Giving hope to rural women with obstetric fistula in Ethiopia

The world is more aware of the problem of obstetric fistula thanks to the work of Catherine Hamlin. The Australian gynaecologist and obstetrician talks to Fiona Fleck.

Courtesy of Catherine Hamlin

Catherine Hamlin has devoted her life to providing repair surgery for obstetric fistula in Ethiopia. She graduated in medicine at the University of Sydney in 1946 at the age of 22 and subsequently gained qualifications in gynaecology and obstetrics. She and her late husband, Dr Reg Hamlin, first arrived in Ethiopia to train midwives in 1959, but soon became aware of the problem of obstetric fistula among women living in rural areas. After providing repair surgery for many years in Ethiopian hospitals, they co-founded the Addis Ababa Fistula Hospital in 1974. Today it is a global centre of expertise and trains surgeons from all over the world. Hamlin has been internationally recognized for her work as a pioneer in fistula surgery techniques, has won many accolades and, in 2010, a life-time achievement award from the Ethiopian president and Ethiopian citizenship, in 2012. She describes her life's work in a book: *The hospital by the river: a story of hope*.

Q: What is an obstetric fistula?

A: This is a condition which occurs when a woman is in labour for four or five days. The bony head of the baby presses on the pelvis for so long that a hole develops between the vagina and the bladder or between the vagina and the rectum, resulting in urinary or faecal incontinence. It's possible to prevent this injury by delivering the baby by caesarean section. But in Ethiopia there are not enough doctors in the countryside able to do this operation. Women with this condition are completely ostracized from society, their husbands leave them, they have no friends, because of the smell of urine or faecal matter that leaks. Women who live with this for months, even years, often have suicidal thoughts. Repairing this childbirth injury gives them new hope and new life.

Q: When you first arrived in Ethiopia, you had never seen a case of obstetric fistula in your life. How did you learn to perform surgery that had become obsolete in the developed world?

A: There were things written about obstetric fistulas. We knew several doctors who had been repairing them. We had a great friend in England who used to go to India to operate and we got in touch with him. We also had manuals, drawings of the actual operation from a wonderful Cairo-based professor Pasha Naguib Marfouz, he was a great help to us. We used to talk to him, we didn't get to meet him, but we learned from his textbooks. We are gynaecologists, so we are used to operating for other things, such as stress incontinence, so we were quite familiar with the anatomy, and we soon learnt. We started with small fistulas which any gynaecologist can fix without much training, and gradually tackled more difficult ones.

Q: What was it like to be a fistula surgeon in Ethiopia in the 1960s? What were the challenges in finding qualified staff and adequate medical supplies?

A: We were in a hospital that was very similar to the ones in Australia. We did not find it primitive in any way. The Princess Tsehai Memorial hospital had good doctors. These doctors were trained at the American University in Beirut, and we didn't have medical training at the university in Addis Ababa until 1966. We had a good nursing school with tutors from overseas, so we were well equipped with nurses.

Q: At that time, in the 1960s and 1970s, you were innovative in your field, but how did you keep up with medical knowledge before the digital age?

A: We had medical journals coming, friends passing through, our doctors had trained overseas. We had Australian gynaecologists who came to work at the Princess Tsehai hospital and several English ones working in other medical fields, including an English physician and a Czech surgeon.

Q: Fistula surgery is complex; spanning the boundaries of urology, plastic surgery, colorectal surgery and gynaecology. How did you succeed in providing such sophisticated tertiary care in a developing country, where primary care is often seen as the priority?

A: We didn't start with the difficult cases, we started with cases that we could do. Once we were successful in curing these, we gradually took on the difficult ones. As you say, it involves urology and so many other fields in medicine apart from gynaecology, but we were able to talk to our colleagues, the urologists, and they helped us. One urologist used to come regularly from England and we would keep the urological procedures to be done by him. He also trained several of our Ethiopian doctors in this particular operation. We had a lot of visitors passing through. We had a good Ethiopian surgeon who was a great help, he was the godson of the Emperor Haile Selassie and had studied in Edinburgh.

Q: One of your colleagues once said: "It's difficult to find a surgeon who is highly skilled enough to perform fistula surgery but also has the drive to work in poor countries." What has driven you to do this work for all these years?

A: My husband was also driven. We came together with the same agenda to help people in a developing country and we felt motivated to come. I believe it was from God that we felt this urge to come. I just love the work and I love the people. I did not feel I was marginalized or that I was missing out on anything. In those days, Addis Ababa was quite an exciting place to be, we had a big international community which included many doctors.

Q: You were invited by the government to work in Addis Ababa on a three-year contract in 1959 and have not left the country since. How did you manage to

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continue working through all the turbulent years of revolution, conflict and war?

