

**UNIVERSITY OF GHANA****SCHOOL OF NURSING****COLLEGE OF HEALTH SCIENCES, LEGON**

Experiences of women with Obstetric fistula in the Bawku  
East District of the Upper East Region.



This thesis is submitted to the University of Ghana, Legon  
in partial fulfillment of the requirement for the  
award of **M.Phil Nursing** degree.

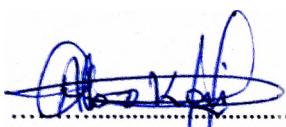
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**DECLARATION**

I declare that except the information derived from published work of others that have been duly acknowledged in the text and the list of references, this thesis is my own work that has not been submitted in any form for any degree or diploma at any university or other institution of tertiary education.



Signature

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**APPROVAL**

The undersigned certify that the supervisors have read this research work and recommended it to the School of Nursing for acceptance.

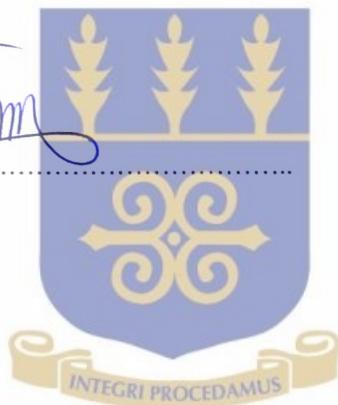
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**DEDICATION**

I dedicate this work to the God Almighty who gave me the wisdom and the strength to carry out this important exercise from the beginning to the end. I also dedicate it to my father Mr. Agana A-erigo of blessed memory and my mother Apaliyam Agana (Mrs.) who nurtured me into who I am today and to my children Lillian, Loretta and Joseph Davidson. Also to my husband Mr. Emmanuel Davidson who has been of great help to me in this tiresome work.



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**ABSTRACT**

The experiences of women who developed obstetric fistulae as a result of complication of labour at the Bawku District Hospital were investigated. An explorative descriptive research methodology was employed to conduct in-depth one -on -one interview with the ten participants between the ages of 20 and 70 years, recruited by purposive sampling. The interviews were audio taped and transcribed verbatim, after which systematic content analysis was done to identify the themes and their categories. The results showed that women with obstetric fistulae experienced negative physical, social and psychological problems. Physical problems identified included genital and perineal sores, urine incontinence and infections. Social experiences of participants included social isolation, loss of job and friends as well as poverty, spousal rejection and divorce. Psychological experiences of participants ranged from loss of self-esteem, stigmatization and sense of hopelessness and unworthiness. Based on the above findings, appropriate recommendations were made to guide future researchers of obstetric fistula, obstetric health practitioners, policy makers and nurse administrators.

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## CHAPTER ONE

### INTRODUCTION

#### 1.0 BACKGROUND

An obstetric fistula is a hole (direct pathological communication) between a woman's birth passage (most often the vagina) and one or more of her internal organs due to prolonged unrelieved obstructed labour (Kabir, Iliyasu, Abubakar & Umar, 2003). The hole may occur between the vagina and the urinary tract (usually the bladder) referred to as a vesicovaginal fistula (VVF) resulting in uncontrollable leakage of urine from the vagina and/or occur between the vagina and the rectum, a rectovaginal fistula or RVF, resulting in leakage of faeces from the vagina. Obstructed labour is a major determinant of obstetric fistula, accounting for about 76%-97% of fistulas in most large series (Wall, Karshima, Kirschner, and Arrowsmith, 2004).

Obstetric fistula is a serious complication of childbirth that adversely affects the lives of millions of women in the developing world (Molzan Turan, Johnson and Lake Polan, 2007) Ninety percent of obstetric fistula cases that occur in developing countries are the result of prolonged or obstructed labour (Women's Dignity Project & Engender Health, 2007). Obstructed labour occurs when the presenting foetal part (usually the head) cannot pass through the maternal bony pelvis. When this happens, the head becomes wedged against the maternal pelvic bones, compressing the soft tissues in between. The uterine contractions force the presenting part deeper into the pelvis, compressing the maternal soft tissues more forcibly. If this process is not relieved by surgical intervention (caesarean section), blood supply to the entrapped soft tissues becomes compromised, ultimately resulting in tissue death and fistula formation (MahfouZ, 1930 cited in Wall, Arrowsmith, Briggs and Lassey, 2003).

Problems and delays at every level of labour management including recognition of the problem, decision-making regarding seeking emergency obstetric care, transport, and availability of

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secondary or tertiary care centres at which a caesarean section can take place all lead to the development of fistulae. Factors predisposing women to prolonged and obstructed labour include malpresentation and cephalopelvic disproportion, which is more common in young or malnourished women (Neilson, Lavender, Quenby and Wray, 2003). While it is important to provide repairs for women living with fistula, it is also critical to address the problem that fistula symbolizes: maternal death and injury (Neilson et al, 2003).

There are other causes (unobstetric) of obstetric fistula such as sexual trauma, injuries from surgery, radiation therapy and penetrating injuries like that from a cow's horn or stick and harmful traditional practices such as the "gishiri" cutting in Northern Nigeria. The latter involves a series of random cuts through the anterior vagina, involving the urethra and the bladder neck, as a traditional remedy for a variety of gynaecological complaints such as dyspareunia, infertility, genital prolapse and obstructed labour (Muleta, 2006).

Obstetric fistula constitutes a major public health issue in the world today, particularly in developing countries. It is almost unknown in Western countries, but highly prevalent in less developed, impoverished third world countries (UNFPA, 2003). The World Health Organisation (WHO) (2006) estimates that approximately 2 million women live with untreated obstetric fistula, with approximately 100,000 new cases occurring each year. Wall et al, 2004 shows that a vast majority of these women live in resource-poor countries, thus obstetric fistula is most prevalent and problematic in Sub-Saharan Africa and the poor regions of Asia.

Obstetric fistula, once common in Western Europe and the United States, has been successfully eradicated from these regions by the inception of caesarean section in the late nineteenth (19th) century (Wall, Karshima, Kirschner and Arrowsmith, 2004). Its prevalence has also fallen precipitously in the more industrialised nations of Asia and Latin America. This is due to the creation of efficient and effective systems of maternity care that provide effective access to

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emergency obstetric services for women who develop complications during labour. With the inception of caesarean section which is one of the commonest emergency obstetric services in Ghana, one then wonders why women are neglected in labour to suffer obstetric fistula.

According to Waaldijk (1994), it is difficult to determine the prevalence of obstetric fistula from community based studies because the condition is underreported as a result of the stigma associated with it and also because it occurs in most remote regions of the world. Literature reviewed however shows an estimated 100,000 women suffering from untreated fistula in Ethiopia alone, with approximately 9,000 new fistula cases occurring each year, 70,000 in Bangladesh and between 100,000 and 1,000,000 in Northern Nigeria (Muleta, 2006).

There is no substantive literature on the prevalence of obstetric fistula in Ghana because very\* little has been done in the area. Estimates are however based on an institutional-based study done by Danso and Martey, (1996) whose findings revealed a prevalence rate of 1 in 1,000 deliveries with 73.8% resulting from obstructed labour. Records obtained following the launch of the global campaign to end fistula by UNFPA which took place in Ghana in 2005, point to the three northern regions namely, Upper East, upper West and the Northern regions as having high prevalence of obstetric fistula. This was confirmed by the deputy minister of Health while addressing 80 participants from 14 countries at the opening of a three-day International Fistula Partners meeting in Accra (Daily Graphic, Thursday, April 17, 2008). At the same meeting, the Vice President of Engender Health disclosed that 300 women have so far been identified from selected areas where the pilot project is being conducted and 111 have undergone surgical repair since 2005. Records from the Tamale Teaching Hospital also shows that a total of 145 fistula patients were identified in Northern Ghana in 2007 and 46 out of this number had their fistulae repaired.

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The main cause of obstetric fistula is unrelieved obstructed labour. However, Kabir et al (2003) identified some factors that predispose women and girls to developing it. These include; lack of emergency obstetric services, lack of transportation, poverty, illiteracy, ignorance, early marriages, malnutrition, poor socioeconomic status of women and the long unfriendly distances these women have to cover before reaching die health facility for emergency obstetric care (Kabir et al, 2003, UNFPA, 2003). Cultural practices such as the practice of waiting for the head of the family (usually the man of the house) to be present before decisions are taken in relation to the choice of birth place even during emergencies has also been identified as contributing to the delay in accessing emergency obstetric care. Obstetric fistula is therefore said to be more prevalent in areas where obstetric services are lacking or for that matter, areas where there are high rates of unskilled deliveries.

According to Graham, and Fitzmaurice (2004), the incidence of fistula rises with increasing rates of unskilled deliveries and is linked directly with maternal mortality, that is to say, its prevalence is high in areas where maternal mortality is high, especially where obstructed labour is a major contributor to maternal deaths. This is because, the two obstetric complications are said to be embedded in a complex network of social issues that have to do with the social status of women, the distribution and availability of health care resources, perceptions about the nature and importance of maternal health problems, and the social, economic and political infrastructures of developing countries, poverty being the common thread linking all these factors together (Graham and Fitzmaurice, 2004).

In Ghana, delivery is conducted by midwives in a health facility and where labour deviates from normal, the midwife seeks the assistance of a medical officer or refers to the next level of health care if there is no medical officer at where she operates. All things being equal, this is the usual process, and in all the regional and district hospitals, there are doctors and midwives though the staff strength varies according to the level at which a facility is operating. In the remote areas

where sometimes only one midwife runs the clinic, the situation is different. One major challenge in the rural area in relation to skilled health care is the longer distances the labouring woman will have to be transported before reaching a health care facility. Often at times, there is difficulty in getting transport, and where this is available; the cost is exorbitant, thus making it difficult for the women to afford.

The situation is worse in the northern part of the country which comprises; the Upper East, Upper West and Northern regions. These are the poorest regions of the country. Poverty is high at the rural areas where the people predominantly have limited or no education (Songsor, 2003, Songsor, Denkabe, Jebuni and Ayidia, 2001). They are not adequately resourced as compared to the other administrative regions of the country in terms of both health facilities and staffing, thus making it even more difficult to access health care even if the facilities are available. For instance, there are three teaching hospitals in the country; the less equipped among them serves the north with only three Obstetrician/Gynaecologists out of the 100 Obstetrician/Gynaecologists that practice in the country (UNFPA, 2002).

Women in the Bawku East District, like their counterparts in other rural areas in the north, are predominantly illiterate and are either unemployed or engaged in petty trading except the educated ones. They have low social status and their views do not count when major family decisions are being taken including their health needs. This implies that their choice of birth place is dependent on their husbands' decision which still holds even during emergencies. Also, 'home deliver' (unskilled delivery) is a norm in this area, as such whenever the process of labour deviates from normal, these unskilled birth attendants are not able to diagnose it in order to seek skilled obstetric care promptly. In some areas, the delay in giving birth is attributed to the woman's bad deeds such as infidelity; therefore, instead of seeking emergency obstetric care, she would be pestered to confess for the baby to be delivered. Traditional practices such as female genital mutilation (FGM) had also been a common traditional practice in the area until the year

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2000 when it became a criminal act punishable by law. There is however no documented evidence as yet as to FGM directly causing obstetric fistula.

Kabir et al (2003) shows that apart from the inconvenience of continuous leakage of urine and/or faeces from the vagina that affected women suffer, the disease has some social, economic, psychological and physical consequences for women. These include stigmatization, abandonment, divorce, social ostracisation, impoverishment of women and physical problems such as rashes and excoriation of the skin, urinary tract infections and foot drop. The latter occurs due to pressure from the foetal head on the lumbo-sacral nerve trunk in the pelvis leading to direct compression of the perineal nerve, or due to direct trauma to the perineal nerve from prolonged squatting and pushing during the second stage of labour.

In some instances, there are social misconceptions that perceive fistulae as being the result of the affected woman's misdeeds. These, coupled with the foul smell that emanates from their clothes due to the constant soaking with the urine and/or faeces, result in a low self esteem thus compounding the psychological effect of the disease. A typical example of some of these bitter experiences encountered by women who develop fistula can be deduced from what two Malawian women said about their predicaments in the following verbatim quotations as cited in Banda, (2007):

"I was forced to flee my home. I settled on a plot adjacent to a cemetery on the outskirts of my village. I couldn't stand the taunting from my own relatives and neighbours. Some were calling me a moving latrine...."

Another woman also reported as follows;

"The misery of fistula is relentless. In spite of efforts to stay clean, the smell of leaking urine or faeces is hard to eliminate and difficult to ignore. The dampness causes rashes and infections, the cleaning up are constant and pain and discomfort continuous as well...."



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Upon reading such bitter experiences by women on this sensitive issue in research endowed countries such as Malawi, Eritrea, Nigeria, the question that comes to mind is, what then will be the experiences of the Ghanaian woman who has found herself in this situation?

Obstetric fistula has a negative toll on victims' family too. For instance, family finances decline when woman with the condition become incapacitated and rendered unemployed. Also, substantial costs are incurred in seeking treatment and in purchasing essential supplies such as soap, sanitary pad and perfumes to mask odour and maintain personal hygiene on a daily basis.

The social impact of the condition on the family is also devastating as the affected woman is no longer able to play her roles as a mother, wife or sister. In Africa as a whole and Ghana in particular, women play major roles in the family such as mothers, wives, home keepers and even breadwinners- Therefore if women are confined or abandoned this way as a result of difficult childbirth, something that is preventable, how then can they play such roles?

Obstetric fistulae are preventable and steps should be taken to prevent complications of this nature. However, if it does occur, one would have thought that it would be considered as an emergency situation manageable by surgical repair or temporarily by conservative management pending surgery, but this is not the case. Studies show that in Africa, women are made to live with this devastating condition for years; up to a decade and over (Wall et al, 2004). Considering the above, one then wonders how these women manage to cope with these problems all through these years. Are they still able to perform those social roles mentioned? If not, then what is the quality of their lives like?

