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Ethiopia: Hamlin Addis Ababa Fistula Hospital

General Introduction

Ethiopia, one of the world's poorest nations, is home to over seventy million. Nearly ninety percent of its people live in rural areas, making delivery of health services extremely difficult. In fact, most Ethiopians live at least three days by foot from a health center (Hodes 1). Medical care, particularly for women, is rare and of poor quality. Astonishingly, skilled attendants deliver a mere six percent of births, with twenty-seven percent of women receiving antenatal care (At a glance: Ethiopia 2). According to statistics gathered by UNICEF, a mother in Ethiopia has a lifetime risk of one in fourteen of dying during or from childbirth (At a glance: Ethiopia 2). Substandard reproductive health care can lead to painful after-affects like fistula. Fistula is a condition caused by severe tearing during labor, which could go on for days in extremely unsanitary conditions. Dr. Catherine Hamlin, affectionately called "St. Catherine" by many, has healed over twenty thousand Ethiopian women who once were ashamed, isolated, and even banished from their families, at the Hamlin Addis Ababa Fistula Hospital (What is Fistula). As a consulting firm, we hope to provide necessary materials, support, and aid to the Hamlin Addis Ababa Fistula Hospital.

In order to understand the current position of women and lack of medical care in Ethiopian society, it is imperative to first understand the country's history. Ethiopia is one of few African territories that never became a European colony. Ethiopia's Emperor Menelik II, the founder of modern Ethiopia, began his rule of the country in 1888. In 1889 Italy declared Ethiopia as a protectorate, colonizing part of what came to be known as Eritea. In 1896, Ethiopia and Italy battled at Adwa, with Ethiopia emerging as the victor (Henze 229). This significant event is considered the first victory of an African

nation over a European power. Menelik II continued to rule until his death in 1913. In 1916 Haile Selassie led a revolution and became heir to the throne, and in 1930 became emperor of Ethiopia. Under the leadership of Mussolini, Italy invaded and occupied Ethiopia during 1931 until 1936. As a result of Ethiopia's determination not to be colonized and the strain of World War II, Italy retreated from Ethiopia in 1936. Selassie returned to power and Ethiopia was restored as an independent nation with the exception of Eritea, under British control until 1952 (Henze 229).

Although no longer under Italian control, Ethiopia struggled to unite itself as a nation. Guerrilla warfare broke out between Muslims and Christians resulting in thousands of deaths, while thousands more died from famine. Ethiopia's political system was corrupt, with wealth going to nobility and the church. Amid a wave of mutinies and demonstrations, Haile Selassie was overthrown in 1974. Ethiopia was thrust into a social revolution, which still continues today. The leader of the military dictatorship, Mengistu Haile Miriam, initiated numerous radical reforms. Those opposing his views were jailed or massacred by vigilantes. Mengistu Haile Miriam's administration was rooted in Marxism, aiming to create a socialist nation benefiting the masses. But the command economy, village resettlements, and new political organization alienated the citizens from their environment, resources, and political allegiances (Ethiopia- Summary of History 4). Ethiopia entered into a steep decline with a discontented population, famine, and war with Eritea.

The last decade has been tumultuous for the country. In 1991 the Tigray People's Liberation Front overthrew the Ethiopian government. In 1993 Eritea succeeded from Ethiopia, and the Ethiopian People's Revolutionary Democratic Front introduced a new

constitution in 1994. In 1998 Ethiopia and Eritea went to war over disputed territory. Between 1998 and 2000, thousands of citizens died as a result of this brutal war. In December 2000 both sides signed a peace agreement. The ceasefire called for a United Nations peacekeeping force to patrol a twenty-five mile-wide area between Eritea and Ethiopia as a Temporary Security Zone (Background Note- Ethiopia 5). Today, Ethiopia and Eritea's relations remain tense and unsettled although both countries insist that they will not instigate war; though minor incidents have occurred between local villagers, militias, or armed opposition groups (Background Note- Ethiopia 6).

Ethiopia is rare in that the country was only occupied by a foreign power for a brief period during the 1930s. For such a strong nation, one would expect the government to take pride in its people and offer them every sort of care possible, but sadly this is not the case. Only six percent of the central government's expenditure is allocated to health care (At a glance: Ethiopia 5). Almost three million babies are born in Ethiopia yearly, with an infant mortality rate of eight hundred seventy-one for every one hundred thousand live births. Those that survive can expect to live to the age of forty-six (At a glance: Ethiopia 3). A 2003 estimate by UNICEF found that AIDS orphans seven hundred twenty thousand children yearly. For pregnant women aged fifteen to twenty-four, 11.7% are living with HIV. UNICEF estimates that seven hundred seventy thousand woman aged fifteen to forty-nine are living with HIV (At a glance: Ethiopia 4).

Women in Ethiopia face complex and interwoven economic and social dilemmas. According to author Diane Taylor, Ethiopia's constitution enshrines women's equal rights with men in regards to marriage, family planning, education, and information, but the reality is a far cry away. According to a study published by Save the Children, Africa

is the worst place to be a mother or child. Save the Children based their conclusion on the high risk of maternal mortality, use of modern contraception, births attended by trained personnel, female literacy rate, and female participation in government (Mitchell 2). Ethiopia's high infant mortality rate of 95.32 deaths per one thousand births is due to the lack of medical attention that women receive during childbirth combined with a general lack of healthcare. Ethiopia suffers from an acute shortage of hospitals, doctors, and medical supplies. The use of contraceptives to prevent or delay birth is only known to eight percent of Ethiopian females (At a glance: Ethiopia 4). Domestic violence towards women is commonplace in Ethiopia with between ninety-one to ninety-four percent of women beaten (More than 1). Unfortunately, Ethiopian women accept such abuse as justified due to objections from their spouse of neglecting children, refusing sex, talking to men, not preparing food, or leaving the home without permission (More than 1). In fact, the UN report states that gender based violence kills and harms as many Ethiopian women between fifteen and forty-four as does cancer.

Key to providing equality for women is to provide adequate reproductive health care. The UN report concluded that a lack of reproductive health care poses a tremendous burden on women's health, productivity, and an even greater burden on the country's prospects of escaping poverty (More than 2). Each year twenty-five Ethiopian women die while giving birth while fifty thousand suffer debilitating affects like fistula (More than 2). These statistics are staggering and we aim to provide our help to end this unnecessary suffering.

The overall objective of our project is to bring about awareness of the Hamlin Addis Ababa Fistula Hospital that is vital to the women of Ethiopia. Through our

contributions, we seek to individually and collectively improve the conditions at the Hamlin Addis Ababa Fistula Hospital and the lives of Ethiopian women. We will do so by aiding in the emergence of similar facilities throughout Ethiopia and bringing about awareness of fistula as well as proper medical care to other African nations.

Global Issue

Maternal health problems are an issue in both industrialized and developing nations. Globally, sexual and reproductive illness account for one third of the number of diseases among women in the reproductive stage (Alesna). Although the rate of maternal deaths in developing countries tend to outnumber maternal deaths in industrialized countries, the statistics are significant enough to warrant global attention. The definition of a maternal death is "the death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (Obstetrical 4). Globally, the proportion is four hundred maternal deaths to one hundred thousand live births. The ratio for developing and industrialized countries is four hundred-forty deaths per one hundred thousand live births to twenty-seven deaths to one hundred thousand live births respectively (Obstetrical 4). According to recorded studies, the estimation of maternal deaths is very difficult to collect, and are most likely understated from the true number of deaths (Obstetrical 4).

Fistula continues to be a problem because distribution of contraceptives and medical care is limited as a result of the Global Gag Rule, also known as the Mexico City

Policy. First put into place in 1984 by President Reagan, the Mexico City Policy was rescinded on January 22, 1993 (Restoration of Mexico City Policy). It was not until January 19, 2001, eight years after the policy was rescinded, that George W. Bush reinstated the Mexico City Policy. The Policy restricts United States family planning organizations to provide assistance to foreign nongovernmental organizations that use funding from other sources. It places restrictions on abortion, contraceptives, and prevents an organization from lobbying to legalize abortion or make it readily available. Because of this, the funding has severely dropped, leaving many women who require medical assistance throughout their pregnancy and labor with little or no medical care.

Fistula was once a global problem, but was eradicated in both Europe and North America by educating young women to postpone marriage and pregnancy until their body was mature enough to have a child. The increased availability of family planning and improved obstetric care in industrialized countries have ended fistula. However, the problem still exists in Africa. The lack of medical services and premature mothers giving birth to children are among the main causes of fistula (UNFPA). Traditionally, females between the ages of seven and eight are committed to arranged marriages. The girls' bodies are not mature enough to handle pregnancy. Other complications leading to fistula include female circumcision. Approximately ninety to ninety-five percent of Ethiopian women are circumcised. The circumcision causes scarring in the vagina, causing obstructed labor during delivery (Addis Ababa). In 2000, only 5.6 % of childbirths in Ethiopia were completed by a trained health care professional (Proportions). Three million women in Ethiopia become pregnant each year, of this 0.3% will develop obstetric fistula (Kennedy 2). In brief, lack of medical care, pregnancy

among young girls, and lack of education are among the main problems leading to fistula in Ethiopia.

Fistula was an incurable global problem up until the middle of the nineteenth century, and continues to be a growing problem in developing countries. Fistula became less of a global problem after a surgical cure was discovered by American surgeons J. Marion Sims and Thomas Addis Emmet (Obstetric 4). After the development of maternal medical health care to aid women in the developing countries was implemented, the number of fistula cases in the developing countries significantly decreased during the twentieth century. According the World Health Organization (WTO), "the best way to reduce fistula formation is to provide essential obstetric services at the community level with prompt access to emergency obstetric services at the first referral level" (Obstetric 42). The number of fistula cases in the developing nations has drastically decreased as a result of the introduction of medical aid including: antibiotics, blood transfusions, safe cesarean sections, better transportation and improved access to care, and trained nurses and doctors (Obstetric 42). Medical research in regards to improved medical care for fistula patients is nearly nonexistent in developing nations. Since fistula is no longer a problem in developed countries, developed countries have lost interest in researching the problem. Maternal deaths are most prominent in developing countries today. Of the total number of maternal deaths, 95% occur in Africa and Asia (Maternal Mortality 10). Women in Africa and Asia are most vulnerable among all other nations of becoming victims of maternal death (Maternal Mortality 9). Maternal health has not received the necessary funding that it has needed because of the concentration of funds on AIDS treatment programs (Maternal Mortality 10).

