I accepted these drawbacks to try to gain insights into that world through the lens of those who had experienced it firsthand.

Throughout this book, I use pseudonyms or omit proper names to preserve the privacy of my patient and staff interlocutors, including that of the local and expatriate fistula surgeons I met, many of whom are well known internationally. I did not, however, utilize pseudonyms for the Hamlins, whose identities are impossible—and perhaps unnecessary—to obscure. Finally, Ethiopians prefer to be addressed by their given rather than their surname, a convention I have followed here and in the references.

Map of the Work

This book is divided into three parts: the social, religious, and bodily practices that frame and condition local responses to fistula prior to surgery (chapters 1 and 2); the historical and institutional dimensions of fistula repair in Ethiopia (chapters 3 and 4); and the extramedical facets of fistula therapy (chapters 5 and 6). This division aims to distinguish and at the same time show the overlap between personal and clinical trajectories generated by fistula and its treatment. Each of the three parts contains a short interlude, which is meant to augment the ethnography of the surrounding chapters and make their themes come to life for the reader.

Given that responses to affliction are always contextual and situated, part 1 of the book examines cultural mechanisms in Amhara society that tie people to larger networks of kin-based, societal, and religious obligations. Chapter 1 focuses on the role of kin in extending care to a woman who becomes incontinent as a result of obstructed labor. It details the care-based quality of Amhara ways of belonging and some of the concerns that animate marital and wider social relations. Against this background, it becomes evident that the contingencies of a woman's experience with fistula—though exhausting and complicated—nearly always leave room for her to assert herself as a member of some kind of a collective.

Chapter 2 locates the event of fistula in relation to women's religious personas, especially in light of strong associations in Ethiopian Orthodox

Christianity between unchecked bodily flows and notions of profanity. The chapter describes the embodied practices women deploy to negotiate life after fistula in various secular and religious spaces. Despite exacting ideals of bodily integrity in the religious realm, there exist multiple forms of devotion in Orthodox Christianity that allow fistula sufferers, just like other lay members of society, to navigate times of compromised purity. Pointing to the gradated nature of the sacred in Ethiopian Orthodox Christianity, the chapter shows, in fact, that recognition of the body's imperfection is built into the very system of Orthodox belief and practice.

Introducing the institutional dimensions of fistula treatment in Ethiopia, part 2 begins with a chapter that provides historical background to the mission of Hamlin fistula hospitals and analyzes core facets of their institutional logic. Based on archival materials of funding pleas sent to prospective donors by the Hamlins, chapter 3 looks at the contradictory work that narratives about fistula perform and how these narratives have inflected treatment and guided assumptions about what it is these patients need. Of particular interest here are the Protestant undertones of rescue and salvation long embedded in fistula treatment—the desire to “save” patients and give them a new life. The chapter also connects the creed of the hospital's founders (and some of those who came after them) to the turbulent history of Protestant Christianity in Ethiopia.

Chapter 4 moves away from the symbolic efficacy of fistula surgery to illuminate its clinical manifestations and patients' experiences of these interventions. In essence, it presents a roadmap for taking a practice like surgery and figuring out how to make sense of it from the viewpoint of patients. In doing so, the chapter reveals the messiness and uncertainty of surgery for fistula and points to the possibility that it is not the utterly sanctifying remedy it has been made out to be. The chapter closes with an account that documents how the failed operations of some patients managed to open up new, unexpected prospects in their lives.

While the extramedical dimensions of fistula therapy emerge only gradually in part 2, they come into full view in part 3. Chapter 5 investigates the role of the fistula hospital as a place of both healing and reform. It demonstrates that the focus of fistula treatment goes well beyond the surgical procedure and entails ambitious efforts at reforming patients—most notably in the classroom, where they learn how to read and count, optimize their hygiene and nutrition, and relinquish their “traditional” practices. When patients arrive at a fistula center in search of healing, they submit themselves to a much more extensive project of moral and social uplift.

The final chapter offers an account of the tumultuous history and pres-

ent of Desta Mender, the outpost for incurable fistula patients with urostomy bags near Addis Ababa. More than any other aspect of treatment, Desta Mender captures the extramedical functions of fistula therapy—and some of its unintended consequences—the most. This chapter unravels the rationale behind the figure of the “patient entrepreneur,” a patient whose health cannot be restored but who must show potential for being rehabilitated into a viable economic actor through business training and microcredit schemes. As part of this project, the chapter asks how their new medical device has transformed women’s bodily, material, economic, and social landscapes.

The conclusion reflects on the main findings of this study and points to their significance beyond the specificity of both fistula and Ethiopia. It wrestles with charting a way forward and away from representations of cultural pathology.

As you make your way through the chapters of this book, I hope you will keep in mind that many fistula patients experience tremendous relief as a result of undergoing successful surgeries. My purpose is not to deny that nor to throw doubt on the important work of institutions engaged in fistula repair. What I do in this book is add some complexity to the idea of fistula therapy as an uncontested good. By directing our attention to the complex realities that are being produced as a result of fistula treatment in Ethiopia, I illustrate how biomedical interventions of the kind I describe here may generate, reconfigure, and sometimes confound healing.