### 1.1 PROBLEM STATEMENT

Obstetric Fistula is rare in developed countries, but in developing countries it is a common complication of childbirth resulting from prolonged obstructed labour. Estimates suggest that at least 3 million women in poor countries have unrepairs vesicovaginal Fistulas, and that 30 000-130 000 new cases develop each year in Africa alone (Global Sisterhood Network, 2006). In Ghana, incidence and prevalence of obstetric fistula are mainly estimations of reported cases in regional and district hospitals where women with the condition seek fistula repair. Several other unreported cases remain unnoticed as many of the women live in rural, deprived places in the country. Most of them are unaware of the availability of treatment centres whilst some are unable to access treatment due to lack of means of transportation and financial constraints (UNPFA, 1996). Current estimates of obstetric fistula in some hospitals in the country are as follows; the obstetric department of the Korle Bu Teaching Hospital has recorded an average of 30 new cases per annum since 2007. Whilst records from the Bolgatanga Hospital indicates an average of 20 new cases annually from 2007 to 2009.

According to the Ghana Demographic Health Survey (2003) about half of the total births (53%) in Ghana occur at home. The Reproductive and Child Health Unit Annual Report (2005) also revealed that Ghana's high institutional maternal mortality ratio (196/100.000LB) has also been blamed largely on the persistently low supervised deliveries (less than 60% of total deliveries).

This therefore means that a number of women still deliver at home unassisted or assisted by unskilled persons. These unskilled birth attendants will not be in the position to diagnose any deviation from normal such as prolonged and obstructed labour in order to seek promptly skilled obstetric care, thus all women attended to by these people in labour risk developing complications including obstetric fistula.

The risk of complications in this part of the country is even higher. This is mainly due to lack of easy transportation and the long distances that women have to cover to get to the nearest health facility. Other factors are poverty (in which case they cannot afford even if there is transport), the culture of wailing for the husband or landlord before any decision can be taken and the lack of emergency obstetric services available in most remote areas. The concept of the three stages of delay that contributes to maternal mortality articulated by Thaddeus and Maine (1994) come in to play in this regard. This probably accounts for the high prevalence of such disabling complications like fistula in these areas than any other part of the country. Being the poorest regions of the country also puts the people at risk of under nutrition which could in turn affect the development of the female pelvis leading to contracted pelvis, subsequently predisposing her to obstructed labour. Considering the above deliberations, coupled with the early age at which girls from this part of the country are given out for marriage, it is clear that as long as the above mentioned predisposing factors continue to exist, women and girls in those areas will continue to be at high risk of obstetric complications, hence the need to make the plight of these women known to all who matter in the prevention of this tragic complication of labour so as to find solutions to it.

## **12 PURPOSE OF THE STUDY**

The purpose of this study is to document the experiences of women living with obstetric fistula.

## **13 OBJECTIVES OF THE STUDY**

The main aim of the study is to explore and describe the experiences of women with obstetric fistulae in the Bawku East District of the Upper East region.

To document the emotional, social and psychological problems as well as physical complications encountered by obstetric fistula patients

To determine duration of time women live with obstetric fistula before they obtain treatment (repair)

To document the challenges faced by women with obstetric fistula in relation to access to treatment

To describe the coping strategies employed by these women to manage their predicaments

#### **1.4 RESEARCH QUESTIONS**

What emotional social and psychological problems do women with obstetric fistulae encounter?

What are the physical complications of obstetric fistula among women in the Bawku East District?

How long do women with obstetric fistula live with the condition before they receive treatment?

What coping strategies do women adopt to live with obstetric fistula?

#### **1.5 RELEVANCE**

It is envisaged that the findings of the study will serve as a guide in policy formulation by authorities of health geared towards improving the situation of women with fistula such as;

drawing educational programmes to educate the public about the condition and their role in its prevention.

-organising in-service training to educate service providers including midwives and traditional birth attendants (TBA) on the condition and their roles in its prevention.

-establishing pre-natal clinics for physical assessment of women and girls before pregnancy in order to identify those at risk early and plan their care.

**Experiences of Women with Obstetric Fistula****1.6 OPERATIONAL DEFINITIONS**

Experience: Anything or situation women with obstetric fistulae went through as a result of the condition be it physical, psychological, social economical or medical

Obstetric: Anything pertaining to pregnancy, labour and delivery

Fistula: An opening between two organs

Woman: Females of the reproductive age and above (15 years and above)

Coping strategy: Any measures employed by the women in order to contain their situation or endure the effects of the fistula on them

Traditional birth attendant: Older women in the family and/or community who have not had any formal training but acquired the skill over years of practice and duly recognized in the communities and homes as such.

## CHAPTER TWO

### LITERATURE REVIEW

An obstetric fistula is an abnormal opening between the urinary bladder and / or the rectum and the birth canal, most often the vagina resulting in leakage of urine and / or faeces into the vagina. (Kabir, Iliyasu, Abubakar and Umar, 2004). This leaves the obstetric fistula victim constantly soiled with urine and /or faeces with the resultant unpleasant odour surrounding her.

Obstetric fistula occurs mostly due to obstructed labour when the head of the foetus cannot pass through the maternal bony pelvis. This leads to a cut in blood supply to the soft tissues trapped in between which if not relieved promptly die and later slough off creating the opening between the structures mentioned above.

There are however other causes such as sexual trauma, injuries from surgery, radiation therapy, and penetrating injuries like that from a cow's horn or stick and harmful traditional practices such as the gishiri cutting in Northern Nigeria.

Kabir, Iliyasu, Abubakar and Umar (2003), studied the medical and social consequences of fistula among patients presenting with vesico-vaginal fistula at a large referral centre in Kano, Northern Nigeria. In the study, a total of 120 patients admitted at the VVF centre of the Murtala Mohammed Specialist Hospital were investigated using structured questionnaires to determine their medical and social problems. Additional information on clinical features was obtained from

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patients' case notes. Data collected on their health and medical conditions include gynaecological problems such as amenorrhoea, dysmenorrhoea, dyspareunia and infertility.

It was found that their ages ranged between 10 and 36 years with a median of 16 years. Majority of the patients 87 (72.5%) were between 10 and 20 years. Most of the patients 98 (81.6%) had their first marriage between the ages of 10-15 years. It was also found out that most of the patients 93 (77.5%) did not book for antenatal care during the index pregnancy preceding development of the vesicovaginal fistula. The commonest associated medical problem among the patients was vulval dermatitis (31%) followed by foot drop (23%) and 17.5% had amenorrhoea. There was also an associated rectovaginal fistula in 7 (6%) of the patients. Other medical problems encountered by these women included recurrent urinary tract infection and dysmenorrhoea Up to half of the patients were bitter about the condition they found themselves in and a third were psychologically depressed while a minority (7.5%) was indifferent. Economically patients were found to be incapable of working because they were shunned by society. They were also considered to have brought shame and dishonour to themselves and their families, and where they managed to avoid not being divorced by their husbands; they quite often lost any form of support from the husbands.

Karshima, Kirschner and Arrowsmith (2004) also carried out a similar study at Evangel Hospital in Jos Plateau State, Nigeria. The objective of this study was to describe the characteristics of women with obstetric vesicovaginal fistula. Records of vesicovaginal fistula patients who were admitted to the hospital between January 1992 and June 1999 were reviewed and analyzed. The following findings were made; Out of a total of 932 fistula cases identified. 899 (96.5%) were

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associated with labour and delivery. ‘The typical patient\* was small and short (44kg and < 150cm); had been married early (15.5years) but was then divorced or separated; was uneducated, poor and from a rural area; and had developed her fistula as a primigravida during a labour that lasted at least 2 days and which resulted in a stillborn foetus,

Gbola (2007) conducted a qualitative phenomenological study on vesico-vaginal fistula and psycho -social well being of women in Nigeria”. The purpose of the study was to unravel the factors responsible for “vesico-vaginal fistula and the impact of the disease on the psychological wellbeing of affected women. A purposive sample of 7 women attending hospital in Lagos participated in the study. Respondents were interviewed using a semi structured interview guide to gather information on factors responsible for vesico-vaginal fistula, psycho-social effects of vesico-vaginal fistula on the affected woman and the coping and survival strategies of woman living with vesico-vaginal fistula in Nigeria. The analysis of the data revealed that vesico-vaginal fistulae were caused by many factors identified by the respondents such as early marriage and childbirth, poverty and illiteracy and lack of skilled obstetric care providers.

According to the study the average age of marriage for many rural females in Nigeria was 12 years. By 14 years these young ladies conceive at an age during which they are not matured enough to endure the demands of pregnancy and delivery. On the issue of illiteracy and poverty, the researcher found out that many victims of vesico-vaginal fistula in Nigeria hail from rural communities are poor and have no education or low educational background. These factors render them ignorant of the need for proper nutrition, rest and sleep as well as antenatal care. They also do not have access to basic social amenities such as good water and clinics, whilst

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parents give their daughters out for marriage at such ages due to poverty which consequently result in early pregnancies and complications such as vesico-vaginal fistula.

The plight of victims of vesico-vaginal fistula according to the study was found to be "sorrowful", they suffer severe pains and bleeding, injuries and infections of the vaginal, urethra, bladder and incontinence of urine. In addition vesico-vaginal fistula (VVF) patients suffer many social and psychological problems such as social isolation, divorce and stigmatization. The study found out that all interviewees were married but were abandoned by their husbands and families upon developing the fistula.

On coping strategies of women living with VVF, the study revealed that many women adapted ways of surviving embarrassment and humiliation by begging for alms and forming associations with other patients in the spirit of self support. Others console themselves psychologically by developing faith in God and devotion to Christian religious activities. The study however lacked both external and internal validity since the sample size was very small, therefore the findings can not be said to be the true reflection of V VF patients in Lagos or Nigeria.

In a similar study Ahmed and Holtz (2006) conducted a retrospective study on social and economic consequences of obstetric fistula; life changed forever? The objective of the study was to summarize the social, economic, emotional and psychological consequences of obstetric fistulae. The researchers identified fistula related articles published between 1985 and 2005 in the electronic databases pub med and Medline. Web-based documents on fistula were also searched using the Google search engine. Publications by organizations devoted to helping

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women with VVF and prevention of the disease such as; the United Nations Population Fund, The World Health Organization, US Agency for International Development, World Fistula Fund, Women's Dignity Project and the UK Department for International Development were utilized and cited in the literature review.

A meta-analysis for 2 of the major consequences of having a fistula; divorce and perinatal child loss was also performed. The results of the study suggested that women affected with obstetric fistulae were “the most dispossessed, outcast, powerless group of women in the world”. According to the study, there is an urgent need for medical attention for these women not only from a charitable perspective, but also in terms of human rights and social justice. Having a fistula changes a woman’s quality of life forever negatively. The study also found out that only a few studies have examined the adverse social, economic and psychological consequences of fistulae. However these studies provide the physical and mental health of affected woman, and provide them with a second chance at participating in family life.

Some of the studies reviewed by Ahmed and Holtz also revealed that some women commit suicide but nothing was published on the risk of domestic violence, murder and horror killing. Four (4) kinds of adverse consequences of obstetric fistulae were identified; physical consequences, emotional consequences, social consequences and psychological consequences. The reviewed literature suggested that very few studies examined these dimensions systematically. Almost all the studies were based on short term follow up after surgical repair. Therefore knowledge remains limited about long-term prognosis following surgery and therefore

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about the long- term contribution of fistula repair to quality of life (QOL) improvement and social reintegration.

Muleta, Fantahun, Kenedy and Tafesse (2008) in a cross- sectional study accessed the health and social problems encountered by treated and untreated obstetric fistula patients in rural Ethiopia; the study was conducted in 7 administrative regions of rural Ethiopia. The participants of the study were sampled from a survey of 19153 households and a total of 53 women were randomly recruited to take part in the study. In-depth interviews of each participant were done to obtain responses about their health and social problems due to the obstetric fistulae. Two different questionnaires were prepared; one for women with repaired obstetric fistulae and the other for women with untreated fistula. The questionnaires were translated into different languages according to the regions from which participants were chosen. Participants were asked to describe social and health problems in detail. Twenty seven untreated and 7 treated women participated in the in-depth interviews. The interviews were later content analyzed and conclusions drawn. The study revealed that majority of women with obstetric fistula (65%) was illiterate. Social and psychological problems faced by women with obstetric fistula were found to include divorce or abandonment by the husband or family members; this was largely attributed to their 'bad smell'. They were not allowed to perform household chores such as cooking and washing of bowls due to the odour they had. Also fistula patients did not share a bed with their husbands or have sexual intercourse with them because their husbands refused to let them get closer to them. Consequently they were prevented from serving their husbands meals or washing their clothes.

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Treatment of fistula was generally accepted by participants to be helpful in improving their status in their families and communities. However, it was still difficult for some women to fully enjoy family and community life because of stigmatization. Most of the treated women complained of stigmatization and avoidance of friends and relatives even after treatment. Discrimination against untreated women with obstetric fistula in the family and community forced some of them to flee from the rural community and either living secluded lives or have access to the Addis Ababa fistula hospital where most of them sought treatment.

Only about one third of the interviewed women with fistula attributed the cause of obstetric fistula to prolonged labour. According to the study this limited understanding could be a major hindrance in seeking health services. Feelings of depression were reported by 36 of 39 untreated women, whilst suicidal ideation was experienced in more than half of the women. Although some husbands of women with obstetric fistula were supportive, many family members and members of the communities were unsupportive. In some instances, in-laws encouraged a husband to abandon his wife. In conclusion, the study revealed that women with obstetric fistula need more than just hospital care and treatment but require proper follow up with support in reintegrating these women back into the society.

In a similar study, Muleta et al, (2005) conducted a cross-sectional study in 7 administrative regions in Ethiopia. Participants were selected randomly by visiting selected houses in rural areas and identifying women who have or had obstetric fistula. The purpose of the study was to determine the prevalence of obstetric fistula in rural Ethiopia and identify the circumstances and barriers to care that enhance development of obstetric fistula and its health and social consequences.

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A sample size of 1800 participated in the study. The total sample size was distributed proportionally to the population size of the administrative districts chosen for the study. Questionnaires were used to guide in-depth interviews of respondents and questions for in-depth interviews were on development of fistula and its consequences and the respondents' life history. The study indicated that the prevalence of obstetric fistula in the study population was 2 per 1000 among women aged 15 and above. Among untreated patients, the prevalence was 1.5 per 1000 women. Overall prevalence of obstetric fistula among women of reproductive age (15-49 years) was estimated at 2.2 per 1000 women.