During the United Nations Summit in 2000, one hundred forty-seven global leaders adopted the Millennium Development goals to eradicate extreme global poverty. The completion of the eight goals included in the project is scheduled for 2015 (Sachs 347). Goal five, Improve Maternal Health, aims to "Reduce [maternal mortality] by three-quarters between 1990 and 2015" (Freedman 131). The major focus is to create universal access to reproductive health services by 2015 (Freedman 131).

According to the Worldwide Fund for Mothers Injured in Childbirth, the following diagram details the route of social and economic problems that lead women to having obstetric fistula:

Leading Causes of Obstetric Fistula in Women	
1. Low economic status of women	5. Illiteracy and lack of formal education
2. Limited social roles	6. Harmful traditional practices
3. Malnutrition	7. Early Marriage
4. Childbearing before pelvic growth is complete	8. Lack of emergency obstetric services

(Obstetric 5).

In terms of maternal difficulties in Africa, the number of female obstetric fistulas is increasingly high due to poor social and political infrastructure. A report published by Engenderhealth and the United Nations Population Fund (UNFPA) identified the lack of the five following instrumental areas to stop fistula in Africa:

1. Africa lacks teaching facilities to educate women on when it is the proper time to conceive a child. In Africa, a girl will get married when she is near the age of fifteen, before she has gone through the menstrual cycle, to ensure that she is a virgin (UNFPA). The implementation of an education system to teach girls the benefits of

postponing marriage and waiting to have a child until the body has fully developed is in desperate need (UNFPA). For example, being able to tell the warning signs of complicated pregnancy is one of several lessons that women in Africa are not knowledgeable of.

2. In Africa, women are not given full rights to both education and healthcare. Since women may be denied an education, they do not learn the skills needed to obtain a higher paying job, therefore are more likely to getting married at an earlier age. In most cases, an African woman's health is dictated by her husband. The husband determines whether or not it is acceptable for his wife to see a doctor. In the event of an emergency, the husband would decide whether or not the woman should be admitted to a hospital.
3. Skilled medical professionals are lacking in Africa. Reconstructive surgery to repair fistula is a specialized procedure that requires specially trained surgeons and nurses. Once the surgery is complete, post-operative care is imperative during the recovery process. Africa relies on the assistance of expatriate doctors to repair fistula. Local surgeons and nurses are not trained to perform the surgery. In East Africa alone, eighty percent of women with fistula are not being treated.
4. Lack of supplies and equipment is a large problem in hospitals where fistula is treated. Financial support is needed to secure a steady supply of medical equipment.
5. Women with fistula live in rural areas far from medical help and lack any means of transportation to a hospital where fistula is treated. Many women travel on foot or by donkey for months to arrive to a fistula hospital.

6. Paying for surgery and accommodations while at the hospital is not affordable for African's who are impoverished. Providing free fistula care to patients is in definite need to provide proper care for women with fistula (UNFPA 6-7).

By completing the above steps, the remainder of the countries devastated by fistula will be able to create a system to end fistula.

Case Study

Addis Ababa Fistula Hospital

Ethiopia is a country with many remote villages where there are no roads. It can take many days for a woman to travel to the closest hospital and can be difficult to afford. Many women have to beg, sell cattle or other personal property to be given a ride to the closest medical facility (Oprah). Also, women in Ethiopia tend to marry at a young age, becoming pregnant as early as twelve years old (Oprah). The female body at this stage of development is not mentally prepared or physically capable to support a full-length gestation period without causing serious damage to both their body and that of the child. These problems, combined with the shortage of medical supplies, personnel, and hospitals, generate a high likelihood of a woman encountering severe, life-threatening problems due to prolonged labor and childbirth. Fistula is one such problem.

What is unknown to many women in Ethiopia and other developing countries that are suffering from the condition is that fistula can be treated successfully, and there are facilities that can perform the required operation. One such facility is the Hamlin Fistula Hospital located in Addis Ababa, Ethiopia's capital. The hospital opened its doors in 1974, treats twelve hundred women annually, and, to date, twenty-five thousand women with the condition have been successfully treated (Fistula Foundation). All of the

services are free, including room and board, so the hospital relies on funds from various donors. The Hamlin Fistula Hospital also trains doctors from Ethiopia and around the world to perform the surgery necessary to cure fistula.

Dr. Catherine Hamlin and her husband Reginald Hamlin came to Addis Ababa in 1959 on a three year contract from the Ethiopian government. Soon after they became aware of the issue of fistula and the dramatic impact it can have on women. This discovery had a strong effect on the couple, who decided to research everything possible about obstetric fistula. Based upon research, they developed a procedure to treat women with fistula (Hamlin Fistula Relief).

In 1961, a clinic was opened at Princess Tsehai Hospital. In the first year, the Hamlins treated thirty-two patients. Into the third year of the clinic's existences, three hundred women had been successfully treated (Hamlin Fistula Relief). Word spread about the clinic, and soon there were more women seeking treatment where there was not the capacity to do so. It is because of the large need for fistula treatment that the Hamlins decided to open a hospital specifically for fistula patients (Fistula Foundation).

In 1974, the hospital opened. Treatment for the patients was given free of charge because they could not afford it, and still is today. Before the founding of the hospital, a treatment facility for fistula was nonexistent. Presently, the Addis Ababa Hospital is the only hospital worldwide that specializes in fistula treatment. Approximately twelve hundred patients are treated annually, with a ninety-three percent success rate. Since the hospital's opening, over twenty-four thousand women have been successfully treated for fistula (Hamlin Fistula Relief).

With the death of Doctor Reginald Hamlin in 1993, a need arose for more residential doctors. The hospital upgraded by building a pathology laboratory, library, and house for another resident doctor. Also, a program was put into place to train both doctors and nurses in fistula surgery procedures, as there was a need for medical staff to be trained in fistula surgery. The hospital has been successful with this program over the years, training thirteen Ethiopian Post-Graduate doctors and fifteen foreign doctors in the technique between October 2004 and March 2005 (Kennedy 2).

Today, the goal of the hospital is not to just provide fistula surgery, but to also "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" (Fistula Foundation). The hospital places emphasis on the mental well being of the patient as well as the physical. An example is the tradition of giving every treated patient a new dress for when they return home. Doctor Catherine Hamlin thinks this is important for the women's confidence. "We give them this new dress to make them feel they're starting a new life" (Oprah).

Fig . 1- Village of Desta Mender, located seventeen kilometers from the hospital (Fistula Trust)

There is also emphasis on taking care of patients who cannot be completely cured and require long-term medical treatment. For these women who cannot be cured, there is the village of Desta Mender. In 2000, the Ethiopian government donated sixty acres to the hospital to build a village where these women could learn to be independent, yet still receive the medical care they require. Located seventeen kilometers from the hospital, Desta Mender is a place for these women to have a community in which they belong and are not shunned (Kennedy 10). Currently the village is home to twenty-three patients, with a capacity for one hundred patients. There are ten cottages shared by the women and two common buildings. Local farmers grow crops for the village and the hospital, and women attend school in the village. The women also partake in maintaining the village, caring for livestock, and making crafts. The women who are patients at Desta Mender earn a wage and can support themselves and others, creating a true self-sustaining community (Fistula Foundation).

However, there are obstacles and problems that affect the hospital. There is a lack of bed space at the main hospital, resulting in a decrease in the number of admitted patients. It is especially extreme after the harvest season, when many families can finally afford the trip to the hospital for treatment. This spike in women seeking medical attention is difficult for the hospital, as there is limited space. The Bethel Ward, which is located on hospital grounds, housed patients waiting for surgery at a ratio of two per one bed as of March 2005. A new ward, Betezatha Ward, was completed in early 2005; hopefully decreasing the overload the hospital is feeling (Kennedy 8).

Fig.2-Map of the five sites throughout Ethiopia (Fistula Foundation)

Ethiopia has a significantly poor infrastructure. The few roads that exist are in a horrible condition that makes travel long, tedious, and almost impossible in areas. Many women that suffer from fistula cannot ever make the journey to the hospital because it is too far, they are too weak, and the trip is unaffordable. It is estimated that between eight thousand and nine thousand women suffer from fistula annually, with only approximately fourteen hundred being able to make the journey to the hospital for treatment (Oprah). To alleviate the number of fistula patients, the hospital planned to expand throughout Ethiopia with the building of five fistula clinics at existing hospitals throughout the region (Figure 2). As of May 2005, the outreach center at Bahr Dar is complete, and patients are being treated. There is also a permanent doctor located at this location (Fistula Foundation, Kennedy 10). The other sites have received some funding, but have not been completed because or lack of further funding. The building of these centers is expensive, and the fistula hospital and organization is reliant on outside funds and donations. The building of the center in Mekelle is being funded by the Australian government, and is estimated to cost approximately AUD$1.2 million. The Hamlin Fistula Hospital is still in need of AUD$600,000 to AUD$700,000 in order to build this center (Hamlin Fistula Relief).

The other planned clinics also require funding not just for startup, but also for maintaining the facilities in terms of staff, supplies, and proper equipment.

Project Proposal

When the United Nations Population Fund (UNFPA) approached Julia Ciriglo, Danielle Swain, Derek Larson, and Kristen Shirley about working for them regarding a medical problem in Ethiopia known as fistula, we had little knowledge of the organization's goals, or how the four of us could make a difference in reaching them. Without a doubt, the members of our group have a wide variety of knowledge and career aspirations; is it possible for a fashion merchandiser, a fashion designer, an accountant, and a psychologist to work together to help combat a major health issue in Ethiopia? We decided that the only way to find out was to research the problem of fistula in Ethiopia, determine what is already being done to combat it, and finally, figure out if there are any steps each of us can take to further alleviate this issue.