A: We did live through a bad period but we couldn't have left. Who would run the hospital? Who would look after these women? They kept ringing us to say, "The last plane out is tomorrow night, are you ready?" My husband and I said, "No, we are not leaving, we are going to stay here." The professor of pathology was an Englishman, he and his wife came to stay with us for a while in our home built in the grounds of the fistula hospital. We had a bad time with bullets and things flying about. One landed on the sofa in our living room. The headmistress of the English school rang me to say, "Are you coming up to shelter in the British Embassy grounds?" I said "No, I am staying here at the hospital." And then a bullet came shooting through the roof and landed just where I had been sitting on the sofa and I told her, "I think you saved my life, you made me get up and come to the phone." It was only a spent bullet, it wasn't aimed at me. We were restricted, we couldn't leave Addis Ababa without a permit, we had to go through checkpoints and get food coupons to buy bread. Getting food for the patients was difficult. But we never turned patients away and, all through those difficult years, we had a full hospital. I don't think we were ever really in danger.

Q: Why, because you were providing health services?

A: Yes, and because we were not making any money. Also, our hospital depended on charity, which was completely against the communist idea. One day, they came to the hospital towards the end of the regime with a lot of wounded soldiers in buses and they said we should take them in. My husband was very wise, he told them we didn't have an X-ray machine (we didn't have one then, we have one now). Some of the soldiers must have had broken limbs, so he said, "You'd better go down to the leprosy hospital, they have one there." It was a tumultuous time, really. We never stopped working and we had our Ethiopian staff, who were very loyal and happy to be there. But everyone was frightened because there were spies, even in our own compound, so we had to be careful of what we said. Then my husband died in 1993 when the revolution was just over.

Q: In your book, you say your work is important but that it's more important to prevent fistula in the first place. Why isn't more done to prevent this terrible childbirth injury?

A: In the cities in Ethiopia you never see an obstetric fistula because there are doctors there. Of course that's the answer. The gynaecologists deal with it. The countryside hospitals are almost denuded of doctors; many of them have left the country. We need to raise the salaries and living conditions for rural doctors. Our midwifery college was set up to prevent fistula. We could flood the country with midwives but, even if we did, where should they refer somebody who needs a caesarean-section? We'd have to set up operating theatres in every antenatal clinic and get midwives to do caesarean-sections, but there is so much more to just doing a c-section than just taking the baby out by a surgical procedure. The woman may lose a lot of blood or have an eclamptic seizure. The midwife must have a gynaecologist somewhere, to whom she can refer cases.

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Q: Do the health extension workers help?

A: They are doing a good job. They often identify women with potential obstructed labour and refer them to health centres. But sometimes it's only to a general doctor, and he's not always able to do a caesarean section. Some, though, are doing this but are perhaps not adequately trained and, while clamping the arteries to stop the woman from bleeding, they can also incorrectly clamp the ureter. We then have to repair this.

Q: Is that a recent problem?

A: Yes, we have general practitioners running many hospitals now but, in many cases, if they don't do a caesarean section, the woman will die.

Q: Are things going in the right direction given that the campaign to end fistula has been going on since 2003, WHO clinical management guidelines for obstetric fistula have been issued and the International Federation of Gynaecology and Obstetrics, the International Society of Obstetric Fistula Surgeons and others have published the first guidelines on obstetric fistula repair surgery?

A: There is certainly more awareness of the problem of obstetric fistula and knowledge as to how to deal with it in the world today, but these initiatives are not making much of a difference in Ethiopia in terms of preventing the problem. I hear that things have improved in Kenya and [the United Republic of] Tanzania. The problem of obstetric fistula can be prevented with the provision of better transport in rural areas for women who are about to give birth and good maternal health-care services. Ethiopia is a difficult country for transportation. It's a very beautiful country of great contrasts, full of mountains and deserts, and the population is enormous. When we first arrived it was 20 million, now it's over 90 million.

Q: In your book, you write about having to beg for donations to keep your hospitals running and the need for sustainable funding?

A: It's because we have so much to support now. Money is coming in, but we need US$ 4.5 million a year to support the hospital and a midwifery college in Addis Ababa and five hospitals in all the big provinces in the countryside where the women go from those areas. And that is a lot of money.

Q: You also talk about the struggle to find a successor, have you made any progress?

A: Yes. You have to have a dedicated doctor for this job. We had one running our centre at Yirgalem in the south of the country. He is now our medical director and is extremely competent and is not likely to leave. We pay good salaries but we need more money to retain the doctors. Our medical director is very good, but we are struggling to find him a house in Addis Ababa, as the rents are terribly high. ■