All fistula patients were found to have had labour of more than one day duration and duration of up to eight days was reported. Home delivery was also more common in untreated fistula patients compared with that of the treated ones. In addition, a high proportion of untreated fistula patients did not visit any health institution at all for difficult or prolonged labour. The time elapse before visiting health institutions for treatment was much higher for untreated patients compared to treated patients. The most common reason for not visiting health institutions when labour was prolonged was inaccessibility of health services (distance) followed by shortage of money. Other factors in this regard included lack of information and home delivery. The median duration of fistula for untreated patients was eight (8) years. This indicates that there are many fistula patients in the community that did not have the benefit of services for a long time. According to the study, obstetric fistula could occur at a young age of 14 years and frequently occurred during the first deliveries. The prevalence of untreated obstetric fistula in rural Ethiopia was estimated at about 1.5 per 1000 women aged 15 years and above.

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Mafakhkharul and Begum (2007) undertook a case study of 132 vesico-vaginal fistula patients to assess the social factors that are related to the condition and its psycho-social effects on them. Patients admitted as well as those attending the Out-patient department of Mymensingh Medical College Hospital, Dhaka Medical College Hospital and two Thana Health Complexes with genito-urinary fistula were examined and interviewed by trained female doctors. Their responses were recorded in a pre-tested questionnaire. Random measurement of length and height were taken from 150 parous women without history of vesico-vaginal fistula with comparable age, socio-economic status and educational level. This group was considered as the control for two variables only; foot size and height.

The findings of this study in Bangladesh revealed that vesico-vaginal fistula is one of the most important causes of morbidity among womenfolk which affects their conjugal life primarily and social life at large. According to the findings, women with the disease become social outcasts both at home and in the community. The study further indicated that high rate of illiteracy, poverty, ignorance; early marriage and inadequate physique are the fundamental underlying causes of vesico-vaginal fistula. To overcome this situation requires an intensive Maternal and Child Health (M.C.H) service delivery system backed by a strong health service infrastructure besides the efforts of wiping out the curse of illiteracy. The study also found out that women with vesico-vaginal fistula face social problems such as "embarrassment in social life, fear of unhappy conjugal life and inability to offer prayers". Physical problems identified also included general body weakness, dyspareunia, local pain and fever.

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Tukur and Sadauki (2002) undertook a cross-sectional survey of consecutive obstetric fistula patients coming for repair in the Murtala Mohammed Specialist Hospital, Nigeria. The purpose of the study was to review the social and medical problems experienced by vesico-vaginal fistula patients. One hundred and ninety one consecutive vesico-vaginal fistula patients coming for repairs at the Murtala Mohammed Specialist hospital, Kano were interviewed using a pre-tested questionnaire. Two trained community health extension workers administered the questionnaires in the survey. In the survey, information relating to participants biographic data, demographic characteristics, antecedent pregnancy, labour and the after care were obtained. Duration of time for which they had the fistula and the number of previous repair were also recorded. The data was analyzed using basic descriptive statistics.

The findings of the study were that spousal response to obstetric fistula was divorce, separation, and prolonged widowhood. In other instances spouses took in an additional wife. Vesico-vaginal fistula was therefore found to be a major cause of marital disharmony and divorce. On the social status and wellbeing of the affected woman, the study revealed that majority of the women did not have formal education, most of them were not gainfully employed and even those with identifiable source of income were mainly in low earning menial jobs. The study also found out that many of the participants who were unmarried disclosed that they lived by themselves, support themselves and are self employed but they declined to disclose the nature of their trade. In addition, vesico-vaginal fistula developed mainly due to obstructed or prolonged labour as a result of home deliveries. Early marriages were also a factor with the mean age of patients at marriages being 15.5 years. Average age at first pregnancy was 16.5 years.

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Tsui and Creanga (2007) examined the role of delayed childbearing in the prevention of Obstetric Fistula. They analyzed data on 4798 deliveries in Niger (1995-1998), 3552 in Nigeria (1996-1999), and 6789 in Tanzania (1991-1999) using logistic regression models. The study relied on retrospective data over 3 and 5 years for births and any accompanying pregnancy complications in surveys in the three countries.

The findings of the study were that adolescent girls who delay marriage and childbearing benefit by completing their own growth first, thus avoid putting themselves and their offspring at a risk nutritional deprivation and serious health consequences. In countries with high Obstetric fistula risk, community programmes to educate young newly married women on the role of delayed childbearing until they reach physical maturity was found beneficial in preventing obstetric fistula. In addition the study found out that obstetric fistulae were more common in countries and areas where early marriages were practiced than in areas where early marriages were uncommon. In this case promoting contraceptive use in areas with high rates of early marriage should be promoted to delay childbearing until the woman is physically and emotionally ready to bear children. Additionally, improving the economic status of adolescent girls can bring about positive changes since economic factors may lie behind early marriage and childbearing. Easily accessible obstetric care should be the goal of health planners and policy makers especially in developing countries where the burden of preventable maternal deaths is high.

Browning, Fentahun and Goh (2007) assessed the impact of surgical treatment on the mental health of women with obstetric fistula. The study was done among women admitted to the Barhirdar Hamlin Fistula Centre in Northern Ethiopia between February 2005 and April 2005. A

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purposive sample of 51 women who consented to be part of the study were recruited. The sample consisted of 49 women with obstetric vesico vaginal fistula and 2 women who had previously had fistula repair but had severe residual urinary incontinence. A qualified nurse collected details of the patients' personal and medical history and administrated pre-surgery interview using questionnaire. All women were subsequently treated surgically and had a 2-week post operative recovery period with free bladder drainage through an indwelling Foley catheter. At the end of the 2 weeks, the catheter was removed and the clinical outcome was recorded, and classified as cured with no continence, fistula closed but with mild residual incontinence on exertion, fistula closed but sustaining severe urethral incontinence on walking, and walking or lying in bed or fistula repair failed . Later another interview was administered postoperatively on their mental wellbeing after surgery.

The study demonstrated that women who undergo successful repair of obstetric vesico-vaginal fistulae improved markedly in mental health scores. This occurs despite the lack of any formal psychological or psychiatric input. Women who had low success rate also scored low on mental health scores. The results of this study suggest that women continue to be under severe mental strain as long as their fistulae were untreated or failed to be treated.

Yeakey, Chipeta, Taulo and Tui (2008) carried out a qualitative study with the purpose of gaining an understanding of the lived experience of obstetric fistula in Malawi. Forty-five women living with fistula as well as 30 of their immediate family members (including husbands, mothers and sisters) were interviewed in their homes to learn how the condition affected them and their families on a daily basis. The study was conducted in Mangochi District of Malawi.

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women living with fistula were identified through hospital records at the Zomba Central Hospital; respondent-driven sampling and key informants in communities were used to identify women who may not have been in touch with a hospital. Potential participants were evaluated verbally using a set of symptoms to screen for obstetric fistula and distinguish cases from women who experienced other types of urinary or fecal incontinence; the presence of the fistula was not physically confirmed. Open-ended interview, using a standard interview guide was used to collect data from participants. Interviewers were women from the same district and were conducted in the local language of Chiyao. All four interviewers were provided with training on: study background and objectives; purpose of qualitative research; interviewing skills; and interview tools. Each interview lasted between 30 and 90 minutes. The interviews were tape-recorded, transcribed in Chiyao, translated into English and typed into Microsoft Word. All coding was completed by hand in Microsoft Word. The data were analyzed using iterative coding of the interview transcripts to discern common and essential elements of living with the condition as identified by participants. Data from interviews with family members was used to triangulate findings and broaden the understanding of how the condition is experienced not only by women with fistula, but also by their families and partners.

The findings of the study indicate that marital relationships of women with obstetric fistula commonly suffered Divorce and/or abandonment by their husbands. For couples who divorced because of the fistula, the decision was usually made on the part of the husband, who left the wife. Divorce left women feeling alone and unsupported. When divorce occurred, some women remained single, without an intimate partner. Some were afraid of men's reactions and therefore rejected male advances. Other women, who wanted to remarry, experienced stigma and could not

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find a partner who would accept their condition. For other women who experienced divorce after the onset of fistula, remarriage was not a problem. Their husband married them in full knowledge and acceptance of the condition. On the opinion of relatives about divorce of the affected women, female relatives reported that, in some cases, they had encouraged the husband to take a second wife due to the woman's condition. This may be a strategy aimed to preserve the husband's financial support and responsibility to the wife while ensuring that his needs are satisfied. Men's perspectives on marriage in interviews with husbands revealed that men discussed their marital relationship with their wives, including sexual intercourse, from their own perspectives. Similarly to the women, they reported a variety of experiences. While some continued to have sex with their wives in spite of the urine, others were put off enough by the condition that they refused to continue intercourse with their wives

Also the study noted that Marriage relationships, roles and expectations play a central role in shaping the lives of women living with fistula. As women, their societal expectations are to marry and reproduce. For many, however, the fistula is a direct assault on their ability to fulfill these expectations. Social expectations come from interpersonal and community relationships, but the effects are experienced primarily at the intrapersonal level as the woman struggles to maintain her identity in society. Finally, the study found out that the ability to bear children may play a central role in determining which marital relationships dissolve in the face of fistula and for participants who experienced fertility problems; a desire for repair of the fistula was synonymous with a desire for a return of fertility

Molzan Turan, Johnson and Lake Polan (2007) explored the experiences of women seeking care for obstetric fistula in Eritrea using open-ended qualitative interviews with new fistula repair

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patients and their family members, and semi-structured interviews with previous fistula patients who were returning for follow-up. Eleven new fistula repair patients, 15 women returning for follow-up for their fistula repairs, and five accompanying family members at Massawa Hospital in the Northern Red Sea Zone of Eritrea were interviewed. Women were purposively selected from different age, education, and ethnic groups, in order to obtain different perspectives on obstetric fistula. On circumstances surrounding labour and delivery resulting in the fistulae, it was found that; Most of the women began labour at home. A few went to a health facility as soon as their contractions began, but most women were only taken to a health facility much later. In several cases, women laboured at home for days (durations ranging from 24 hours to 5 days) before medical help was sought. The situations described were similar for births that occurred recently and those that occurred 10 or more years in the past. All the women and family members interviewed described complications with the labour and delivery when the fistula occurred.

In addition to prolonged labour, complications described by the participants included the baby being 'stuck' (three cases), losing consciousness during labour (three cases), difficulties in pushing (two cases), excessive bleeding (one case), premature labour (one case), a dead baby 'blocking the womb' (one case), difficulties with the placenta coming out (one case), and seizures (one case, possibly pregnancy-induced hypertension). In all cases, the infants died. During home births, women were assisted by female relatives, neighbours, and sometimes by traditional birth attendants (TBAs). In some rural areas of Eritrea, it is traditional for a woman to have her first birth in her mother's home, so in many cases mothers were present during the birth. Female relatives and neighbours appeared to be the main decision-makers regarding what was done during the birth. In several cases, these older women appear to have decided that it was best to wait until the woman eventually delivered instead of seeking medical help. Most of the women were transferred to a health facility at some point during the birth, usually after the situation became very bad, and people feared for the lives of the mother and baby. Distances

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from the villages to a health facility were often long and it was difficult to arrange transportation. Several women walked or were carried on stretchers made of blankets for several hours

Most of the participants realized the urine leakage soon after the delivery. However, one woman reported that she thought it was normal that she was soaked with urine and blood because of the delivery and did not recognize the urine leakage as a problem until after she returned home. Those who discovered the problem at a health facility received very limited information about the problem. In only one case did the woman get any information about possibilities for fistula repair? Some participants linked the fistula with the fact that they did not receive antenatal care, that they did not have assistance from a trained health worker during labour and delivery, or that they did not go to a health facility for the delivery. However, a father noted that even those who deliver in health facilities can develop this problem.

The study revealed negative effects described which include; discomfort because of physical symptoms (such as soreness, irritation and itchiness in the genital area, pain when sitting, a burning feeling, pus and blood in urine, constipation, and painful sexual intercourse); the need to wash and change pads constantly; social isolation; negative psychological effects; being unable to support themselves economically; having to live separately from family members due to the smell; and being abandoned or divorced by their husbands. Inevitably, fistula had effects on the husband- wife relationship. In some cases, men divorced or left their wives. In other cases, men stayed with their wives, but those couples had problems with their social and sex lives. It appeared that the main thing that would encourage a man to stay with his wife after the fistula occurred was the presence of children

Similar to the work of Molzan Turan. Johnson and Lake Polan 2007, the Women's Dignity Project and Engender Health in partnership with Health Action Promotion Association, Kivulini Women's Rights Organization, and Peramiho Mission Hospital 2006, conducted a study in three

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districts in Tanzania entitled Risk and Resilience, Obstetric Fistula in Tanzania. The purpose of this study was to understand the many dimensions of fistula and its related social vulnerability through the experiences and views of girls and women living with fistula as well as their families and communities and the health workers who care for them. The study also explored participants' recommendations on locally appropriate solutions to prevent and manage fistula. Study participants included 61 girls and women living with fistula, family members, community members, and health care providers. Data collection instruments included in-depth interviews, group discussions, problem trees, and free listing and ranking exercises.

Women were asked about their experiences related to health care during pregnancy, access to resources and social support, antenatal care, and access to health care services. Additionally, women were asked about their recommendations on pregnancy-related information and services for pregnant women. Also, personal and social impacts of fistula were explored as the women were asked how fistula had affected their lives and those of their family - psychologically, physically, financially, and socially. Additionally, women were asked about the coping mechanisms they used to mitigate the impact of fistula.

Nearly all of the women in the study had gone for antenatal care (ANC) at least twice. Of the women who mentioned how they made the decision to go for ANC, fewer than half said they had decided by themselves to go. For these women, their decision to attend ANC was largely because they had seen other women go or because their friends encouraged them to go. Of the remaining women, fewer than half went for ANC because a family member - parents, husbands, in-laws - had decided that they should go, while a few mentioned deciding jointly with their husbands to go for ANC. In one situation, a woman indicated that she only decided to attend ANC when she was seven months pregnant. She reported that her mother-in-law told her that pregnancy is not a disease; therefore, there was no need for her to attend clinics. For the women who did not go for ANC, it was mostly because the distance to services was too long.