The UNFPA is a development agency within the United Nations which works to make certain that every man, woman, and child is able to live a life full of health and equal opportunity. The organization strives to ensure that every pregnancy is wanted, every birth is safe, no more young people suffer from HIV/AIDS, and every girl or woman is treated with dignity and respect. Two of the main goals the UNFPA has been focusing on lately are improving reproductive healthcare and making motherhood safe. Healthcare initiatives include providing universal contraceptive methods and quality obstetric and gynecological care, as well as prevention, management, and counseling for sexually transmitted diseases and HIV/AIDS. The UNFPA plans to improve the safety of

motherhood by implementing family planning to reduce unwanted pregnancies, employing skilled attendants at all births, and providing emergency obstetric care to those who develop problems during the birthing process (Our Mission).

Perhaps the most relevant work of the UNFPA, for our purposes, is its Campaign to End Fistula, a global initiative that began in 2003 to prevent this injury, while at the same time restore the health and dignity of those who have suffered from it. The Campaign to End Fistula has greatly aided in the relief of fistula in over thirty countries worldwide, including twenty-six countries in Africa alone. The Campaign has trained health workers specifically to correct fistula and has supplied countries with equipment, beds, and facilities in order to perform the surgeries. The Campaign is also responsible for creating a number of prevention, education, and rehabilitation programs, as well as communicating its various initiatives through a number of resources in order to reach as many victims as possible (Campaign). While the Campaign to End Fistula has begun making progress in improving the situation for thousands of women worldwide, there is still much work that needs to be done in order to eliminate the problem of fistula globally, and more specifically in Ethiopia.

After extensive research into the UNFPA and its efforts concerning fistula, it was decided that if the United Nations assembled the four of us as a consulting group and sent us to work in Ethiopia, we could in fact lend a hand in helping control this unfortunate problem. Fistula is a major women's health problem affecting an estimated 9,000 women every year in Ethiopia. Unfortunately, the Addis Ababa Fistula Hospital is the only treatment center in the entire country specially equipped to deal with this problem (What is Fistula?). The doctors at the Fistula Hospital are able to cure approximately 1,200

women every year (Hamlin Fistula Relief and Aid) and while this is a great success rate, these women are just a portion of Ethiopians suffering from this problem.

Unfortunately, the majority of fistula victims in Ethiopia do not receive treatment. For the women living in remote villages, Addis Ababa is a far too treacherous journey to make. For the few who have cars, of the 33,000 kilometers of highways in the country, only around 4,000 kilometers are actually paved. These often dusty, bumpy roads make the journey for the few fistula patients who have access to a car too uncomfortable to bear. The railroad system is in even worse shape, as there are only approximately 681 kilometers of train tracks in the country, which does not allow access to villages far from the capital city. However a majority of Ethiopia's population lives on less than $100 a year; most fistula victims are poor women who cannot afford a car or a train ticket. This lack of transportation can cause the voyage may take days, even weeks to complete by foot, which becomes especially long and painful in their condition (Ethiopia).

However, there is an even bigger barrier to reaching the Addis Ababa hospital than lack of transportation. Many victims of fistula lack the knowledge that such a place even exists. Most women in rural villages are forced into hiding by other community members as soon as they learn of their problem. In this poor African country almost twice the size of Texas, with little television or radio access in small villages (Ethiopia), a majority of fistula victims do not even know that there is a place in their country where their problem can be fixed. How can a woman even attempt to find a cure for fistula if she does not know that one exists, or where she can find it? It is these obstacles that prohibit the Addis Ababa Fistula Hospital from being an even greater success than it is today.

Our group has created a number of goals, which upon being met, we feel will increase the number of fistula victims who are cured in Ethiopia. If our actions turn out to be successful in Ethiopia, perhaps some of these plans could even serve as a model for other developing countries with high rates of fistula. Our first major goal is to improve the conditions, number of cases seen, and recovery programs at the Addis Ababa Fistula Hospital. The second goal of our group is to collaborate with the women of Desta Mender, a village affiliated with the hospital for incurable women, in order to raise additional funds which would benefit the hospital. Our final major goal, and probably the most extensive, is our hope to join the Addis Ababa Fistula Hospital and their plans to extend their services by building five satellite facilities throughout Ethiopia. Along with raising enough funds for these sites, our group will also take part in securing enough supplies, equipment, and employees, as well as implementing quality recovery programs.

Our group's first goal of improving conditions at the Addis Ababa Fistula Hospital will most likely be the easiest to meet, as the existing conditions of the hospital are fairly adequate. However, as in almost any situation, there is always room for improvement. For example, while the hospital has trained over one hundred doctors from around the world with regards on how to correct fistula, there are actually only six resident doctors currently working there (Hamlin). One step our group could take would be to increase funding to this hospital in hopes that more doctors can be hired; with an increase in resident doctors, perhaps even more patients can be cured.

Along the same lines, if we intend to increase the number of patients seen at the facility, our group would have to raise money for more supplies, equipment, and beds, or have them donated, so that these added doctors have enough materials to work with.

Procuring enough money to cover all of these expenses may prove to be a monumental task, with so many causes asking for donations in the world today. While our accountant, Derek may be able to raise more funds, or adjust our existing assets, other group members may have to promote initiatives that could help bring in additional revenue.

One proposal our group came up with involves our second main goal, collaborating with the women of the hospital affiliated community, Desta Mender. Although it may appear that the Fistula Hospital performs miracles, a small percentage (around 3%) of the women who come to the hospital are so badly damaged that they cannot be surgically repaired. These women are sent to live and be provided for at Desta Mender, a sixty acre community about eight miles outside of Addis Ababa; the plot includes ten cottages and two common buildings. In this "self-help" village the women come together as a family, and are taught new skills such as agriculture and craftwork so that they are able to support themselves and have a purpose in their lives (Hamlin).

More specific to our goal of collaborating with Desta Mender to raise funds, Danielle and Julia have offered to share their knowledge of fabrics and materials to implement sewing classes, along with the other crafts taught at Desta Mender. With the new skills that these women are learning some of the them may be able to produce clothing or other wares, that Julia, with her combined education in fashion and business, may be able to help market and sell and use the profits to help provide for the hospital.

Kristen's contributions to our work in Ethiopia would also have a lot to do with Desta Mender. With her degree in psychology, she would work with Julia and Danielle to oversee many of the classes and activities aimed at rebuilding confidence, as well as design counseling sessions to help these women work past feelings of shame and

inadequacy. As satellite facilities are created, Kristen would hope to expand the counseling services as well as the confidence and skill building workshops in each location.

Our final goal, which will require the most time and effort, involves assisting the administrators of the Addis Ababa Hospital to branch out its services to five other locations in Ethiopia, in order to provide care to a larger population. Due to the geographical remoteness and lack of knowledge of its existence, the Addis Ababa Fistula Hospital already has extensive plans to open five satellite facilities in provinces located hundreds of miles from the capital city in order to provide more available health care to the women who cannot make the journey to Addis Ababa (Hamlin Fistula Relief and Aid). Hospital staff intend these satellite centers to offer treatment, prevention, and education for women who are at risk or suffering from fistula. Plans for all five centers are solid and once they are built, will offer hope to a large majority of afflicted women in remote regions of the country.

However, at the present time, only the first of the five satellites has been built. Hospital administrators are hoping for the other four facilities to be completed in the next five years. In order for this goal to become a reality, an immense amount of support will be needed. Millions of dollars will have to be raised and allocated to each of the facilities, supplies for five new centers will need to be purchased or made, and a number of doctors, nurses, and other staff will need to be hired and trained to be qualified to treat the needs of these women.

Our group accountant, Derek Larson will be essential when dealing with financial aspects such as fundraising and distributing money for each of the facilities. After

performing extensive research on the financial situation of the satellite hospitals, Derek is working on a plan which could potentially save millions of dollars and produce greater efficiency regarding the construction of these other facilities. Derek recommends combining the resources of all of the donating institutions and securing contracts for supplies, equipment, etc; for the five satellites as a whole, as opposed to different organizations trying to produce five separate contracts. Although Derek will continue to create and implement a strategy which allows for the most efficient raising and allocation of funding, there are other ways our group can make sure that each hospital has the supplies that it needs to operate.

Making sure that each hospital is outfitted with quality supplies and equipment will save money in the long run, as they will not have to be replaced as quickly. Again, Danielle and Julia will work together on this issue. Danielle has used her knowledge of fabrics and finishes to design cotton sheets and hospital gowns that are durable and will resist soil. Certain finishes will also help prevent the spread of mildew and bacteria throughout the hospital. Working from Danielle's designs, Julia has proposed to buy the cotton that Danielle will need. In addition to that particular fabric being useful for the hospital, Julia has theorized that buying cotton from local mills will also help boost the economy of Ethiopia; in a sense, Julia can help combat two problems in one. Along with promoting the local economy and hospital sanitation concerns, the work of these two will provide the hospital with quality garments and sheets with a longevity that will end up saving the hospital certain costs in the long run.

Similar to her work in the original site, Kristen will continue to develop her rehabilitation program, combining skill and confidence building classes, with group

therapy to mend the psychological damage fistula can create. In order to fulfill these goals she will have to work with Derek to secure the funds to employ enough therapists for the new sites, as well as work with Danielle and Julia to implement basic sewing and craft classes that every woman can be a part of.

Obviously a lot of work is needed to help curtail the problem of fistula in Ethiopia. While the country has made great strides in treating this problem, due to the efforts of the Addis Ababa Fistula Hospital, there is still a long way to go. Fortunately, the ideas and the will are there. There is no doubt that the members of this group have very different expertise; however this may turn out to be one of our strengths. Because the members of our group all specialize in a different area, each of us will be able to help this project in our own distinct way. Whether, it is strategic financial planning, buying or creating quality supplies for all of the hospitals, or developing programs for complete physical, as well as mental recovery, our different backgrounds and training will enable us to each accomplish an important part of our plan. In the end we will be able to combine our efforts for the common goal of expanding the Addis Ababa Fistula Hospital and the help it provides for thousands of women each year.