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The majority of the women with fistula reported no serious problems during pregnancy. Also, majority of women had taken traditional medicine at some point in the pregnancy process; however, only a minority had taken it during labour as a way to stimulate labour. Reasons women reported for taking traditional medicine during pregnancy included ensuring that the baby was in the right position, facilitating a smooth pregnancy or detachment of the placenta after delivery, stopping vomiting, and curing other diseases and infections related to the pregnancy. A few' women mentioned taking traditional medicine during labour to stop labour pains

The majority of the women interviewed indicated that they wished they went to deliver at a health care facility but eventually they were unable to do so due to lack of access to transportation facilities, and inadequate information about the importance of facility-based delivery. Of the women who indicated how they made a decision about where to deliver, the majority did so in conjunction with their husbands or their family. Fewer than half of the women were not involved in the decision about where to deliver because it was made by a family member and/or a husband.

Nearly all of the women started labour at home; of these, the majority went into labour in the evening or at night, when it was more difficult to access assistance. A few started labour while outside the home, either while doing chores, while at church, or while visiting relatives. A few also started labour when they were in transit to the hospital or when they were already at the hospital. Nearly all of the women who began their labour at home had to make at least one move. Their move was based on seeing that there was a delay or problem that needed appropriate care. Only seven women delivered where they started labour - five at home and two at the hospital.

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Most of the women with fistula had a stillbirth. Fewer than half of the women delivered vaginally, and a similar number delivered by caesarean section. A minority of the women had a vacuum deliver.<sup>1</sup> In general, the type of care given by the health care provider depended on the level of facility that the woman reached.

Women, their families, and community members had different views about the causes of fistula. According to findings, majority of girls and women with fistula believed their condition was caused by factors related to the delivery process itself. Fewer than half of the women reported fistula to be caused by a delivery delay. In addition, fewer than half of the women attributed the fistula to hospital procedures or to the provider medicines and perceived bewitchment to be a cause of fistula. A few women believed that their fistula was the result of people inserting their fingers into the vagina during labour. Some of the other reasons given by women as causes of the fistula included: the baby was too big; the woman was scared to push during labour; it was God's will; and it was bad luck to speed up labour, "being short," being malnourished, marrying early, and having initiated sex at an early age.

There was a large range in the length of time the girls and women had lived with fistula, spanning from one month to 50 years with majority having lived with fistula for two years or more at the time of the interview. For some women, the length of time before seeking treatment was because they did not know treatment was available. Others knew treatment was available but could not afford to get to the hospitals that provide repair. A few women mentioned not receiving repair because they were in poor health after delivery. Nearly all of the women with fistula said that fistula affected their ability to work. Of these women, the majority could not work at all, while fewer than half could work, but not as hard as they did before the fistula. A few of the women reported that they could not work, but had to in order to meet their basic needs. Some of the reasons for not being able to work or for working less than before had to do with the health effects of fistula (e.g., feeling pain or in poor health), the constant need to clean

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themselves and change clothes, and, in a few cases, stigma. Fewer than half of the women mentioned being ridiculed or being segregated by community members. Fewer than half of the women appeared to be treated well by the community and did not isolate themselves. The majority of the women with fistula isolated themselves from other community members, remaining in their homes as much as possible and forgoing public activities such as funerals, celebrations, meetings, and social visits. This isolation was caused by a strong sense of shame about their condition and by a strong desire not to soil themselves in front of anyone or to smell badly.

Family members described how they perceived fistula's impact. The majority mentioned that women experienced isolation, mainly as a result of shame (fear of leaking in front of people or of smelling), of fear of harassment/ridicule, or of weakness due to their compromised ability' to walk. A few family members also indicated that fistula had an impact on the spiritual lives of the women because of their inability to attend church and/or mosque. A minority of family members explicitly mentioned the sadness of living with fistula. Community members also mentioned loneliness, shame, and isolation after fistula, as well as the fact that in some cases, women with fistula are discriminated against by their family and friends. Health care providers also mentioned isolation, shame, and loneliness as a result of fistula.

Two women mentioned not using health care services because of shame or because their problem would be revealed. Money for treatment, clothes, and soap were the most frequently mentioned expenses incurred by the families of women with fistula. Treatment included fistula repair and related expenses (such as transport costs for the person accompanying the woman to the hospital, food and other expenses at the hospital, and lodging for the person accompanying the woman), as well as treatment from traditional healers. In addition to the expenses related specifically to fistula, families were also affected because there was one less person working in the home or on the farm or bringing in income from other sources. The remaining family members, therefore,

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had to do the work that the woman previously did or forgo the income that she previously contributed.

The majority of the women interviewed had sought fistula repair or were seeking fistula repair at the time of the interview. These women and their families had sacrificed a significant amount of time and money to attempt to get them this treatment. Of the women who had sought fistula repair prior to the interview, fewer than half had a successful repair. Of the women who sought fistula repair, fewer than half went to only one facility. In addition, fewer than half went either to multiple places, including traditional healers, or to the same facility multiple times seeking repair. Of these women, about half had a successful repair, while the rest had failed repairs.

Also, the women's Dignity Project and Engender Health, 2007 carried out a study in four rural districts of Uganda: Kasese, Masaka, Soroti, and Kaberamaido. The study was under the topic Sharing the Burden: Ugandan Women Speak About Obstetric Fistula. The purpose of the study was to prevent obstetric fistula and promote maternal health overall, by utilizing the testimony of girls and women with obstetric fistula to develop effective recommendation and interventions. The study was a qualitative and participatory analysis of obstetric fistula in Uganda. The research was conducted to understand girls and women's vulnerability to fistula through their own view's and experiences, as well as the views of family and community members, and local health care providers. Eighty two girls and women living with fistula, 63 family members, 120 community members, 21 health workers, and 54 traditional birth attendants participated in the study. Several different instruments were used for data collection: in-depth interviews, group discussions, problem trees, and frelisting and ranking exercises

The findings revealed that slightly less than half of the women were 20 years or older when they sustained fistula. It was also found out that, the type and quality of antenatal care services that the women reported receiving were inconsistent and inadequate, and differed greatly from the

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Ugandan Ministry of Health guidelines (UMOH, 2006). Fewer than half received any type of immunization services, and no hemoglobin tests, urine analysis, syphilis screening, or voluntary counselling and testing for HIV were reported. Only a minority of women reported that the health worker listened for the foetal heartbeat. Moreover, no counselling on risk factors and warning signs and symptoms during pregnancy were reported, and only three women were told anything related to delivery. With respect to delivery care, nearly all of the women were satisfied with the care they received at their final place of delivery, because the facility had saved their life and/or their baby's life or because staff identified the problem they were experiencing. However, about half of women reported that they were not treated well or were not treated in a timely manner. In addition, nearly all of the women believed that the cause of fistula was providers' mistakes or hospital procedures, and family members cited these reasons most often as well.

About half of the women in the study described constraints they faced when planning for facility-based delivery'. The top three limitations were lack of money, high transportation costs, and high hospital costs. Indeed, the majority of the women planning to deliver at a facility had set aside some funds to cover expenses, but still did not go when labour started. In addition, two-thirds of the women faced multiple delays in reaching a facility with the necessary services to enable them to deliver safely. Inability to access transport was the most frequently cited the delay factor.

The majority of women in the study who were married at the time they sustained fistula were subsequently divorced, and nearly all the women suffered isolation. In addition, the majority of women said that fistula affected their ability to work due to the health effects of the condition and the smell. About half said they could not provide for themselves and/or their families as a result of not being able to work. Women and their families also incurred substantial costs in seeking to access treatment and in purchasing essential supplies—soap, sanitary padding etc.—to manage the condition on a daily basis, often driving them into deeper poverty. The majority of the women also indicated that their family members suffered from stress and worry about how?

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the fistula affected the woman's life. At the time of study, nearly all of the women had been living with fistula for over a year, and half of respondents had the condition for over 4 years. Sixteen women had endured fistula for more than 10 years. About half of the women had sought fistula repair at a facility, and among these, around half had gone to two or more sites before receiving treatment. One woman had made seven different visits seeking appropriate treatment. At the time of the study, only three women had been successful in achieving repair. A minority of the women had also not sought any type of repair services, primarily because they did not have sufficient funds to seek treatment. For the women who tried to access repair services, both they and their families sacrificed immensely.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 INTRODUCTION

This chapter deals with description of the research setting, the research design, sample and sampling methods that were used, tools and method of data collection and data analysis, data management, trustworthiness of the study and how the ethical requirements were met.

#### 3.1. RESEARCH DESIGN

Consistent with the purpose, research question and the aim of this study, a qualitative design using an exploratory descriptive approach was employed. Qualitative research is the method of inquiry in which phenomenon are explored in their natural environment (Mayan, 2001). According to Cresswell (1994), a qualitative study is “an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting”. A descriptive qualitative research primarily seeks to explore and understand phenomenon of interest of the variables under study. This kind of approach is a choice when the investigator seeks to uncover the experiences of clients with a particular disease condition. It gives insight and meaning to the phenomenon it studies, creating in-depth, rich and subjective perspective (Bums & Groove, 1993; Polit & Hungler, 1993).

A descriptive qualitative method was preferred because it is also unique to nursing as it involves description and interpretation of a shared health or illness phenomenon from the perspectives of those who live it (Thome, Kirkham and MacDonald-Emes, 1997).

Some research problems that are best explored using qualitative method include: behaviours, feelings, thoughts, actions and experiences (Mayan, 2001; Bums and Groove, 1993; Polit & Hungler, 1993). Qualitative research reflects for knowledge about aggregates in a manner that does not render the individual case invisible and recognizes that there are multiple realities, which are subjective and mentally constructed by individuals (Polit and Hungler, 1995).

Literature reviewed indicated that researches, mostly quantitative studies have been done extensively elsewhere on obstetric fistula but in Ghana very little has been done in this area, more so what has been done is only quantitative study with no findings on qualitative studies. This therefore provided the bases for which this research study was embarked upon.

### **3.2 RESEARCH SETTING**

The study was conducted in the Bawku East District of Ghana, (now split into two; Bawku Municipal and Garu Tempane District). However some of the research participants were recruited from Bolgatanga Regional Hospital where the repairs are done. Bawku is one of the administrative Districts of the Upper East Region of Ghana situated in the north-eastern part of the country. It is bordered on the east by the northern part of Togo, on the north by Burkina Faso, on the south by the East Mamprusi District of the Northern Region and to the west by the Bawku West District. The District covers an area of 121,505 square kilometers and is approximately 1,000 km away from the nation's capital Accra.

Bawku is predominantly a rural district with an estimated population of about 400,000 with about 80,000 being women in the reproductive age (15-49). The district is relatively flat with vegetation which is characteristically guinea savannah. The area is very arid and receives very little rain during a short period (June to September) of the year. Temperature ranges between

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wenty-two and forty degrees throughout the year with the hottest period occurring from March to May and the coldest in December and January when the harmattan wind is at its peak. The mainstay of its rural economy is subsistence farming (maize, groundnuts and millet) and many of its people have to migrate to the southern part of the country to be able to earn a living.

here are several public and private social facilities in the district and significant among them are the health facilities: one hospital (the Bawku Presbyterian Hospital), five Government Health Centres, one private hospital, nine clinics, one training institution, two Maternity Homes, fifteen Traditional healers and fifty Chemical Shops (Presbyterian Primary Health Care, 2007). The district also has several public and private schools. The district does not have good road network except at the business district (i.e. Bawku central) which links up with major towns surrounding the district by deplorable and untarred roads. Road network to several communities within the district is very poor and in some cases non-existent thereby making transportation problematic especially during the rainy season and rendering some inhabitants inaccessible. The main and easy form of transportation therefore is by motorbike and bicycle.

The main way by which the people move to and out of the district is by road transport which is predominantly provided by the private sector. During the dry season, the district faces severe water shortages. Culturally, the settlements are dispersed to make way for farmlands around the residential compounds.

The population is comprised of several ethnic groups with the major one being the Kusasis (the indigenes). The rest are settlers and significant among these include the Mamprusi, Moshie, Busanga and Yaanga. The common language spoken is Kusaal (the native language). Other

languages spoken by the people of Bawku include Mampruli, Busansi, Moshie and Hausa. The dominant religions practised by the people of Bawku include Islam, Christianity and Traditional African Religion. The people of this district are served by the Bawku Hospital as far as health and emergency obstetric services are concerned. There are also three Health Centres in the district that complement the services of the hospital, with the hospital serving as their referral point.

### **3J POPULATION AND SAMPLING**

Sampling in qualitative studies involves selecting those who the researcher is convinced would provide adequate and appropriate information to answer the research question (Morse, 1991). Sample representativeness remains a concept common to all research methodology and a determinant for generalizability of results of research findings. However, a distinction exists between sampling in quantitative and that in qualitative studies. In qualitative study, the researcher is looking for insights into a particular phenomenon whereas the primary objective of quantitative study focuses on theory development.

Convenient and purposive sampling was employed to recruit ten respondents based on the concept of data saturation and redundancy in which the initial selected population is subject to change depending on whether new data emerge or not. Based on predefined criterion and the concept of inclusion - exclusion, women of the reproductive age and above (i.e. 15 years and above) who have developed obstetric fistula in the Bawku East District were selected for the study. The age 15 was particularly chosen because it marks the beginning of the reproductive age and since obstetric fistula is a birth complication, it is very possible that a girl at that age could get pregnant, deliver and develop that complication. It was also thought that girls of that age are

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more likely to develop complications during birth due to the immature nature of the pelvis at that age, and for that matter if that age bracket was left out the researcher was more likely to leave out some fistula victims.

The participation Information Sheet (Appendix B) was used to explain the purpose of the research, procedure, benefits and associated risk. This helped participants to make informed choices. Willing participants signed a Consent Form (Appendix C) for purposes of record. Ten respondents were recruited and data saturation was achieved after interviewing 8 participants.

The respondents had been living with the fistula for at least two years with most of them living with the disease for up to eight years. Seven of the participants were interviewed in Kusaal; the native language of the place and the rest interviewed in Bisa; another local dialect spoken in Bawku.

**3.4 RECRUITMENT OF THE STUDY SAMPLE**

A total of 13 interviews were conducted between May 2009 and February 2010. Saturation was reached by the time the eighth participant was interviewed but two more interviews were done to confirm the emerging themes. The rationale for the number of interviews was based on the concept of theoretical saturation. Ten interviews were carried out in Kusaal, the native language of Bawku. Three however preferred to be interviewed in Bisa (another local language spoken by the people of Bawku) even though they could speak Kusaal.

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The research participants were recruited from the Bolgatanga Regional and the Bawku Presbyterian Hospitals. With the aid of contact addresses taken during the first meeting, the participants were traced to their individual villages and communities where in-depth interviews were conducted at venues identified by the participants and at their convenience.

**3.5 METHOD OF DATA COLLECTION**

Qualitative interviewing constitute a primary strategy for data collection that utilizes open-ended questions that allow for individual variations and the opportunity for the researcher to observe, document and analyze responses in order to uncover how people think and feel about the circumstances in which they find themselves (Thome, 2000).

The primary method of data collection in this descriptive exploratory study was individual interviews using an interview guide. Open ended semi-structured interview was employed to enable the subjects explore their thoughts and express their views freely. However, some flexibility in the order and nature of questions in the form of prompts were permitted to enhance an understanding of the unique experiences of participants. Semi-structured interviewing strategy is employed when the researcher knows something about the topic but not enough to know' the answers to the research question (Mayan, 2001). These kinds of interviews are conducted on the basis of a loose structure consisting of open ended questions that define the area to be explored. Individual interviews facilitated a more open and free wheeling dialogue between the study participants and the researcher. This made it easier for participants to share personal views which they might not have discussed in the midst of others. Further, it enabled a rich database to be obtained (Mayan, 2001). Data that were generated include demographic and other needed background information (Appendix-F).

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Prior to meeting the fistula victims at the hospital, permission was sought from the medical directors of the hospital (Appendix E). The Principal Nursing Officer (PNO) in-charge of the Maternity Unit of the Bolgatanga regional hospital was then contacted for the date scheduled for the visit of the fistulæ patients to the hospital so that the researcher could meet with them. At the first meeting, the principal nursing officer in-charge introduced the researcher to the patients and briefed them on the study. The researcher explained the purpose, objectives and benefits of the study to them using the Participant Information Sheet (Appendix B). Those who willingly expressed the interest to participate in the study were recruited. The consent of the prospective study participants was then sought and permission sought from the PNO- in-charge and their particulars including their home addresses taken from their hospital records. Those whose addresses were not very clear to the researcher (i.e. not easily traceable), assisted the researcher with directions and descriptions of certain “popular” joints, structures and/or people that the researcher could use to help her trace them in their communities where they wished to be interviewed.

A meeting was also held with the participants who wished to be interviewed at the Bawku Hospital and date and time for their interviews scheduled at their convenience after duly seeking permission to use the facility. A room was given in the hospital where the interviews would take place. With the assistance of Public/Community Health Nurses in the district, the researcher traced those who preferred to be interviewed at the communities.

During the time of the interviews, the researcher encountered some difficulties worth noting. At the community, two participants who also gave their addresses could not be traced because they

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had left the district; one in search of herbal treatment in the Northern Region and the other had gone back to her father's house in the Bawku West District. However, through some of the fistula patients (those recruited for the study), the researcher identified some other fistula patients. These women were also briefed on the purpose of the study with the aid of the Participant Information Sheet and they willingly accepted to participate in the study, hence some were recruited in the community.

After the recruitment process, arrangements were made in consultation with the participants (at their convenience) towards the conduct of the interviews. For those who wanted to be interviewed in the communities, arrangements were also made in terms of the date, time and venue of the interview at their convenience. The researcher then arranged a meeting with prospective participants on individual bases either at the hospital or at home according to their preferences.

At each place, details of the research study were explained to each participant with the help of the Participant Information Sheet. Following the explanation and acceptance of the information, participants were provided the Consent Form (Appendix - C) to thumb print after the researcher had read the written consent and explained its content to the participants' understanding in the local dialect (Kusaal). Fortunately, all who were available consented and took part in the study. Two were interviewed at the hospital and the rest were interviewed in their individual homes, often in their own rooms. However, this did not go without hitches as on a number of times the interview process had to be paused and the venue changed in order to avoid intruders.

After satisfying the above conditions, in-depth interviews were conducted using the semi-structured interview guide (Appendix D). Each interview lasted about 45 minutes to one hour.

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With the aid of the background information sheet (Appendix A), participants' demographic data and other background information were obtained at the beginning of each interview session.

On the scheduled date, the researcher and participants met at the agreed location. Before commencement of interviews, each participant was reminded of and informed about her rights as outlined in the consent form. In addition, permission was sought from participants to tape record the interviews which would later be transcribed. Participants were also assured of anonymity.

During the interview process the researcher endeavored to maintain a friendly but purposeful atmosphere to elicit the needed responses and encouraged respondents to voice out their thoughts and feelings using non verbal cues such as nodding and facial expressions without interruptions. The use of open ended - questions created an ultimate and personal sharing of confidence between the researcher and the participants (Morse & Field, 1995). This motivated participants to give out information willingly, enabling the researcher to obtain a comprehensive account of their experiences (Mayan, 2001).

The semi-structured interview guide (Appendix D) was pre-tested with two obstetric fistula patients who were not included in the main study sample. This clarified and made the set of questions much comprehensible. Pre-testing the interview guide also enhanced the credibility and dependability of the guide since amendments were made to portions of the guide to enable the questions generate data that meet the desired expectation of the study.

The interviews were conducted in private rooms with the participant alone. A field diary of all other observations and activities regarding the participant and the environment during the interview was also kept. Four participants had a follow up interview a week after the first interviews were conducted to verify unclear statements and explore more in-depth information about the themes that arose from the first interviews. These were arranged at the participants' convenience.

### **3.6 FIELD NOTES**

A journal was kept for recording detailed field notes about the cultural and contextual responses not expressed in the verbal information being recorded. The incidences that were heard, seen, experienced and thought about during the process of data collection were recorded in writing in order to comprehend and interpret the content of the interviews better, (Bogdan & Biklen, 2003). Stem, (1985) noted that field notes assist in developing subsequent interview questions, deciding future settings for the study and making theoretical sampling decision. Field notes also guide the researcher to ask relevant questions and particularly assist to validate the information being gathered to make it credible and trustworthy.

### **3.7 DATA ANALYSIS**

In this research study, systematic content analysis was employed. The analysis began with identification of the concepts emerging from the raw data, a process sometimes referred to as "open coding" (Strauss & Corbin, 1990). The analysis was done concurrently and this provided the opportunity to know what to ask in the next interview and to cross check information from each interview with other participants. It also assisted the researcher in recognising the level at

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which no new information emerged from the data (saturation). The transcribed data was read and re-read to get an insight and deeper meaning into it in order to identify concepts and themes that were expressed by participants. This was used to build subsequent interviews with other participants until saturation is reached. Data from field notes were also utilized to enhance understanding of the various categorizations and themes that emerged.

### **3.8 ETHICAL CONSIDERATIONS**

The safety of all human participants involved in any research study is paramount, as such various precautionary measures were taken to minimize or eliminate any potential injury to the participants. First and foremost, the research proposal was submitted to the Institutional Review Board of the Nuoguchi Memorial Institute for Medical Research for ethical clearance and approval.

After this requirement was met, permission was sought from the Medical Superintendents of the Bolga Regional and Bawku Hospitals to use their facilities as well as have access to patients' records with the consent of participants (Appendix C).

To secure the consent of those who agreed to participate in the study, the purpose of the study and the issues on the consent form (see appendix C) was provided and explained in the native language (Kusaal) to them since they cannot read. All the participants accepted the information on the consent form; consequently the consent forms were made available for them to thumb print.

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Privacy and confidentiality was also ensured to provide a safe research environment for those involved. To ensure this, all discussions were done in privacy as much as possible. The interviewees were also assured that the information given will remain confidential and only utilized for the purpose for which it is gathered. They were also assured that all the information gathered will be kept under lock and key and will only be available to the investigator and supervisors and not made available to any third party

The issue of anonymity was also addressed. Concerning this, necessary precautionary measures were taken to safeguard the identities of participants (interviewees) and the information recorded from them such as; not indicating participants' names but rather describing them by specially coded names and alphabets in whatever information that is recorded.

The right to refuse or withdraw from the study was made known to participants. They were assured that refusal to take part in or withdrawal from the study will not affect the care given them, therefore one was at liberty to withdraw from the study at any point in time. The researcher demonstrated impartiality, but exhibited sensitivity to the traumatic experiences interviewees suffered. Another important ethical concern was the need to minimize distress to the research team caused by the research process. In view of this, efforts were made to offer physical and psychological protection to the participants including phrasing interview questions in a manner that minimizes trauma of any form to the participants.

### 3.9 METHODOLOGICAL RIGOR

There are varied discussions on how to measure the trustworthiness of data in qualitative studies. Some qualitative researchers believe that reliability and validity could be employed in qualitative research (Mayan, 2001; Morse, 1999 & Johnson 1997). According to Lincoln and Guba (1985; 290), the basic question addressed by the notion of trustworthiness in qualitative research is "How can an inquirer persuade his or her audience that the research findings of an inquiry are worth paying attention?" In ensuring trustworthiness, Lincoln & Guba (1985) identified four key elements namely: credibility, transferability, dependability and conformability (cited in Polit & Hungler, 1993; Streubert & Carpenter, 1995).

#### 3.9.1 CREDIBILITY

Credibility refers to the factual nature or truth-value of the data (Polit & Hungler, 1993). Credibility is ensured through choosing the appropriate method to answer the research question, spending enough time in the field to investigate the phenomenon, verifying data and eliminating researcher biases (Mayan, 2001; Polit & Hungler, 1993; Streubert & Carpenter, 1995).

To ensure truth value or credibility, the researcher reported the truth, explored meanings, clarified issues, produced accurate report of the experiences of subjects and made segments of the raw data available to her supervisors.

The researcher also cross checked and confirmed information with the participants. Peer review was done to provide the opportunity for colleagues to evaluate the research process and the data. The data and all procedure employed was monitored by supervisors to provide external checks on the research process, which is referred to as audit trail.

### **3.9.2 DEPENDABILITY**

Dependability or consistency of qualitative data refers to the extent to which, data from a qualitative study is stable over time and conditions (Polit and Hungler, 1993). This is enhanced through use of stepwise replication, which implies using two groups of researchers and different data sources and comparing the results (Polit & Hungler, 1993). A reliable test is the one that yields comparable results each time it is administered. Guba & Lincoln (1981) proposed that consistency in qualitative study should be measured by a criterion called audit ability. The audit inquiry involves the subjection of data and all documents for evaluation by a thesis supervisory committee. To meet this objective to ensure dependability of this research, the researcher's work was audited by the supervisors whose feedback indicated that consistency had been supported even though the criterion could continuously be tested over time.

### **3.9J CONFIRMABILITY**

Confirnability is the agreement that exists between two or more independent persons about the usefulness and meaning of information gathered in a research process (Polit & Hungler. 1993).

Lincoln & Guba (1985) also defined it as “the degree to which the researcher can demonstrate the neutrality of the research interpretations, through a “confirmability audit.” This implies that two or more independent people must agree on the data’s relevance (Polit & Hungler. 1995). The audit inquiry as mentioned earlier allows for verification of the research process by thesis supervisors. Also, the recordings, transcripts, field notes, journals and memos would be kept for reviewers to evaluate.

## CHAPTER FOUR

### RESULTS OF THE STUDY

#### 4.0 INTRODUCTION

A detailed description of the research methods and design used in this study is shown in Chapter 3. In this Chapter, the realisation of the planning that was emphasized in Chapter 3 was discussed. The experiences of women who developed obstetric fistula as a birth complication in the Bawku East District of the Upper East Region were investigated and presented. To ensure confidentiality the researcher used pseudonyms so as to change any identifying characteristics for each of the participants.

Appendix F provides a description of the participants' background information and the order in which each entered the study. The information includes the demographic characteristics of the participants and their obstetrical histories.

#### 4.1 DEMOGRAPHIC CHARACTERISTICS OF THE STUDY PARTICIPANTS

The demographic characteristics of the participants were diverse in some respects whilst others were similar. The participants were between the ages of 20 and 70 years. This however may not be a true reflection of their ages as most of them did not know their true ages and only based on guessing, some according to events presumed to have coincided with their births as there were no documentations of their birth dates. Hence, some of the ages did not correspond with the physically wrinkled appearance of the participants. Though the participants belonged to different



tribes, they all spoke a common language (Kusaal). Their religious affiliation, marital status and parity however varied considerably as indicated in Appendix F

#### **4.1.1 Marital Status of the Participants**

Regarding the marital status of the participants, they were all married before the development of the fistula however, at the time of the interview only five of the participants were still married, although two of them were being neglected by their partners but still living in the marriage. Of the remaining five, two were widowed, two divorced and one separated.

#### **4.1.2 Participants' occupation before and after the development of obstetric fistulae**

All the participants were previously gainfully employed but at the time of the interviews, only five were self employed. Two were peasant farmers while three were petty traders. The majority (7) were unemployed whilst (3) depended on relatives and sympathizers for their basic needs. Ironically, all the participants interviewed had no formal education.

#### **4.1.3 Participants' experiences with labour, and ANC attendance**

While only two participants visited the prenatal clinic twice and thrice respectively, majority (8) of them never had any antenatal care during the pregnancy that resulted in the development of the fistulae. All the participants commenced the labour at home lasting at least three days and at most four days before seeking medical intervention at the last hour. By the nature of their child birth ordeals majority (7) of the participants have on average 2 children while others (3) have none. One characteristic that appeared significant and striking was that, all participants lost their babies during the labour that resulted in the fistula formation.

## 4.2 FINDINGS OF THE STUDY

This section covers the discussion of the findings that were generated from the study. The report of experiences about obstetric fistula by the participants has been discussed. Applying the technique of content analysis, several themes and categories emerged from the data. The themes and categories are summarized in Table 1.