Individual Contributions

Derek Larson- Finance and Accounting

As an emerging businessman in America, I can use my skills to capitalize on the strengths of the Addis Ababa Fistula Hospital and pool my expertise with international organizations to focus on maternal problems in Ethiopia. To date, the hospital has treated in upward of twenty thousand fistula patients (Obstetric 3) of the approximate two

million individual global cases of fistula (Fast Facts). To meet the mortality goal of the Millennium Development goals by decreasing mortality rate by two-thirds by 2015, the health industry in developing countries is in definite need of improvement. In meeting this goal, the Hamlin Addis Ababa Fistula Hospital is a pivotal organization in treating fistula patients in Ethiopia. My goal is to increase the availability of fistula health care in Ethiopia and expand to neighboring countries in the long term. To aid in the long-term sustainability and development of the Addis Ababa Hospital, I will focus on the reorganization of the Addis Ababa Hospital business structure.

The Addis Ababa Hospital is not equipped to accommodate the growing number of fistula patients that are flocking to the hospital for treatment. According to the Addis Ababa Fistula 2005 Annual Report, "no matter how hard we try to provide space…we never seem to have enough room". The Addis Ababa Hospital has overpopulated their limited space by admitting two patients for every one bed. Postoperative care is also very limited and patients may have to be relocated off campus for care (Kennedy 7). With the limited number of spaces available, the hospital performed five hundred eighty-nine surgeries in the first quarter of 2005, January-March, at the Addis Ababa Hamlin Hospital (Kennedy 2). At this rate, the hospital will treat 2,386 patients in 2005. However, harvest season occurs during this time, which may account for the large number of fistula patients. Families cash in on their crops and use the money to transport their loved one with fistula to the hospital (Kennedy 7). According to most reports, the average number of patients treated each year is twelve hundred (With the annually added average 9,000 fistula cases in Ethiopia, the Addis Ababa Fistula hospital treated 26.5% of

these cases in 2005 (Kennedy 7). In order to accommodate the new and old cases of fistula, expansion is a necessary to treat fistula patients in Ethiopia.

The Addis Ababa Hospital does not have the financial resources to effectively handle fistula cases in Ethiopia. Since care at the hospital is free of charge, the average cost of treating each patient is $350 (Chilingerian 10). The research that I have compiled does not specify whether or not the $350 charge includes overhead costs, such as physician's salary and utilities expenses. The Addis Ababa Hospital has an evident need for increased funding. In 2003 & 2004, the hospital reported the following financial indicators:

Key Financial Indicators	**2004**	**2003**
Gross Revenue:	$ 1,085,851	$ 751,005
Operating Surplus/(Deficit):	$ 829,420	$ (172,531)
Net Assets:	$ 1,957,758	$ 1,128,337
Major Assets:	1) Cash - $1,927,118.	
Major Revenue Sources:	1) Fundraising - 95%. 2) Investments – 5%.	

(Hamlin Welfare)

From 2003 to 2004, the hospital increased its operating income from -$172,531 to $829,420, which indicates a positive growth in fundraising activities. The longevity of each individual donor is unknown based on the research that I completed. However, the monetary resources that the hospital has secured in 2004 indicates a positive growth. Of the many donors, Ethiopiaid contributed $250,000 to the hospital in 2004 (Annual Report). This single donation equates to the care of approximately 715 fistula patients. To meet the demand of curing the 9,000 new fistula cases in Ethiopia, the hospital must

have $3,150,000 to provide actual treatment, not including costs for covering building and operating expenses of new facilities.

To appeal to NGOs and other donors, I will introduce an internal auditing committee as well as hiring an external firm to conduct an external audit. According to Transparency International, on a scale from 1-10, with 1 being the most corrupt, Ethiopia is given a score of 2.2 (Survey). NGOs and donor organizations that are considering giving money to Ethiopia may be hesitant to donate considering that the money is being used to fund the Ethiopian government's corrupt actions. If the Addis Ababa Hamlin Hospital were to create a solid organization that is annually audited, it will attract potential donors and have solid financial statements that will detail how the donated funds are being spent. I will personally set up the auditing program for the hospital. I have been hired to work within the auditing department at PricewaterhouseCoopers, an international accounting firm, and I will use my expertise to conduct the audit free of charge until I locate an auditor that will do it for free. The benefits of conducting an audit are to measure structure, process, and outcome (Maher 410). Both financial and health quality facts will be measured to make sure that the hospital is running efficiently and providing optimal health care.

In order to effectively treat fistula patients and meet the Millennium Development goals by 2015, I propose the implementation of microfranchising as part of the Addis Ababa Fistula Hospital business plan. Microfranchising can be simply defined as "small businesses that can be easily replicated by following proven marketing and operational concepts," which is the new business solution to alleviating poverty (What is Microfranchising?). Microfranchising has been used in Africa and has created

measurable success. For example, Vodacom, the world's largest wireless telephone company, owns only 35% of Vodacom in South Africa. Much of the business is owned by low income vendors, who operate 5,000 Vodacom franchises throughout the country. Local franchisees own their equipment and inventory and purchase phone cards from Vodacom and sell to their customers. On the average, each stand employees 5 people, which is a total of 25,000 jobs in South Africa from Vodacom's use of the microfranchise (Magleby 30). By implementing a microfranchising strategy, theAddis Ababa Fistula Hospital may spread its successful enterprise throughout other developing nations.

The Addis Ababa Hospital is opening 5 new locations in Ethiopia, but is experiencing funding problems at the locations in Bahr Dar, Harer, Yirgalem, Makelle,and Metu (The broad plan). Of the five proposed locations, all of the locations have been matched to a donor except for the proposed Metu location. The hospital has had significant success in finding donors to fund the sites, but they could more effectively use their donated funds to more quickly build sites.

Expansion parallels the objectives of the organization, but there are ways in which money could be saved to provide even greater results. By merging fundraising efforts with an NGO or a related organization, the Addis Ababa Fistula Hospital would create a larger financial base. According to the United Nations, in 2003, there were 23 donor organizations working in Ethiopia for both different and similar causes (Human). Each organization has reporting expectations that are costly, in terms of both time and skilled labor hours (Human). Each donor operation has to generate multiple reports and is then monitored by representatives from the donor organization to grade performance. In some instances, two or more of these donor organizations may be working on the same

research and producing similar results (Human). Considering that these organizations are non-profit and are not working in a competitive environment, it would be cost effective to merge forces to drastically cut costs. The Addis Ababa Hospital should consider the same option. The hospital could seek out NGOs or other donor organizations and join forces to work towards the larger picture of ending poverty in Africa. In the case of finding four separate organizations to individually fund the opening of each satellite fistula hospital, financial resources may be inefficiently spent to operate the hospitals. For example, the estimated yearly operational costs of the new cite in Mekelle in Ethiopia is $73,915 (The broad plan). I propose that the Hamlin Fistula Corporation create a central funding organization to choose how all of the funds are allocated. Combining financial resources can secure cost saving decisions. By creating a financial powerhouse, the Hamlin Fistula Hospital may attract NGOs and secure more funding for future hospital openings.

I will also be working very closely with my colleagues Kristen, Danielle, and Julia to seek financial support for their efforts. As Kristen hires more staff to provide counseling for fistula patients, I will seek additional funding to provide salaries for these added administrative costs. Both Danielle and Julia will be donating their own services and locating private donors to cover all of their business expenses. Our goal is to create an internal infrastructure within the hospital, which will require minimal additional costs. We have succeeded in keeping our costs to strictly administrative and building expansion costs.

To cut costs and establish a supply infrastructure that will support microfranchinsing, I will reorganize the distribution system of medical supplies to the

Addis Ababa Hospital and its 5 satellite sites. I will rely on the expertise of DELIVER, which is a technical assistance support contract that is funded by the US Agency for International Development. DELIVER is a program that focuses on supply chain management in developing countries to strengthen available health services (Process Mapping 1). Once hired, DELIVER will implement a strategy called process mapping, which evaluates the steps taken in a process. According to DELIVER, as much as 80% of organizational work is informal and undocumented and 50% of the steps in processes can be eliminated to make the process cost effective. Both Julia and Danielle will be using DELIVER as a consulting service to find the most efficient supply line to move cotton from mills in Ethiopia to the Dupont in the United States. DELIVER provided consulting services to the Ghana Health Services and efficiency was drastically improved. DELIVER mapped out the steps of the hospitals drug supply management and reduced inventory costs by 43%, valued at $1.4 million (Process Mapping 3). In preparing for the future of the hospital and it's satellite locations, efficiency is very important to keeping costs at a minimum.

The Addis Ababa Hospital has a successful training outreach program in place to train health professionals within Africa on how to perform surgery on fistula patients, which would be a great asset to microfranchising hospitals throughout Africa. Within the Addis Ababa University curriculum, all doctors are required to undergo training at the Addis Ababa Fistula Hospital during their postgraduate training (Kennedy 1). The hospital serves as a teaching hospital for physicians to learn a skill and apply it in their own communities. For example, Dr Gutsav Barkett attended one month of on the job

training to take back to the Mercy Ship project to open a fistula hospital in Sierra Leone (Kennedy 1).

The Addis Ababa Hospital is a training center for nursing assistants that are later outsourced to other fistula hospitals in Ethiopia. Many of the nursing assistants are recovered fistula patients that were treated at the Addis Ababa Fistula Hospital. Recovering fistula patients are given job opportunities as well as the rewarding task of helping other suffering fistula patients. I will be working closely with Kristen in selecting her patients that would be good candidates for being nursing assistants. In 2004, doctors from the Addis Ababa Fistula hospital operated on 85 patients outside of Ethiopia (Kennedy 3). People living on the street without a home are also recruited to become nursing assistant. As new satellite hospitals are opening up around Ethiopia, there is a growing demand for nursing assistants. Currently, nursing aides are being trained and going to be relocated to two of the satellite sites: Yirga Alem or Mekelle (Kennedy 1). With the growing demand of fistula cases, Ethiopian citizens are given opportunity to work after recovering from surgery.