**TABLE 1 : Themes and categories generated from the study**

Themes	Categories
Circumstances surrounding prolonged labour in childbirth	<ul style="list-style-type: none"> <li>• Perceptions and beliefs held by traditional birth attendants</li> <li>• Cultural practices and traditional beliefs regarding prolonged labour</li> <li>• Suspicion of wrong doing by the woman in labour such as infidelity or otherwise</li> <li>• Prolonged and difficult labour being seen as a punishment for wrongdoing (often infidelity) rather than something beyond the knowledge of traditional birth attendants</li> </ul>
Reasons for non attendance for hospital delivery	<ul style="list-style-type: none"> <li>• Long distance of walk/ lack of transport</li> <li>• Financial constraints</li> <li>• Husbands' roles in making decisions for hospital delivery</li> </ul>
Diagnosis / duration of stay in hospital.	<ul style="list-style-type: none"> <li>• Problems with accumulated hospital bills</li> </ul>
Psychosocial experiences with obstetric fistula	<ul style="list-style-type: none"> <li>• Social isolation/ostracism</li> <li>• Emotional problems of obstetric fistula</li> <li>• Worry about the smell of urine</li> <li>• Social stigma and discrimination</li> </ul>

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	<ul style="list-style-type: none"> <li>• Negative reactions from people</li> </ul>
Socio-economic impact of obstetric fistulae	<ul style="list-style-type: none"> <li>• Loss of job</li> <li>• Financial drain from excessive spending</li> <li>• Impact of condition on family finances</li> </ul>
Other physical problems of obstetric fistulae	<ul style="list-style-type: none"> <li>• genital sores,</li> <li>• Intermittent abdominal pain related to urinary tract infections</li> <li>• Pain</li> <li>• menstrual changes</li> <li>• foot drop (partial paralysis)</li> </ul>
Effect of obstetric fistulae on participants marital relationship and Sex life	<ul style="list-style-type: none"> <li>• No more sex life</li> <li>• Divorced in disguise</li> </ul>
Availability of Family / Social support systems	<ul style="list-style-type: none"> <li>• Significant others including siblings, parents and relatives</li> <li>• Rare spousal support</li> </ul>
Coping Strategies	<ul style="list-style-type: none"> <li>• Frequent washing of rugs</li> <li>• Frequent body wash</li> </ul>

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	<ul style="list-style-type: none"> <li>• Use of perfumery</li> </ul>
Treatment modalities	<ul style="list-style-type: none"> <li>• Traditional/herbalist</li> <li>• Lack of knowledge about orthodox treatment</li> </ul>
Suggestions from participants on ways to improve treatment	<ul style="list-style-type: none"> <li>• Free repairs of obstetric fistulae</li> <li>• Food aid to obstetric fistulae victims</li> </ul>

Narrations from the participants will be used to highlight the themes and the categories in the table above. These narratives represent the descriptions given by the participants on their experiences with obstetric fistulae. The participants also described the coping strategies employed to deal with their discomfort and the impact of these experiences on their lives.

The findings on each theme were reported and supported with verbatim quotes from the participants that reflect their lived experiences as a result of the fistulae. The narratives were identified by pseudonyms according to the participants' pattern of entry into the study in order to ensure confidentiality and anonymity. For instance, participant 1 (P.1) is identified by the name Bugn, P.2 as Puya-anga, P.3 as Tanga-Kpalsako, P.4 as Awanamas Setande, P.5 as Lamboya. P.6 as Zambala No.2, P.7 as Bugri-Daa, P.8 as Binaba No.1, P.9 as Binaba No.2 and P. 10 as Gabulga.

#### **4.2.1 Circumstances surrounding prolonged labour in childbirth**

The findings of the study showed that the participants had similar experiences during labour. Almost all the participants interviewed experienced some difficulties during labour. One important observation made was that, all of them laboured at home and had prolonged labour. On average, women laboured for at least three days, with some labouring for as long as four days.

All the participants interviewed were initially attended to in labour by community birth attendants (unskilled persons) who have successfully assisted other women in labour in the past. These women (often elderly) are members of the families and communities who have acquired the experience over years of practice and recognized as such by members of the communities.

The findings showed that perceptions and beliefs held by these birth attendants and some cultural practices and traditional beliefs contributed significantly to the labour being prolonged and that resulted in the various obstetric problems encountered by the participants. For instance, some of these perceptions included suspicion of wrong doing by the woman in labour such as infidelity or otherwise. Prolonged and difficult labour was therefore seen as a punishment from God to each of the women for wrongdoing (infidelity/adultery) committed against husbands rather than something beyond their knowledge and understanding of labour and child birth. Hence the labouring woman was expected to make some confessions before the baby could be born. These perceptions led to certain decisions and actions taken which further prolonged the labour and increased suffering. Participants recounted their experiences in the following sub themes:

#### 4.2.1.1 Perceptions and beliefs held by traditional birth attendants

Traditional birth attendants believed that every labour starts and ends naturally, therefore any labour that failed to progress as expected was perceived to be the result of wrongdoing on the part of the woman in labour as recounted by the following participants:

I was in labour from night to the following day evening.  
I was in pain and tired, but instead of taking me to the hospital, they rather suspected that I had committed adultery and that was why the labour was difficult. They (the old women who were assisting me during labour) therefore insisted that I confess the alleged adulterous act to enable the baby come out, but I also insisted on my innocence. Not convinced by that, they went and had some consultations with their gods and offered some sacrifices but still I could not deliver so they then took me to hospital (Binaba No.l).

similarly this participant expressed her experiences this way:

When the labour failed to progress and I was in severe pain, the attendant told me that the difficulty in giving birth was probably due to something that I had done, and if so, I needed to confide in them so that the baby could be delivered (Puyanga)

Another woman who was in labour for three days also stated:

“I was in labour for three days. All the caregivers (old women in the family) did was look on while I went through the pain and from time to time tried to convince me to confess if I went behind my husband (that is to say if I committed adultery) when I visited my father’s House as such the difficulty in giving birth, but I refused to yield to their pressure,

One woman reported that the community birth attendants had a different view of her delay in giving birth. In her case the attendants said because she was so young and being her first

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pregnancy, she was exaggerating a false labour which according to them usually precedes the true labour. For this reason they only sat and waited for the true labour to begin. She narrated:

I was in labour for four days. They said it was a youthful pregnancy and for that matter not true labour as our people always say young ladies often exaggerate pains prior to the actual labour. As such, I was left there until my abdomen appeared to be divided into two, it was then that a certain man who visited us saw the state in which I was and insisted that they send me to hospital before they did (Awanamas)

**4.2.1.2 Cultural practices and traditional beliefs regarding prolonged labour**

As a result of the erroneous belief that every labour is normal and must therefore end naturally, every difficult labour was therefore seen to have an underlying cause which must be unveiled. The traditional practice of consulting with soothsayers and divinations was the norm for traditional birth attendants. According to one participant, what contributed to her labour being prolonged and difficult was due to the evil doing by her rival (husband's other wife) who envied her because their husband loved her more and for that reason wanted her dead. She presented it this way:

She caused my sickness because she felt our husband took care of me better than he did for her, so she wanted to kill me during labour. This was revealed by a soothsayer who was consulted when I could not give birth after days of labouring.

Yet another participant was suspected of adultery and urged to confess for the baby to be delivered, but she insisted on her innocence reported:

They (the old women who were assisting me during labour) therefore insisted that I confess the alleged adulterous act to enable the baby come out, but I also insisted on my innocence.

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Not convinced by that, they went and had some consultations with their gods and offered some sacrifices but still I could not deliver so they then took me to hospital (Binaba No.2)

Similarly, one participant stated:

Hospital delivery involves money (transportation cost, hospital fees), The men on the other hand would not go in for hospital delivery like that until they are sure there is nothing fishy after consulting their gods, so it was after the consultations that 1 was sent to hospital.(Puyanga)

Further, this participant emphasized:

They looked on until the consultation with the soothsayer revealed that they had to offer some sacrifices to their ancestors before I could deliver. It was after the sacrifices were made and I had still not delivered that they sent me to hospital. (Binaba No.1)

**4.2.13 Suspicion of wrongdoing by woman in labour**

The erroneous perception and suspicion that the victims of any prolonged obstructed labour was due to wrongdoing (often infidelity), led to the victims being urged to confess the alleged adulterous acts in order to deliver safely. For instance Binaba No.2 narrated her predicament:

I was in pain and tired, but instead of taking me to the Hospital, they rather suspected that I had committed adultery and that was why the labour was difficult. They (the old women who were assisting me during labour) therefore insisted that I confess the alleged adulterous act to enable the baby come out, but I also insisted on my innocence.

Similarly, Lamboya reported:

I was in labour for three days. All the caregivers

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(old women in the family) did was look on while I went through the pain and from time to time tried to convince me to confess if I went behind my husband that is to say if I committed adultery) when I visited my father's house as such the difficulty in giving birth, but I refused to yield to their pressure.

Also, Binaba No. 1 recounted her experience this way:

I was in labour from night to the following day evening. I was in pain and tired, but instead of taking me to the Hospital, they rather suspected that I had committed adultery' and that was why the labour was difficult. They (the old women who were assisting me during labour) therefore insisted that I confess the alleged adulterous act to enable the baby come out, but I also insisted on my innocence. Not convinced by that, they went and had some consultations with their gods and offered some sacrifices but still I could not deliver so they then took me to hospital

Even though prolonged labour often preceded the birth, some participants attributed their problem to the intervention by skilled persons at the hospital (assisted deliveries). These interventions which were carried out at the hospital following the prolonged labour include manual removal of the placenta, vacuum extraction and caesarean section. It must however be noted that participants referred to any form of assisted delivery as an "operation". For instance, one stated:

I have given birth four times but never experienced such a thing. I developed the condition following the fifth delivery after undergoing an operation. I never experience this (the fistula) throughout my three deliveries even though I delivered at home with the assistance of unskilled persons. (Bugri)

Another narrated:

I delivered all my first four children spontaneously at home, but for the particular labour that resulted in the development of this condition, the baby blocked the birth passage until I was taken to hospital where it was brought out dead by operation and then my bladder burst and urine started dripping all over me. (Kpalsako)

#### **4.2 Reasons for non attendance for hospital delivery**

Findings of the study showed that all the participants who were interviewed never sought any skilled help from hospital until labour became prolonged and difficult. Various reasons were given by different participants for not seeking hospital care initially. Notable among these reasons include; financial constraints, husbands' roles in decision making, decisions for hospital attendance and long distance of walk to the hospital/transportation difficulties. The verbatim quotes supporting these themes are as follows:

##### **4.2.2.1 Difficult Access to Hospital**

Most of the participants reported living far away from health facilities where they could have skilled care during labour to avoid complications such as the fistula. Besides the distance, there were also concerns raised about the inaccessible nature of their communities. There are no roads linking the communities with the major towns where the hospitals are situated. In some cases, one would have to cross a river which renders them cut off from the other communities and towns during the rainy season. In cases where there were roads, their inaccessible nature scared off drivers who would want to go there, and where drivers were ready to go, they charged exorbitant

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fares making things difficult for the people. The participants and their families were predominantly peasant farmers who could not afford high fares charged by drivers. Puyanga expressed her view's this way:

There were no Lorries here to carry passengers to Bawku Hospital because the path long and not good, the stream that separates us from the other villages also prevents lorries from reaching here if even you manage to hire one (Puyanga).

Binaba No. 2 stated:

You know Bawku is very far from here and at the time, there was no vehicles to board to Bawku hospital. Also that time there was no road linking us there so it was very expensive hiring a lorry to come here and pick a woman in labour and apart from hiring, there were no Lorries coming to this place. So considering the cost of transport, hospital bills and other expenses involved, they would definitely prefer a woman giving birth at home to hospital delivery.

Bugri Daa also narrated:

As for hospital delivery, it is good but where the hospitals are situated are so far from here that we cannot go. As you can see, the road to this place ends at the place where you hired this motorist to bring you and that is even because it is dry season, during the rainy season there is no access route to this place so no vehicle will come here even if you are ready to hire it.

Zambala also had this to say:

we were by then in the cocoa farming area; a village in the southern part of Ghana where there was no health facility nearby, there was also no motorable road to the area thus posing transportation difficulties. It was for this reason that I was made to labour at home

#### 4.2.2.2 Financial constraints

Majority of the participants expressed concern about the financial commitments hospital delivery went with. According to them, the cost of delivery itself attracts a fee, besides this, one needed money for transport and what to feed on while at the hospital. Considering the poverty levels among these rural folks, they preferred trying labour at home. What this participant narrated summarizes what most of the participants said;

Hmm my daughter, do they go to the hospital like that?  
Considering the distance to the hospital, we cannot afford  
the transport cost if we have to hire one to the hospital.  
Also hospital delivery is expensive if you take into  
account the cost of the delivery itself, transport in and  
out of hospital and worse of all what to eat and where to  
sleep. You know what we eat at home here cannot be  
carried to the hospital where other people will be around  
to see. So you understand why we prefer to give birth at  
home (Kpalsako).

#### 4.2.2.3 Husbands' roles in making decisions for hospital delivery

It was observed that majority of the participants had not much say when it came to deciding where to give birth. These women even though would like to be sent to hospital to deliver, had to wait for their husbands' decisions. The men make such decisions as has always been with major family decision making. Also because it is the men who have the money and therefore will be the ones to settle the hospital bill, women have no choice but to wait for them. For instance, Binaba No. 1 who was in labour for three days expressed her mind:

As I said earlier, the men make such decisions so if  
my husband did not ask them to send me, what could  
they as women do. What they could was what they did.

Bugri expressed her frustration this way;

if you bypass your husband and go to hospital and incur any cost you cannot pay. Also, you the woman have no right to take such a major decision; it is the men who take such decisions and even if you defy that, you can still not go because it is the same men who have to look for transport for you since you can not do it by yourself. So I had to wait for the men to finish what they went to do. If I had the power, at that time I would have gone to hospital.

Kpalsako also said this;

I had to wait for my husband and his brothers to take the decision since it is the men who make such major decisions especially where it involves money. (Kpalsako)

Gabulga also stated;

When I was in labour, my husband was not around. He had gone to another village the previous day to farm and considering the distance to the place nobody could reach him to inform him about my situation, neither could they take any decision in his absence, so they waited for him to return and that kept me in labour for three days. It was when he returned that the decision to take me to hospital was made.

Binaba also expressed her frustration as follows:

I did not have the power to go to hospital, and those who should have sent me decided that I try it at home, it is the men of course; my husbands (i.e. her husband and his brothers). They will not tell you why but I know it was due to financial difficulties. (Binaba No.2)

#### 4.2.3 Diagnosis / duration of stay in hospital.

Participants invariably noticed the problem soon after delivery. Some did not notice immediately due to the presence of a "rubber" [Foley's catheter], however as soon as the catheter was taken out they started leaking right in the hospital. This afforded them the opportunity for early treatment as the diagnosis was made promptly. Unfortunately, they were managed conservatively using the Foley's catheter which prolonged their hospital stay following delivery. Attempts were made to repair the fistulae but these attempts were unsuccessful.

On average, participants stayed in the hospital for about three months, with some staying for as long as seven months depending on the magnitude of one's problem and her ability to settle her hospital bill. This affected participants and their families greatly as some of them went through some difficulty before settling the hospital bills.