My focus is to increase and maintain efficiency to create an efficient hospital that can microfranchise to other areas of Ethiopia and the world. In order to realistically reach the Millennium Development Goals by 2015, immediate action must be taken. Building upon the strong foundation of the Addis Ababa Fistula Hospital will be of great value in terms of aiding fistula patients in both Ethiopia and the rest of the world.

Danielle Swain- Fashion Design

Africa is a continent with many sources for textiles, especially Ethiopia. A problem for many fashion and textile designers in developed countries today is they must outsource their fabric and manufacturing of goods. This is because of the shortage of domestic manufacturers, which causes domestic sourcing to be more expensive than if done offshore. Ethiopia is a country with a large amount of cotton, which can make manufacturing textiles domestically faster and more efficient (Zane), and also cheaper than if the textiles were to be outsourced. There are many fashion designers in Ethiopia who have the benefit of having textiles and a rich heritage available to them.

Cotton has long been a part of Ethiopia's heritage. It was woven and cultivated after its introduction by early European visitors (Picton 29). A rare technique of felting wool and human hair is found in few places in Africa, such as the highlands of Ethiopia, where the technique was used to make cloaks (Picton 46). Weaving is a strong tradition in many cultures, including those of Ethiopia. In Ethiopia, weaving is done primarily by men and a double heddle loom is used. This craft was used to make all sorts of apparel for both chiefs and the rest of the community (Picton 19, 99).

Ethiopia also has a rich and diverse religious heritage. The major religions in Ethiopia are: Christian, Islam, Animist, and Rastafarianism. Christianity in Ethiopia is older than in Europe. Ethiopian Orthodoxy was founded in 341 AD, after the arrival of two Christian Syrians (Parker 53). There are elements of Judaism as well as the possibility of ancient Egyptian traditions that are incorporated into the Ethiopian Orthodox church. It is estimated that between thirty-five to forty percent of Ethiopia's population is Ethiopian Orthodox (Ethiopia). It is Ethiopia's rich religious and cultural

heritage that serves as a strong backbone to create decorative as well as utilitarian textiles.

Because of the Hamlin Fistula Hospital's intended expansion into other regions of Ethiopia, there is a strong need for medical supplies. The hospital relies on funding and in the case that the funding stopped due to unforeseen circumstances; these supplies must be able to last. It is difficult to preserve certain medical supplies after first time use. But other items, such as dress gowns and hospital sheets can be made in such a way that they are durable and can resist soil. This is important if there is a shortage of water and thus cleaning is not possible. Because Ethiopia produces cotton and has approximately five mills that process it, it is easily feasible that cotton materials can be made with a soil and stain resistant, durable finish to ensure the longevity of the of the supplies (Zane).

Soil and stain resistant fabric is achieved through the application of a finish either to the surface of the fabric or within it. For fabrics that are hydrophilic, meaning they are more prone to soil and stain than a hydrophobic fabric, there are soil-repellent finishes that prevent water based stains and soils, as well as oil based substances, from penetrating the fabric and ultimately staining it (Collier 190). Also, there are soil release finishes that are applied to fabrics that have a natural affinity for oil based substances, such as polyester or polyester blends. A soil release finish makes the fabric more hydrophilic, meaning its ability to absorb water increases. Because of this, water with a cleaning agent can penetrate the fabric more deeply than if it did not have the applied finish and release the stain (Collier 190-200).

Called nanotechnology, these specific finish applications are achieved on the microscopic level, and are done before the construction of the fabric, or in its fiber state.

An example of applied nanotechnology is a cotton fiber applied with smaller fibers, about 30 nanometers wide. One nanometer is one billionth of a meter. These fibers are treated with fluorine. Fluorine naturally has a negative charge, which in turn makes the whole textile have a negative charge after construction. Because of this charge, any positively charged solution is repelled from the fabric (Jones 45). This is turn increases the life of the textile because it does not have to be laundered as often. Also, if the textile does become stained, the finish promotes easy soil release so the textile will become clean when laundered.

Other finishes can also contribute to the longevity of textiles. For example, a wrinkle resistant finish for cotton developed by Cotton Incorporated increases the tensile strength and tear strength by twenty per cent and abrasion resistance by three hundred per cent. This finish also helps to increase the fabric's shape retention and allow for quicker drying (Cotton Gets Tough). This is important in an area where supplies have to last a long period, and the means to launder and dry is not as readily available as it is in a more developed area.

Currently, these applications of finishes to textiles are used primarily in consumer apparel and sportswear. However, this does not mean that this technology cannot be applied towards medical uses and products.

Another category of finishes, and perhaps more important, is that of antibacterial, antimicrobial, and antimycotic finishes. Antimycotic finishes protects against other types of fungus besides mildew (Collier 239). Antimicrobial finishes protect against the production of mildew, and is applied to the surface of the fabric, or by cross linking with the polymer, or fiber before fabric construction. When the finish is embedded into the

fiber, it is slowly released over time to increase the life of the finish, and is activated by an external catalyst like moisture or light (Collier 239). However, antimicrobial finishes do decrease in their effectiveness over time. How long it takes for the finish to decrease in its effect depends on how often it is laundered. The exception to this is a polyethylene glycol (PEG) treatment that is cross linked. First developed in researching how to increase the thermal attributes of textiles, it was discovered to be effective in bacteria prevention. This finish can protect against *S. aureus, E. coli,* and *K, pheumoniae* (Vigo 737-743).

Antibacterial agents, when applied to textiles, protect against bacteria. They can easily be applied to any fabric, and will instantly increase the ability of the fabric to protect or kill bacteria. One such agent is Nimbus™, which was developed by Quick-Med Technologies, Inc. Nimbus™ is a microbicidal (meaning the bacteria is actually killed, not just repelled) agent that can be bonded to cotton, cotton blends, or polyurethane permanently (Agents 52). This technology allows for advanced hospital products to be made, such as wound dressings, doctor's masks, bedding, and gowns. Test results have shown that the Nimbus™ agent can kill up to 99.9999% types of bacteria. The permanent bond makes it impossible for germs to develop a resistance to the agent because molecules cannot diffuse into the wound, which increases the probability of bacteria to develop a resistance against the antibacterial agent (Agents 52).

Another antibacterial agent that is being used and developed for the textile market is the use of silver. When silver particles on the nano level are incorporated into polypropylene, a material is created that can be used in any textile, and thus has infinite end uses. Silver has been proven to kill over 650 disease causing bacteria (Lampam).

Many companies are developing the use of silver as an antibacterial agent, such as DuPont and Dow Chemical (Kitchens). However, Noble Fiber Technologists have licensed a brand of silver antibacterial agent called X-Static.

X-Static relies on silver's strong affinity to bond with other substances. In warmer, moister environments, this characteristic increases. The bacteria are killed because silver bonds to proteins that are found both inside and outside the membranes of the bacteria, which prevents respiration, and thus reproduction of bacteria cells (Kitchens).

These antibacterial, antimicrobial, and antimycotic finishes are necessary for the Hamlin Fistula Hospital and the other fistula centers. All of the above finishes are more important for the new centers because they do not have the foundation and stability that the hospital in Addis Ababa does. It is possible that because of the conditions of road throughout Ethiopia that it would take much longer for supplies to get to these other branches, so the supplies that these centers have must be able to last.

In collaboration with Julia Ciriglo, it has decided that the raw cotton for the hospital will be cultivated in Ethiopia, as proposed by Julia. Also textiles for the hospital will be manufactured in Ethiopia at the five textile mills within the country. Depending on when the finish is to be applied, the raw or manufactured cotton will be sent to textile finishing companies in the United States for finishing. DuPont is one such company, as well as Schneider-Banks Inc., Fabric Finishing Services. After the fabric finishing is complete, I will design hospital supplies such as gowns, sheets, and blankets for the hospital.

Also, many of these women who are treated at the Hamlin Fistula Hospital are young with no skills or training. I propose to set up classes for these women to learn how to sew garments for themselves and their children, as well as sew supplies for the hospital. These are skills that can help women to be more independent and confident, and can also lead to employment. There is an increasing emphasis on fashion in Africa, and if these women posses sewing skills, they can design and be part of a community. In Addis Ababa, there is a plan to build a fashion institute, with completion set for July of 2007 (Fashioning Textile Exports). I propose establishing a program with the institute upon completion where patients at both the hospital and Desta Mender can take courses in fashion design if they so please. As the institute in Ethiopia's capital is not in existence presently, it is unknown what sort of degrees they will offer. However, it can be assumed as to what basic courses will be offered. Tshwane University of Technology, based in South Africa with campus throughout the country, has a fashion curriculum that severs as a possible model for the curriculum that will be offered at the institute in Ethiopia. TUT, as the school is also known, offers one year bachelor degrees in fashion technology. It also offers master's, doctorate, and national diploma degrees, lasting 1-3 years, 2-5 years, and 3 years, respectively (Tshwane University of Technology). Courses include sewing, garment construction, patternmaking, draping, and drawing, all of which increase in difficulty with each sequential course. Classes are also offered in other fields of fashion, such as marketing, merchandising, textile technology, fashion history, and fashion theory (Tshwane University of Technology). I believe an established program for patients of both the hospital and those living in Desta Mender can be positive. These women, who have been to a traumatic experience, can gain their confidence again, and be

able to take care of themselves, and help the hospital. It is also possible for those who decide to attend the institute to pursue a career in fashion if they are interested. Ethiopia is an untapped resource of both textiles and fashion creativity. With the country's rich culture as inspiration, I am sure these women could be successful fashion designers if they chose to be.

Julia Ciriglo- Fashion Merchandising

As a fashion merchandiser I have many opportunities to utilize my business and textile expertise to aid the Hamlin Addis Ababa Fistula Hospital. Working with fashion designer Danielle Swain, I will locate affordable high-quality, local materials needed for the hospital. I also plan to will work with others in my industry to form a campaign benefiting the hospital. Along with female peers in the industry, I will attend the National Women in Business Conference in Nairobi.

As a merchandiser, my goal is to acquire high-quality goods at the lowest price. But as a socially responsible merchandiser, I will source materials from local mills and factories. I hope to not only source materials that will help improve the quality of life of the hospital's patients, but also boost Ethiopia's local textile economy. Danielle Swain, fashion design consultant, has informed me that cotton would be ideal for use at the hospital due to its strength, resilience, and ease at which finishes can be applied. Over fifty percent of Ethiopia's economy is dominated by agriculture (Agridev Consult 1). A recent study by the Ministry of Agriculture concluded that there is 2,575,810 hectares of land suitable for cotton production in Ethiopia. Despite this immense potential for cotton growth, Ethiopia utilizes only 42,371 hectares, accounting for 3.6% of the total cotton

produced in eastern and southern Africa (Agridev Consult 5). By sourcing in Ethiopia, I will boost awareness of their cotton industry in hopes that other local and global businesses will source from Ethiopia rather than outsource to countries like India and China that benefit from economies of scale. State farms, private commercial farms, and smallholders produce Ethiopia's cotton. Of the seed cotton annually produced in the country, thirty-seven percent is sold to domestic textile mills and the export market. Textile and garment factories account for thirty-six percent of Ethiopia's total manufacturing sector (Agridev Consult 13). Ethiopia has seven integrated public textile mills, two spinning mills, two thread factories, one blanket factory, and two Hessian sack factories. These establishments employ twenty-four thousand Ethiopians (Agridev Consult 14). Regardless of the fact that I will not take advantage from purchasing garments in a country that benefits from economies of scale, therefore getting cheaper prices, I will source raw materials from Ethiopia. Not only will I help the women and hospital staff by providing durable, quality garments, but also support the local economy and heighten awareness of their many factories and mills. The following are registered cotton factories that I will contact:

- Birale Agricultural Development PLC
  P. O. Box 100037 Addis Ababa
  Telephone number: 663593
  Fax: 654505

- Middle Awash Agricultural Development Enterpirse
  P. O. Box 13007 Addis Ababa
  Telephone number: 525606
  Fax: (02) 114593

- SAMADCO International PLC
  P. O. Box 12607 Addis Ababa
  Telephone number: 614262
  Fax: 614231
  Email: samadco@telecom.net.et

- Sodec PLC
  P. O. Box 55860 Addis Ababa
  Telephone number: 750777
  Fax: 757979

- Tendaho Agricultural Development Enterprise
  P. O. box 13464 Addis Ababa
  Telephone number: 513651/514113
  Fax: 513651
  Email: tendaho@hotmail.com

I hope to use all five of the cotton factories for materials, in order to boost Ethiopia's cotton industry as a whole. Depending on the fabric's stage at which finishes will be applied, I will source cotton fibers and/or cotton yarns. Then the raw materials will be transported to DuPont for finishing. I am hoping that DuPont will finish the garments at low to no cost. I will entice them to do so by creating a press release on our consulting firms' work, and publishing it in such trade publications as *Woman's Wear Daily, Just Style, Fashion Business International,* and *Manufacturing Supplies and Fabrics*. The firms offering low to no-cost services will be mentioned as socially responsible companies. Not only will the firms be seen as socially responsible, but they will also receive publicity in the industry.

Some professionals in my field are already looking to the future of Ethiopia's textile market. Elias Meshesha, a native Ethiopian, has launched a new fashion line with Ethiopian designer Gadol Ton. Meshesha and Ton produce garments made from locally manufactured materials, mainly cotton. The new line takes advantage of the local goods, therefore supports domestic industry (Zane 3). Like Meshesha and Ton, I will source

materials from Addis Ababa's Sara Garment Designers and Manufacturers. Female owned companies like Sara create employment opportunities and skills that are essential to lift women out of poverty (African Growth 1). This company is founded and owned by a local Ethiopian woman. I will source finished goods at Sara Garment Designers for items that do not require additional finishing; those that do not need to last as long for use in medical situations. These may include dresses, hats, scarves, and aprons for the women who reside in Desta Mender. The fashion design portion of our overall plan for Addis Ababa will include training the women in sewing with the hope of providing them with skills, which they can utilize when they return home. Also, I will source fabric, yarn looms, and thread from Sara for use by the women in Desta Mender. With these materials, the women can create crafts and clothing for themselves and patients as well as those that will be auctioned though a charitable sale.

I feel that my contribution to the Hamlin Addis Ababa Fistula Hospital should not end when our consultation is over. It is common to see campaigns benefiting AIDS awareness, cure for Breast Cancer, or natural disaster funds, but fistula is a problem that is under the radar of most Americans. Recently, some new campaigns and nonprofit groups have emerged in the fashion industry. Fashion Delivers Charitable Foundations Inc. was established in October 2005 to collect clothing donations for victims of natural disaster, particularly those victims of Hurricane Katrina (Young 1). Vogue and the Council of Fashion Designers of America are spearheading the return of "7th on Sale", with a black tie gala and proceeds from sales at Skylight Studios in New York City to support the CFDA/Vogue Initiate's goal of raising $3 million for the fight against AIDS (Karimzadeh 1). The industry has come together to donate more than ten thousand items,

sixty percent of which will be auctioned on eBay. Vogue has created an advertising campaign called “Shop till AIDS Drops” which will run in magazines like *Vogue, The New Yorker, Cosmopolitan,* and *Vanity Fair*. Kenneth Cole Productions took on the logistical role for the gala; receiving and storing donated goods in their warehouses. Dolce & Gabbana recruited many volunteers and solicited donations. According to Anna Wintour, *Vogue* editor-in-chief, the fashion community has joined forces to bring about awareness that AIDS, unfortunately is not a disease that has gone away (Karimzadeh 2). Fistula is a problem that can be treated, and more importantly prevented, with proper health care. I feel that the “7th on Sale” campaign is phenomenal and wish that such a large-scale event could take place to benefit the Addis Ababa Fistula Hospital and its satellite centers. Fistula is not an issue to American women because of our superior health care. As a woman, I am outraged that such an easily cured and preventable disorder takes place to begin with. I propose joining forces with the larger, more influential CFDA.

The Council of Fashion Designers of America, CFDA, is a not-for-profit company that was organized to raise funds for charitable campaigns on behalf of the fashion industry. The CFDA was founded in 1962 to advance the status of fashion as culture and art as well as a means to define ethical standards and benefit society through philanthropic efforts (CFDA). Founding member include such fashion industry elites as Bill Blass, Donald Brooks, Jean Louis, and Pauline Trigere. Past presidents of the CFDA include Oscar de la Renta, Bill Blass, Perry Ellis, Carolyne Roehm, and currently, Stan Herman. The CFDA’s charitable efforts include Fashion Targets Breast Cancer, CFDA-Vogue Initiative, and Fashion for America. With five-member advisory board, the CFDA

selected five priorities for use of 7th on Sale's proceeds (CFDA). They include: supportive housing for persons with AIDS, emergency loans to community based programs in Africa, programs for women and children, national advocacy and public policy, and unforeseen opportunities where one-time funding can make a significant difference (CFDA). The following is contact information for the Council of Fashion Designers of America:

- CFDA- Vogue Initiative c/o CFDA Foundation
  1412 Broadway/ Suite 2006
  New York City, New York 10018

I believe that a fundraiser will significantly help the Addis Ababa Fistula Hospital's new satellite hospitals. Organizing the fundraising gala will prove to be a difficult task. I will follow the *International Journal of Nonprofit and Voluntary Sector Marketing*'s plan for organizing a fundraising event. First donor development and acquisition of new support must be achieved (Webber 122). Maintaining a well-known name along with the charity is key; therefore my choice to partner with CFDA will be beneficial. Also, the total amount spent by those attending is motivated by two factors: private benefit of enjoying the event and a philanthropic donation to support a charitable cause that they believe to be meaningful (Webber 124). I also plan to hold a silent auction with items donated by fashion designers as well as those created by the women of Desta Mender. Webber explains that items that achieve the greatest return at auction are those that are unique with no observable market value. Because the items created by the women at Desta Mender will only be available at the auction and on CFDA's website, they have the potential to raise a great deal of money to benefit the hospital. In conclusion, key to maximizing revenue for the hospital at the fundraiser event is to

understand the willingness of the attendees to spend money, underlying motivations of the attendees, and ways to cater fundraising methods to maximize returns (Webber 127).

As a businesswoman, I will not be able to directly change Ethiopia's culture towards women and its health care, but I can bring about awareness of the hospital to peers in my industry. I will contact generous individuals in my field like Anna Wintour of *Vogue* and the CFDA to hold a similar event to bring about awareness of fistula and raise money for the hospital's building of its satellite centers. The Fistula Foundation currently offers a bracelet on their web site for a donation of $125 or more. The Dignity Bracelet was designed by a hospital volunteer in order to provide an item that could create a personal connection to the hospital. It is distributed and handled in Minneapolis, Minnesota (Dignity Bracelet 1). As a buyer I will most definitely carry this bracelet in my stores. I will also provide information about the bracelet to peers in my industry so they too can offer it at their retailer. Currently the bracelet is only available online. A small item like this will help bring about awareness to the problem of fistula and support the Addis Ababa Fistula Hospital.

With the help of the Council of Fashion Designers of America, I propose implementing a fund-raising campaign to promote the Dignity Bracelet similar to CFDA's partnership with Nike and Style.com for the "Wear Yellow/Live Strong" campaign. In July 2004, the CFDA partnered with Nike and Style.com to raise money for the Lance Armstrong Foundation through the "Wear Yellow/Live Strong" campaign. All of the proceeds from the one-dollar yellow wristbands went to the foundation as well as one hundred percent of proceeds from a gala auction. The plastic wristbands have become a fashion accessory, with people using their wrists as a billboard for a cause. The

"Live Strong" bracelet has raised over fifty-eight million dollars for programs to benefit those living with testicular cancer (Mayer 2). Unfortunately, charity bracelets have lost some of their value as a way to show support by becoming merely fashion trends. Author Joshua Blackburn describes this phenomenon as charity that one gives and then forgets (Blackburn 1). For one dollar a wristband shows support for a cause, but many times the wearer forgets or doesn't care what the cause is (Blackburn 1). This is a challenge that I will face when promoting the Dignity Bracelet. Because of the high price tag of the Dignity Bracelet, it is unlikely that it will become a fashion phenomenon reaching millions, like the yellow "Live Strong" bracelets, but it will reach influential buyers in my industry who will offer the item at their retailers. Numerous retailers create specialty items with proceeds going to the fight against cancer and AIDS. Lily Pulitzer, Clinique, Lee jeans, MAC, and Avon are a mere few examples of those fighting for a cause. Like the Lily Pulitzer scarf, priced much higher than the one-dollar plastic bracelets, I hope that the Dignity Bracelet will become an item that will become a charitable fashion statement while maintaining its important message of the importance of prevention and treatment of fistula. Fashion is a luxurious and often times frivolous industry while charity is its polar opposite. Author Fleur Britten believes that fashion is an ideal industry to draw attention to charity because it is humbling to know that the money you are spending is for a good cause (Britten 1). The Dignity Bracelet is a sign of bettering women's reproductive health care in Africa as well as benefiting the Hamlin Fistula Hospital. With the help of the CFDA, the Dignity Bracelet will be offered in participating retailers, through the CFDA website, and at the fundraising gala.