##### 4.23.1 Problems with accumulated hospital bills

An accumulated hospital bill was one of the factors that affected fistula victims and their families greatly. As a result of the long stay in hospital for conservative treatment using the Foley's catheter, a lot of the participants had huge hospital bills to settle at the time of discharged. This further prolonged their stay at the hospital as they could not afford to settle the bills immediately and would also not be allowed home until all the bills were settled. Some of the participants recounted their experiences at the hospital this way:

each time the robber was removed I started leaking and it was put back. This went on and I was in hospital for several months. Later when I was discharged, I could not go home for sometime because I could not settle my bill. Finally, my husband had to sell some property to enable him pay my hospital bills before I went

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home (Bugri Daa)

Another participant also recounted hers this way:

I stayed in the hospital for long because of this problem and when I was discharged, my husband could not immediately afford to pay the debts incurred during my stay there so my stay was further extended. My brothers had to pull resources together and pay before getting me out of the hospital. (Puyanga)

Similarly, Gabulga narrated her experience as follows:

My experience at the hospital is something I don't usually want to remember. You know because of my problem my stay at the hospital was prolonged, and that also came with a fat bill making it impossible for my husband to settle immediately and as a result I continued staying there whilst my husband looked for money. He had to sell some property including millet to settle it and this resulted in food shortage that year.

**4.2.4 Psychosocial experiences with obstetric fistula**

Participants reported on a number of psychosocial issues. Majority of the participants experience some of these problems on daily basis as they go about their lives including worry about their condition (odour) and disdainful remarks from associates and other people. The participants experienced abuses and suffered insults, stigmatization in addition to the loss of baby and loss of job. This invariably resulted in social isolation and self ostracism among the participants.

**4.2.4.1 Social isolation / ostracism**

Isolation was reported following urinary incontinence resulting from obstetric fistula and this increased the worry. One reported:

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I don't go to gatherings because when I am with people and the urine starts pouring like that, they make all sorts of derogatory remarks which embarrass me. One time, somebody remarked that why is this woman walking and pouring like a leaking pot?  
Since then, I don't go to gatherings. I attend only funerals of close relatives and even in such cases, I stay indoors where people will not see me much and leave when it is dark. (Puyanga).

Awanamas also stated:

I feel pathetic and dirty everyday, I cannot mix with friends and other women anymore, and I can't work but only sit at one place. I cannot be like my fellow women again nor be able to play my role effectively as a woman; this is a very difficult and pathetic situation to bear. (Awanamas)

Yet another affected woman expressed her frustration in tears;

I do not sit with people, when I go to the market; I buy my things and return home immediately. I don't attend gatherings as such occasions such as funerals, wedding and naming ceremonies etc are completely out of my way except those of very close relations.  
Even in such cases, I attend briefly and leave (Bugri Daa)

Kpalsako also recounted her experience as follows:

Some sympathise with me because sickness is from God but others insult me. Sometimes they insult my children, they laugh and make fun of me, it disturbs me but I cannot do anything about it so to avoid this humiliation, I stay away from people.

Some participants also reported being ostracized. For instance one participant stated this;

There is this big tree in front of the house under whose shade everyone sits during the hot season

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but each time I got there the people leave, I cannot also stay indoors with the heat so, during that time I stay at our farm settlement where no one would get me to stigmatise and only return whenever the heat is over and I can stay indoors. (Zambala)

Bugri also put hers this way;

When you have this condition, embarrassment is always at your door. I say this because you know urine has a very strong scent as such if you do not keep yourself well, anywhere you are, should there be any pollution of the air by any one, all eyes will turn on you since they know of your problem. Because of the foul odour, they no longer invite me to any family gathering.

**42.4.2 Emotional problems about husbands' treatment**

Generally, participants were very emotional about the way other people treated them, especially their loved ones. The following narratives summarize what most of them reported. Tearful Lamboya who sustained paralysis of her lower limbs in addition to an obstetric fistula was abandoned by her husband in a native doctor's house where she was initially undergoing treatment. She narrated her ordeal this way:

He abandoned me in the native doctor's house where he sent me for treatment of my paralysis. I was informed by people from our village who came to the area where I was, that my husband said  
he cannot suffer with my problem when he has not even benefited a single child from me.

Another participant reported:

My husband sleeps in his separate room because of my urine. I felt very bad and disappointed because I did not buy the condition, it was as a result of childbirth that I developed the condition. I was not like that when he first married me. The pregnancy was caused by the two of us but now I am carrying the problem alone, and

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only God knows for how long I would have to be in this messy situation! (Kpalsako)

Daa who was highly emotional said;

my husband who should have been with me through these trying times, has neglected me and insults me on the least provocation; sometimes indirectly through my children and at certain times directly even in the presence of people, it is sheer wickedness for him to abandon me with such a problem. When he married me I was not like this? We both contributed to it and I think It is very unfair to leave it all to me just because he has other wives to serve him.

**4.2.4.3 Worry about the smell of urine**

One woman was so worried about the odour that emanated from her as a result of the urine incontinence. She tried all means possible to stay odourless; according to her she spends the better part of her day washing herself and the rags she uses. She also uses nicely scented soap and perfumes to mask the odour of the urine. She still faced some difficult situations that made her uncomfortable and worried. She narrated her predicament as follows;

Because of the stench that follows the leakage, one spends most of her time “cleaning” in order to avoid embarrassment. However, no matter how much one cleans oneself, one still smells. Sometimes some people start to hold their nose (implying they cannot stand the odour) when you get close to them whilst others would openly remark that you are spoiling the air. This embarrassing situation usually makes me sick and worried (Zambala)



Another woman stated that:

I was disturbed and thought of it often, apart from the agony of losing my baby and becoming sick with urine dribbling from me all the time, my menses also ceased to flow thus making it impossible for me to ever become a mother. If I had the baby and even developed this condition, I would have been consoled a bit.

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Sometimes I sit alone in the house and cry from morning to evening without anyone to console me. (Awanamas)

Bugri Daa also expressed her worries as:

I think a lot about it and often pray that God should let me get healing. The people who were once around me now shun my company. My rivals stigmatise me In fact, I feel frustrated that I don't resemble my colleagues again, but...

**4J.4.4 Social stigma/discrimination**

A number of social issues including stigmatization, isolation, neglect and ostracism were reported by participants. These issues impacted greatly on affected women's lives in that their abilities to continue to do things that they previously did was affected. For instance, isolation which stemmed mainly from stigma was a major issue and led to loss of jobs and belongingness which is a basic need according to Maslow (1987). Stigma appeared to have a significant impact on the lives of women with obstetric fistulae. Stigma was mostly associated with neighbours, friends, and business colleagues and in some cases family members including rivals and even the husbands.

The consequence of the stigma was self isolation of the woman with obstetric fistulae in order to avoid embarrassment and humiliation. Both enacted (the social rejection that takes place as a result of being discredited) and felt stigma (perceived social rejection of a stigmatized condition which is shared by the sufferer) was reported. The findings of the study showed that the participants predominantly, expressed felt stigma rather than enacted stigma. With regards to the

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former, participants believed that knowledge of their condition implied a need to be isolated and away from friends. For instance, the following verbatim quotes indicate the widespread social isolation reported by the participants as a result of this felt stigma. As a 60 year old Puyanga who once earned a living through the brewing of pito (a local beer brewed from sorghum) had this to say:

As for this condition, it is not something that people should be allowed to experience because it makes other shun your company, because of the stench that emanates from me, each time I got close to people they disperse, so I know it is because I smell. Otherwise, these are people who once patronized my pito but..

Binaba No.1 also presented hers this way;

Even your mother avoids you how much more the outsiders. It has affected my public life because when you are in public and you get soiled, it is embarrassing so it is better to stay at home. People insult you or behave to suggest that you have bad odour, some even sometimes openly say it to your hearing that your presence is causing them a lot discomfort so you should leave the scene.

Binaba No. 2 also put hers this way;

When people get to know that you have such a condition, they will not want to have anything to do with you, not even your own sibling can stand the stench of the urine. A friend of mind who previously did everything with me does not even want me to come close to her anymore for fear that she will also be stigmatized.

Enacted stigma;

Binaba No. 1 expressed hers as:

When I developed this condition initially and people did not know, it was better but as soon as the news of my condition spread, no

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wanted to get near me. For instance a friend who shared everything in common with me even stopped visiting me when I fell ill and when I went to her house one day to find out, she openly told me things were no longer the same and I should not come to her again.

Similarly, Bugri reported her experience with friends this way:

There has been a difference in the relationship between my friends and I. since I developed this urine incontinence, some things we used to do together like eating together and others, they do not do that with me again, they shun my company. I think it is because the incontinence of urine and the fact that they know I have it

Lamboya reported her experience as follows;

As for illness, nobody can dodge sickness except after death so I know I am neither the first nor the last to get it but it is the way people treat me especially those who were once close to me behave. For instance, even my husband shuns my company, how much more eat my food? No one ate food prepared by me and anytime, I came to their mist, they would start leaving one by one and in no time all leave

Most of the participants reported being discriminated against, especially when it came to job opportunities. For instance, 40 year Lamboya was discriminated against when after losing her trade, went in search of one. She tearfully narrated:

Someone who used to supply me with rice arranged for a job for me at a chop bar to be washing bowls, but as soon as I got there, the bar owner who had initially agreed declined the offer on the grounds that I will drive away her customers.

Another stated:

I was refused a job that had been advertised simply because someone had informed the owner about my situation. It was pathetic and embarrassing.

As for Bugri Daa, she reported being discriminated against by her own husband also stated:

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He does not mind me, when I complain of being sick, he won't even ask how I am doing but as for my rivals, he will buy drugs for them or if necessary send them to hospital. The last time I was going to Bolga for treatment, he did not even say that my wife take this and buy water on your way

**42.4.5 Negative reactions from people**

Generally, it was observed that people's reactions towards fistula victims were negative even though in some few instances the direct opposite is the case. There is a lot of resentment, rejection and disapproval. Most of the participants expressed feelings of embarrassment and humiliation whenever they encounter this. Participants reported being rejected by their loved ones as well. Stated below are some narratives that reflect this:

One participant expressed her experience as follows:

As at now he does not relate well with me. He does not even sleep with me again. For instance, when I was called to come back to Bolga hospital he did not see me off or even give me money to buy water on the way. Even when I was going to Accra .he did not did not say that my wife is traveling let give her something for water (Bugri Daa)

Kpaisako also recounted her experience this way:

Each time I get close to outsiders (i.e. neighbours and non family members), they shun my company by either moving away or asking me to leave if I have nothing doing there. As for friends, I don't have friends any longer. With this stench emanating from me, who will agree to come and sit with me inhaling it?

Similarly, Awanamas stated hers:

When I am in the mist of people, some of them behave to show that they are uncomfortable with my presence such as holding their noses (demonstrating). This is very demeaning as it signifies that they can not stand the stench from me.

Zambala also narrated her experience this way:

Even if you feel sick in any part of your body, it will be better than this. Nobody likes to get nearer you, even your own siblings shun you. When I was admitted for the operation, I was put in a separate room from other patients and people hardly entered there to attend to me including healthcare staff. I thought this attitude towards me was because I was on a strange land, little did I know that even my own relatives will stigmatize.

Binaba No.1 also recounted her experience as follows:

people did not know at the beginning as such there was no untoward reaction towards me even though I felt uncomfortable in their presence but ever since they got to know about it, the situation has changed. Even my friends find excuses to keep away from me, so I also stay away from such people.

#### **423 Socio-economic impact of obstetric fistulae**

Participants reported that their economic status was insufficient to meet their basic needs or treat their conditions. Most of the participants reported that they lost their sources of livelihood as a result of the incontinence of urine. Those who remained in business did mainly petty trading. This did not go without obstacles as some people openly abused, stigmatized and mocked them, thus making them shy away from people and gatherings. This further strengthened their desire to stay in isolation and felt stigmatized. According to the participants the self imposed isolation has been a major challenge for them since their businesses cannot flourish or even exist without people patronizing them. Some reported being stigmatized, mocked or avoided whenever they visited gatherings or market to sell or buy their wares. This resulted in the participants stopping their trading activities all together and staying at home to rely on close relatives to buy from

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them. The following subcategories give a clear picture of the participants' socio-economic encounters.

**4.2.5.1 Loss of job**

A participant who formerly earned a living selling cooked rice narrated her experience as follows:

I used to sell cooked rice but my condition has compelled me to stop. When I developed this problem, I tried to hide it and continue with my trade, but as you know odour is something that cannot be done away with easily so in no time people got to know about it and my woes began. My sales started dwindling as the news of my urine incontinence spread until one day I failed to make any sale and lost my capital. Since then, I lost my job. Now I gather these onion leaves and sell every market day, on a good day, I make about two Ghana cedis from which I buy soap and ingredients, but on an ordinary day I make between one Ghana cedi and one cedi-fifty pesewas which is barely enough to buy my needs (Bugri Daa)

Another Participant expressed her frustration this way:

I don't have any job ever since I developed this condition. I used to cook rice and sell in the market but as you know a lot of people shun your company because of the persistent smell of urine perceived from you, I now depend on people for my survival and sometimes I go over people's farms after they have harvested to search for left over. It is not easy but...

One woman who previously earned her living brewing pito also stopped with her business because of the condition. According to her, the condition affected her family as a whole, her treatment and the search for it was costly. She also had this to say:

I could not mix up with other people considering how the urine constantly drip down, I used to sell pito but had to quit the business because many will not come near you. I do not go to market again. I now depend on my people for my needs, it's not easy but (Puyanga)

Binaba No. 1 also reported as stated below:

The condition disturbs me so much because I can no longer travel to other neighbouring village markets as I used to in order to buy millets and other goods for retail in my village market.

#### **4.2.5.2 Financial drain from excessive spending**

Besides loss of jobs and difficulties involved reported by the participants, there are serious financial constraints experienced by the fistula victims. Many of the participants complained about the constant odour that emanated from them and in an attempt to stay odourless, each of them resorted to various means to stay clean and free from smell. Some of their activities included constant washing and buying of detergents. Many wanted to use scented soaps (perfumed) and body sprays to mask the foul odour.