Along with my female peers in the industry, I will attend the National Women in Business Conference in Nairobi. This conference rewards African women and promotes self-reliance and economic independence. By speaking at the conference, I will form relationships with others in my field working to better the lives of Ethiopian women (Women In Business 4). The Conference was recently held October 13–14, 2005. Topics included: how to venture into the international fashion industry spearheaded by Rose Kimotho, Managing Director of Kameme Fashion Merchandising, as well as challenges women face doing business in Kenya led by Betty Maina, Executive of Kenya Association of Marketing. An awards ceremony and fashion show showcasing African designers was held the evening of October 13th. The conference is open to females and males in the business arena who champion women's participation in African business.

I hope to attend next year's conference to share my views on the importance of self-reliance of women. I will share will them my and Danielle's program that we look forward to implementing at the Addis Ababa Fistula Hospital. By sharing my experience and goals, I hope to create awareness and network with African businesswomen who will look out for these women who may enter the workforce. Along with Danielle, I hope to implement sewing classes. If the women ever leave the village, they will have a useful skill that will benefit not only themselves but their family and community as well. The women who reside in the hospital's village, Desta Meder, can use their sewing skills to create clothing for themselves and patients. The cultural structure of Ethiopia is so that women's role is tending to house and family. We do not want to impose our cultural beliefs on the women. Therefore I will implement a program that will teach them the basics of fashion, sewing, and business. It is their choice if they wish to work outside the

home as such places as Sara Garment Designs, enter Addis Ababa's fashion institute opening in 2007, or simply use the skills they were given to benefit their families and community.

My overall objective, as well as those of my partners, is for the women at the Hamlin Addis Ababa Fistula Hospital to feel like productive member of the family unit and society once again, with choices in their lives. The women were shamed and isolated for years. It is time that they are able to see their usefulness and importance to their families and society. By organizing a fundraising gala, promoting the Dignity Bracelet, and auctioning items created by the women at Desta Mender, I will raise much needed funds for the improvement of the Addis Ababa Fistula Hospital as well as the building of new satellite centers. With my connections with females in the industry in Africa, I will create lifelong relationships to better the lives of Ethiopia's women.

Kristen Shirley- Psychology

While fistula has not received as much attention as some of the other major problems plaguing Africa, and Ethiopia in particular, it is one of the immense obstacles devastating the bodies and spirits of millions of girls around the continent each year. Beyond the physical injuries that ravage these young women's bodies, their pain is further compounded by social ramifications as well. In most cases, once a young girl's husband learns that, as a result of overlong labor, she has produced a stillborn baby and may not be able to have any more children, he will often demand a divorce and abandon her. When she returns back home, her family and the rest of the village generally ostracize her because of her inability to control her bowel movements, which causes a

constant, offensive smell. This isolation reinforces the girl's beliefs that she is a worthless disgrace (Preventing Fistulae). After being shunned by their communities and having their self-esteem destroyed, it is impossible for these young women to live the fulfilling lives they deserve.

Currently it seems that the only way fistula sufferers in Ethiopia are receiving any type of treatment, medical or psychological, is if they are able to visit the Hamlin Addis Ababa Fistula Hospital. This hospital is the only center in Ethiopia designed specifically for combating the problem of fistula. Of the 1,200 patients who receive the surgery every year, between 93-97% of the women are completely cured. Once these young women make a full recovery, although no extensive counseling is given, they will receive a brand new dress to boost their self-esteem for the return home to their lives (Hamlin).

While the Addis Ababa Fistula Hospital has essentially been performing miracles for thousands of women annually for over thirty years, there is still more to be desired when it comes to the psychological treatment of these women. Because of limited resources many organizations worldwide, including the Addis Ababa hospital, are only able to provide the surgery for these women. Once the women are repaired they are urged to return to their normal lives. The only continual care the hospital can afford goes to support the small percentage of incurable women who reside in Desta Mender. In the past, little information was known regarding the mental state of the so-called "cured" women.

However, a 2005 study by a number of prominent fistula-oriented gynecologists, including, Andrew Browning from Addis Ababa, have shed some light on the true mental health situation of women suffering from fistula. The results of these studies conclude

that 97% of women suffering from fistula screened positive for mental health dysfunction, including anxiety, insomnia, and social dysfunction. Along with these disorders, it was also determined that between 23.3% and 38.8% of women with fistula suffer from major depression (Akhter). Although surgical reparation is the first step for these women to regain their lives, years of shame and being ostracized do not disappear overnight.

To address this issue, I would attempt to spearhead an initiative in Ethiopia to expand the mental health care of all of the women who are seen at the Addis Ababa hospital, whether they can be surgically repaired or not. My program would be based on the FORWARD Initiative, a model project in Dambatta, Nigeria, funded by the United Kingdom and local philanthropists. After surgical repair and healing is complete, the women are exposed to educational and vocational activities, such as soap making, sewing, knitting, animal husbandry, rice milling, and management skills. These skills are meant to empower the women, while providing a supportive learning community. After sufficient skills are learned, a small loan is given to the women when they complete the program, which aids them in returning to their home village and opening their own small business which will support them. Without these educational opportunities, these women may not have had the option to return home with their pride, knowing that they are self-reliant (Reclaiming Lives).

Although this initiative appears to be very similar to Desta Mender at Addis Ababa, there are a few differences. As previously stated, the FORWARD Initiative is intended for women who have benefited from the surgery and who plan returning to their former lives, while the women of Desta Mender usually remain confined to this village

for their entire lives. While learning a new skill acts as a therapeutic tool to boost self-esteem in both cases, the skills taught within the FORWARD Initiative take it one step further, to ensure that these women will be able to enjoy the rest of their lives in their own communities, happy and healthy, supporting themselves.

While the idea of teaching healed women a new skill appeals to me, as it will help boost self-esteem and pride, I would add a few components to my overall mental health rehabilitation program. Years of social torment can build up and cause an immense amount of psychological stress which ends up surfacing as a mental dysfunction. With the realization of such a high prevalence of depression and other mental disorders in fistula patients (Akhter), I feel that actual counseling is necessary to help fully heal these women. However, because of the mental health system in Ethiopia, (or lack thereof) putting this plan into action will prove difficult.

The state of mental health care in Africa as a whole is not much to speak of. With so many other devastating problems to worry about, mental health is usually last on the list of issues to correct in Africa. Health services in general are inadequately funded throughout the continent, with health services being the most poorly developed. In fact in some African countries, mental health policies or programs do not even exist. The exception to this fact, as it is in many conditions in Africa, is South Africa. South Africa possesses a number of mental health facilities throughout the country, including six in the Western Cape Province alone. Compared to virtually all other African countries, South Africa appears to be in good shape, psychologically speaking.

However, between 1939 and 1989, at the mandate of the apartheid government, most of the care was provided to heterosexual white men. The few black patients who

were seen during this period were reportedly treated cruelly. During the 1980's and 1990's, post-apartheid, a number of treatment techniques and equipment were advanced due to international trends and a number of mental health bills were passed in hopes of providing fairer mental healthcare. However, a number of human rights abuses against black patients are reported to this day (Dis-ordered). Although this country may possess the greatest mental health resources, the psychological care in South Africa, along the rest of the continent, is still dismal to say the least.

In 1975, one World Health Organization report stated that, ''the most important constraint in meeting mental health needs in the developing countries is the extreme scarcity of mental health professionals. This situation is unlikely to improve within the next decades, because of the small numbers at present being trained in mental health care, and the migration of those who have completed their training to developed nations" (Mental). Thirty years later the situation has appeared to make little progress. In 2000, in some parts of Africa, the psychiatrist to population ratio was as low as 1 to 5 million, as compared to a ratio of 1 to 1,000 in most areas of Europe. More specific to Ethiopia, there are currently 10 psychiatrists to treat the country's 61 million people. Because psychiatrists are virtually non existent in Ethiopia, 85% of the mentally disturbed people who do seek treatment, rely on a traditional healer, who knows little, if anything about medicine and psychology (Mental).

Despite all of these disappointing figures there have been no solid plans made to improve the psychological conditions in Ethiopia. Even the WHO, the major promoter of mental health in Africa seems to hint at a feeling of hopelessness regarding this situation. Due to the countless disruptions facing Africa from raging wars to continent wide

pandemics to unthinkable poverty, there always seems to be something overshadowing the lack of mental health care. The WHO acknowledges the need for better mental healthcare policies in Africa, and while it believes the first steps are identifying the major mental health problems of the continent, and then training enough skilled workers to treat these problems, actual implementation of these policies are far from a realization (Mental).

Because mental health care in Ethiopia is almost nonexistent, my hope would be to create counseling programs in the Addis Ababa Hospital that all of the women could attend while they are recovering from their surgeries. Healing from the physical wounds is one thing, but these women need to mend their psyches as well. These counseling groups would be a place for women to vent their feelings of hurt while restoring their sense of self-esteem. One of my main responsibilities in this project would be structuring the counseling sessions. I would most likely employ a humanistic approach during each session, which allows each woman to explain how her injury and its stigma left her feeling. With this approach, it is important to validate and repeat everything the patient says, in order to make sure they know you are listening and that what they are saying is important.

Because so few Ethiopians have ever experienced any type of Western medical or psychological care, there may often be skeptical of these treatments. This skepticism is another reason that I feel that humanistic therapy sessions can work. Being from a collectivist culture, Ethiopians tend to rely on their families and communities for help and support (Kloos and Zein). Because these counseling sessions are not intimidating one on one encounters between one patient and myself, I feel that these women will be more

open and accepting of this approach. Due to their collectivist upbringings, these women are likely to want to support each other and share their common experiences. Also, because no drugs or complicated therapy techniques, such as psychoanalysis, will be used during counseling, the women should not feel overwhelmed with "fancy" Western treatment.

As the sessions got more in-depth, I would utilize a number of confidence building exercises to repair self-esteem. If these sessions are held almost every day, I could envision the patient being able to return to her life in a matter of six to eight weeks, hopefully healed on the inside and out. Obviously this plan for extended health care would mean making housing available for these women during their stay. This issue would be something that I would work on with Derek, to determine how to fundraise money for this project, or possibly allocate existing funds. Eventually as each of the five new facilities are built and become established, I would attempt to integrate the FORWARD Initiative, as well as the counseling programs into each of them.

However, because mental health is one of the least developed areas of healthcare in Ethiopia in terms of facilities and employees, implementing this plan will be easier said than done. As stated before, the psychiatrist to patient ratio in Ethiopia is one to six million and the only specialized mental health facilities are located in Addis Ababa (WHO). Because Ethiopia is such a large country there is no way that a handful of trained therapists and I could reach most of the population of Ethiopia, let alone those suffering from fistula. Especially with the addition of five new fistula hospitals, the need for mental health workers will greatly increase. Therefore, before a majority of these group sessions can be administered, a number of additional mental health workers, either sent from the

United States or trained in Ethiopia, must be educated on the psychological problems created by fistula, along with our goals for treatment.

Overseeing the hiring and the training of more mental health workers is the last component of my contribution to our project. Because finding suitable mental health workers has been an ongoing problem in Ethiopia, this task may prove to be the most challenging. For that reason, I would contact Doctors Without Borders and try to obtain their assistance. Created in 1971, Doctors Without Borders/ Medecins Sans Frontieres (MSF) is an international independent medical humanitarian organization which provides its services in over seventy countries. The main mission of MSF is to provide emergency aid to people in countries troubled with war, natural disasters, and epidemics, as well as those who are excluded from healthcare. Whenever these situations arise, MSF rehabilitates and runs hospitals and clinics, performs surgeries, fights epidemics such as AIDS and malaria, delivers vaccinations, and creates centers to feed malnourished children (Mental Health).

Beginning in the early 1990's MSF began to realize that their services would not be complete until they added a mental health component. Today, this organization makes a strong effort at confronting mental health issues, such as post-traumatic stress disorder in war-torn countries and depression and shame caused by many diseases (such as AIDS). At the heart of the MSF mental health approach is recruiting and training mental health workers (Mental Health). Therefore because training workers is one of their strengths, I would try to align my efforts in Ethiopia with this organization in hopes of securing enough knowledgeable psychologists and technicians to deal with the effects of fistula.

Nevertheless, the lack of mental health workers and facilities is not the only obstacle facing the psychological treatment of these girls. The culture of Ethiopia itself, may prove to hinder the efforts to save the futures of these girls. While a majority of these girls who return home are immediately banished from village life, the ones who are taken back in by their families may not receive proper treatment for their social and psychological problems because of traditional Ethiopian beliefs regarding mental illness. Mental illness, including depression and anxiety disorders, has traditionally been attributed to supernatural forces and evil spirits. Typically any form of psychological problem is seen by a religious leader in the village who tries to banish the evil spirit out of the person with holy water and prayer. Western medicine or therapy is often seen as a last resort, if it is even considered at all (Kloos & Zein).

However, if these fistula victims are slowly acclimated into some *basic* types of Western mental health care techniques, much progress could be made. As previously discussed, I envision these women joining in and benefiting from simple group therapy sessions where they can help each other work through their feelings. In order to improve the quality of mental healthcare as a whole in the country, more Ethiopians need to be educated with regards to the true underlying causes of mental illnesses such as depression, as well as the goal of modern day treatment. Whether this education takes place in the form of written literature, radio advertisements, or village meetings, these girls and their families may not realize the benefits of psychological counseling unless they are enlightened about how much it could help.

There is obviously much work to be done regarding the psychological treatment of fistula victims in Ethiopia. In order to ensure that all victims are able to regain their

lives and their dignity, counseling as well as educational and vocational training programs need to be implemented at Addis Ababa, along with the five future sites. However, I alone will not be able to procure enough funds, supplies, facilities, and mental health workers to reach this lofty goal; I will need the help of Derek to procure enough funds in order to hire enough quality mental health workers and counselors. Likewise, Danielle and Julia's skills with fabrics and sewing will be crucial to me as I attempt to create a number of workshops that will build the women's skills, as well as their self-esteem. Therefore, while these ideas and initiatives may be my individual project which I am in charge of organizing, they will only be possible with the help of my group mates.

Conclusion

Although our goal is to assist the Addis Ababa Fistula Hospital, fistula is not a social and economic dilemma unique to Ethiopia. The World Health Organization estimates that more than two million women in developing countries, particularly in sub-Saharan Africa, are living with fistula. They estimate fifty thousand to one hundred thousands new cases occur each year (Zarb 1). Launched two years ago by the United Nations Population Fund (UNFPA), the Global Campaign to End Fistula is able to provide only partial support to thirty developing nations (Zarb 1). Therefore it is key that generous individuals and businesses come to the aid of the Addis Ababa Fistula Hospital and others throughout developing nations to organize programs, benefits, and resources similar to what we proposed.

Fistula is a problem that can be eradicated. It costs around three hundred dollars to restore the health and dignity of a woman suffering from fistula. Fistula has been

eliminated in Europe and North America because of superior health care. If the current demand for family planning services in sub-Saharan Africa were met, the UNFPA estimates that death and injuries caused by labor could be reduced by twenty percent (Zarb 1). Clearly, improvements to prenatal and antenatal health care can greatly enhance the lives of women and children. An even greater achievement to be met is changing cultural perspective of women, reproduction, and societal stereotypes toward gender.

Our group faced many problems with organization and implementation of our plan. The most significant issue faced was communicating with individuals who work for the Hamlin Addis Ababa Fistula Hospital. We were fortunate to receive one email from a woman working at the hospital with a brief mention of their plans. Danielle Swain, fashion design consultant, created a questionnaire for further information that was vital to our project. Unfortunately, we did not receive a response. Because we are thousands of miles away it is difficult, nearly impossible, to receive information privy to the hospital's staff. Certainly, this information would have greatly helped our project. Overall, through Internet research, we did the best we possibly could to pinpoint areas in which the hospital needed aid.

Along with communication problems, we came across cultural barriers. For instance, there is a lack of mental health workers and facilities in Ethiopia. As mentioned in Kristen Shirley's individual contribution, a stigma is attached to mental health care, and even worse, some Ethiopians do not even know what mental health care is, or where to get it. Kristen wanted to implement counseling sessions at each hospital. But because of limited workers and knowledge on the subject, she would need a great deal of money to train and hire staff. Mental health care is not a priority for Ethiopians, with many

relying on traditional African healings like holy water and chants. Sadly, some believe that a fistula is a curse or punishment for a woman and one that they deserve. Furthermore, women's low social status and lack of education leaves them disempowered to make decisions about their health. The physical consequences of fistula make life difficult; but even worse are the social and emotional consequences. Oftentimes, husbands or family members abandon or mistreat the women because of their condition. A patient interviewed by the United Nations expressed that in her opinion, it is better to be blind than suffer from fistula because with blindness, at least people are willing to help you (Zarb 1).

Another problem faced was creating a charitable campaign to benefit the hospital and bring about awareness of fistula. Julia Ciriglo proposed joining forces with a well-known philanthropic organization in the fashion industry. Unfortunately, more communication issues arose because the organization did not respond. Furthermore, because fistula is a sensitive subject, it will prove to be difficult for a mass media to promote the cause. Individuals are more inclined to donate to well-known organizations or those that they are comfortable supporting. Because American women have superior health care, fistula is not a known disorder. It will take time to educate American women on the severity of fistula.

The complications from childbirth and fistula are likely to continue until improved health care reaches the most vulnerable of African society. Key to eradicating fistula in developing countries is changing the mindset and cultural beliefs of their people. Reducing the number of adolescent pregnancies is the first step to decreasing the frequency and severity of complications from labor (Taking a Comprehensive Approach

1). Postponing age of marriage, delaying first pregnancy by access to family planning, and spacing births further apart, also by access to contraceptives, will allow women to reach physical maturity and reduce complications. Strengthening health care systems as well as education will raise women's economic and social status as well as promote maternal health (Taking a Comprehensive Approach 1). Also key is providing counseling to women living with fistula after surgery. A minor percent of surgeries do not repair more sever cases of fistula, therefore family members must also be counseled in order to accept the woman into the family and see her as a human being and productive member of society (Taking a Comprehensive Approach 2).

As four individuals from vastly different professional backgrounds, we succeeded at harnessing our expertise in order to offer the Hamlin Addis Ababa Fistula Hospital a promising plan for the future. We combined our efforts and ideas to provide the hospital with funding, garments, counseling, and medical supplies. Fistula is a problem that can be healed individually as well as on a national level. We hope to inspire others to donate their expertise to help those less fortunate. On a larger scale, with campaigns in place to bring awareness and funding to the hospital, we aim to change the mindset of the country's government about women's rights as well as that of foreign nations and Ethiopia to provide more adequate reproductive education and healthcare for women. With our plan, we brought a promising future to women suffering from fistula, as well as a commitment to Catherine Hamlin and the gracious volunteers and doctors, that the Addis Ababa Fistula Hospital will continue to help the misfortunate for many years to come through the addition of satellite hospitals. More importantly, we brought hope to

the victims of fistula through psychological care and teaching of skills to become productive and valued members of Ethiopian society once again.

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