They also frequently contracted genito-urinary tract infections that required treatment with costly drugs. Some of the participants put their experiences this way especially for one participant who tried to keep her condition secret from her husband's other wife indicated:

I wash myself and my clothes frequently. In fact I cannot even tell the number of times I wash in a day, as soon as the rag (old cloth) that I used gets soiled, I wash it. If you want to gather them for sometime before washing, the odour will be too strong to remove. Besides this, any time I get money I buy 'turali' (perfumed body spray) which 1

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always use on my clothes to mask the scent (Bugri).

Also, Bugri described how keeping herself clean drains her financially:

All the proceeds I get from my onion trade is always used on this, even sometimes I find it difficult getting the soap as this petty trade does not yield much profit. Sometimes if my daughter has money, she helps buy soap for me and occasionally, "turali" (perfume) to mask the odour (Bugri)

Another participant expressed her experience this way:

Eh, it is the rags (pointing at a heap of them) that I usually use as pad and when they get soaked, the next morning I wash them for subsequent use I buy soap always because I have to wash the 'rags'. All the proceeds I get from my shea butter is always used on this, even sometimes I find it difficult getting the soap as this petty trade does not yield much profit. Sometimes if my daughter has money, she assists me financially in order for me to buy the soap (Kpalsako)

**4.2.53 Impact of condition on family finances**

A number of the participants also reported on the impact their condition had on the family.

According to them, their conditions brought some hardships to their families as some family finances had to be spent on their treatment. Also their individual contributions that would have added to take care of the family upkeep, was also missing as they were no more in a position to work. This therefore, compounded the financial problems of the families with obstetric fistulae. Following a costly and long stay in hospital that necessitated waiting until her family could pay, one woman explained:

I was in hospital for close to a year. When I was discharged, I could not go home for some time due to financial problems.

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Finally, my husband had to sell out some properties to enable him settle my hospital bills before I could go home even though the leakage urine persisted (Bugri Daa)

Another participant who had been supporting her family after her husband lost his job reported:

This my problem had a great impact on my family because my children look up to me for their needs since my husband has other wives and only gives us millet for food. It was from the trading that could buy ingredients to cook and take care of my children's school needs, but since my business got affected, things have not been easy for us (Binaba No. 1).

Another participant reported:

My son spent so much moving from place to place in search of a cure for me. We travel far and near, seeking both orthodox and traditional medicine so this affected both his Finances and business as he used to leave whatever he had doing and accompany me in search of treatment. On one such trip, we were away for so long that by the time he returned his millet farm had been overtaken by weeds, that year the harvest was not good  
(Puyanga)

#### **4.2.6 Other Physical problems of obstetric fistula**

It was also observed that almost all the participants reported suffering some degree of physical trauma because of their condition. Most had genital sores, intermittent abdominal pain related to urinary tract infections, pain, menstrual changes, foot drop (partial paralysis) and genital tract infections (GTI). The following narratives summarize participants' experiences:

##### **4.2.6.1 Genital sores**

All the participants developed genital sores due to irritation of the skin around the genital area by the constant contact with urine. One participant had this to say:

I get sores at my genital region very often. Sometimes the area becomes so itchy that I am not able to bear it, whenever this happen I scratch it and that tends to worsen the sores (Bugri)

Puyanga also described her experience as follows:

The acidic nature of urine makes irritates the skin around the genital region resulting most often in redness and rashes there. Whenever this happens, it leads to intense itching and when I scratch then t develops into sores.

Similarly, Kpalsako narrated her experience this way:

It causes serious irritation, my genital area often gets so sored that I am not able to use the rags as pad any longer but only hang some in front and some at the back to cover my nudity.

Another participant also stated:

sometimes I feel itchy and uncomfortable at my vulva, this usually culminates in the development of sores around my genitalia. Other times I develop sores and my urine colour changes to paleness (Lamboya)

#### **42.6.2 Intermittent abdominal pain related to urinary tract infection**

Some of the participants frequently contracted urinary tract infections owing to the constant leakage of urine and poor hygiene. This resulted in some of them experiencing intermittent abdominal pain. Some participants resorted to self-medication (buying over the counter drugs) to treat these symptoms because they cannot afford for a proper investigations and treatment at the hospital and subsequent recurrence. For instance, Bugri Daa narrated her experience as follows:

I often get fever, loss of appetite and abdominal pain, sometimes the abdominal pain becomes so severe that I buy a drug called “sukuru” and take.

Similarly, Lamboya shares her experience:

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Sometimes my urine also becomes pale and cloudy. Whenever this happens, I experience lower abdominal pains as well but my main problem is the urine.

Binaba No.1 also shared her experience as follows:

I also do experience abdominal pain and itching of my vulva and inside me at times. Whenever this happens and I have money, I go to the drug store and buy some capsules and take.

**4.2.63 Pain**

Majority of the participants reported experiencing pain often. Apart from the abdominal pain which is associated with the frequent urinary tract infection, participants complained of pain due to constant irritation of the genital sores by the “acidic” urine as they described it. Awanamas shares her experience as follows:

They also used the solution to spray into me, whenever this was done, I got very weak, it also caused severe sores in my genital region but I still had to use it on the sores even though it was very irritating. Each time this happened I only lay on my back and pat my thighs and cry.

Lamboya also described her experience this way:

There is constant pain because of the urine touching the sores but since I cannot control the passage of urine, I have now taken the pain from irritation as part of me.

Bugri also stated:

I experience persistent pain because of the sores which are constantly being bathed with urine.

Similarly, Zambala stated her experience this way:

Sometimes I develop sores at my genital region, which becomes very painful when the urine touches them.

#### ♦.2.6.4 Menstrual changes

Some participants reported about menstrual changes including menstrual irregularities such as dysmenorrhoea and complete cessation.

Lamboya expressed her worry about her menstrual change as:

Now my problem is that when I get my menses, it is painful and mixes with the urine which makes me uncomfortable. Sometimes my menses flows with the urine for about ten days.

Awanamas also expressed her worry this way:

At first the menses was heavy and irregular, but now it has ceased to flow, therefore I am worried that if it does not resume I will forever remain childless (Awanamas)

Bugri also stated:

When my menses starts to flow now, I cannot do anything. I don't know whether it is because it is mixed with urine or what, it comes plenty, Sometimes it come so much that I cannot even tell the number of times I change my rags (Bugri)

Another participant also expressed her menstrual experience as stated:

Ever since this problem came, my menses have changed. Now I don't know when it is due because it is irregular. Whenever I get it I experience severe lower abdominal pain and it also usually mixes with the urine, giving it a meat like odour (Gabulga)

#### 4.2.6.5 Foot drop (partial paralysis)

A number of participants experienced foot drop. According to literature reviewed, foot drop is not caused by obstetric fistula but linked to it in that it results from prolonged pressure on the

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nerves supplying the lower limbs which occurs when one adapt the squatting position for long such as in labour. For instance one who experienced foot drop reported:

As soon as the baby was removed, the urine started coming and I could not move my legs, so I was just lying down. I stayed at the hospital for sometime and was discharged without even regaining my legs so I went for local treatment (native medicine) to regain use of my legs since they could not (Kpalsako)

Another tearfully stated:

I became paralyzed in one leg and was sent back to my father's house since my husband refused to take responsibility. It was not easy coping with the situation as my ailing mother was blind and could not offer me any support. I therefore had to be with the paralysis for a long time since I could not afford any treatment other than the native one. (Lamboya)

Similarly, Gabulga expressed her sentiments this way:

It started right at the hospital and I could not walk as well, one of my legs was paralyzed so I stayed at the hospital for a long time, but there was little they could do for me. At the end I was carried from hospital straight to a native doctor's house for treatment. It was not easy but at the long run I regained the strength of my leg (Gabulga)

**4.2.7 Effect of obstetric fistulae on participants marital relationship and Sex activity**

The findings revealed that the development of an obstetric fistula marred the victims marital relationship. Majority reported having no sexual intercourse with their husbands from the inception of the problems while others were either totally abandoned/neglected or divorced.

**4.2.7.1 No sex life**

Majority of the women indicated they ceased to enjoy sex in their marriage from the day they developed the obstetric fistula. Sex is something that is not easily talked about by these rural

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folks so most of them even though are not happy with their sexual activities, do not talk about it.

Regarding the effect of the condition on marital relationship and sexual activity, many had bitter experiences such as neglect or abandonment when it was obvious that the condition was chronic.

For instance, Gabulga expressed her frustration this way:

As at now he does not relate well with me. He does not sleep with me again. I am just there; they don't involve me in anything.

Yet Zambala simply put it:

My husband lives in Kumasi (several kilometers away) and ever since I developed the condition, we have not been together as husband and wife, so no sex.

Bugri Daa on the other hand expressed her displeasure about her situation as follows:

We don't have sex and he does not talk to me nor help me. I am not happy about the situation but I have to bear it. I am only here because of my children (Bugri Daa)

This participant hopelessly put her situation this way:

he does not sleep with me again ever since the urine incontinence started. I am bothered about it but what can I do? (Binaba No. 1)

Only one did not report a change in her sexual relationship. She stated:

My husband has been very helpful and caring. I was and am still his only wife. Our sex life has not changed despite my condition. Whenever I get my menses and the pain becomes severe, he takes over the household duties until I get better (Bugri)

#### 4.2.7.2 Divorce in disguise/divorce

Though many participants are still in their marriages, some are more or less divorced, some of them only still live in their husbands' homes but there exist nothing common between them and their spouses. For instance, participants reported being neglected by their husbands, no involvement in family matters such as family gatherings, decision-making and so on. Zambala narrated her experience as follows:

My husband lives in Kumasi and ever since I developed the condition, we have not been together as husband and wife even though he remits me occasionally. He has other wives so I have been left here to care for the old lady (mother-in-law). Because he still remits me once in a while and I am living in his family house I consider myself as still married otherwise, I am a divorcee.

Gabulga also expressed her frustration as follows:

Initially my husband was helpful and caring. He tried to seek treatment for me but after a while, he neglected me.



Similarly, Bugri Daa stated her predicament:

He has neglected me. As at now he does not relate well with me. He does not even sleep with me again. He has nothing common doing with me, even when I am sick, He will not mind me but for my rivals he will take them for treatment, how can this be termed marriage? (Bugri Daa)

#### 4.2.8 Availability of Family / Social support systems

The most reliable family members that took care of the fistula victims were the victims' spouses, their children and in some cases siblings. The form of support was mainly provision of basic needs such as food and money for detergents. Sometimes these relatives went a step further by

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taking victims to hospitals for treatment however they could not offer much as they had limited resources. Some spouses did not offer any support to their wives even though as several participants noted, the fistula resulted from a mutually concerned pregnancy.

**4.2.8.1 Significant others including parents and relatives.**

Support from this group of people was mostly in the form of provision of detergent and in some cases foodstuff. Puyanga presented her as follows:

My husband was not capable but my sons did very well. They took me to many treatment centres including both orthodox and traditional. They also catered for me as well as provided me with detergents for cleaning.

Another participant stated:

My children help me with money to buy soap for the constant washing.

Similarly, Kpalsako explained:

Sometimes if my daughter has money, she assists me financially in order for me to buy the soap,

Awanamas also indicated:

My brother-in-law (late husband's brother) occasionally gives millet and my own brother who lives in Kumasi sometimes sends me some money to help buy detergents.

One participant also stated her source of support as follows:

He has refused to treat the fistula. He says he has no money. He no longer remits me. My brothers have assisted me up to date. My children also sometimes give me money to buy soap and wash my things. When recently they were taking us to Bolga for treatment, he did not even give me money to buy water on the way, and when I asked he told me not to go if I did not have (Bugri Daa)

#### 4.2.8.2 Rare spousal support

Zambala stated:

My husband remits me occasionally but it is not enough to suffice my needs. He also tried at the initial stage to treat me but it was not successful.

Another participant whose husband has been very supportive narrated her experience as follows:

My husband is very supportive. He takes care of me and provides me with money for detergents and perfume. He feels obliged to assist me as much as he can. This has made it possible for me to keep it away from my rival (Binaba No.2).

Lamboya also described her situation this way:

I don't have anyone to support me. I have no living sibling and my husband has divorced me. I only struggle on my own to care for myself and my mother who is old and blind.

My husband has refused to treat the fistula. He says he has no money. He no longer assists me in anyway (Bugri Daa)

#### 4.2.9 Coping Strategies

All the participants devised similar ways of handling themselves in order to reduce the strength of the odour on them. All of them use rags as pad as they cannot afford for sanitary pads. Also, in order to control or reduce the strength of the odour that emanate from them, participants took to frequent washing of the rags for reuse, sometimes participants used nicely scented soap to wash the rags and bath whenever they could afford. Some also used perfumes to mask the odour.

#### 4.2.9.1 Frequent washing of rags

Zambala, who in attempt to stay clean and odourless, reported washing the rags she uses frequently. She stated:

I always wash my rags as soon as they get soiled with urine. You know urine has a very strong smell when it is left on something for long, so in order to avoid this strong scent, I wash even at odd times such as at night. However, anytime I come by these perfumed washing powders, I can afford to soak them overnight and wash the next morning.

Similarly, Bugri reported:

I use pieces of old cloth as pad and to keep these clean and odourless, I always ensure that at all times I have soap and dettol which I use in washing them whenever they are soiled.

Another participant recounted her experience with frequent washing this way:

As for the washing of the rags, it has become part of me. It is a daily routine that I carry out for countless no of times in a day. In my bid to remove or prevent the odour of the urine from me, I have become obsessed with washing to the extent that even when it should be postponed, I will still wash it (Awanamas)

#### 4.2.9.2 Frequent body wash

Findings showed that most of the participants wash down as soon as they are soiled with urine, except when they are not near anywhere that they could wash down. Binaba No.1 has been so worried about the urine that she even goes into people's house to beg for a place to wash down.

She stated:

I usually wash myself immediately I get wet regardless of wherever I am. Sometimes if I get soiled outside my house, I go to any nearby house and beg for water and wash myself and my rags and change. This does not however happen always as some people do turn my request for a place to wash myself down.

Binaba No.2 also reported as follows:

In order to keep myself clean and odourless, I always wash myself frequently. How can you have this condition without washing often. Just imagine what people would have done to me, especially my rival if I were not looking neat.

Similarly, Bugri stated:

It is the frequent body washing and that of the rags that you are able to sit here and talk with me. So as for me, I don't joke with bathing and washing for they are the only means by which I can make myself comfortable and also come out.

#### **42.9.3 Use of perfumery**

All the participants expressed the desire for perfume because according to them, it helps mask the odour a bit. They however indicated that it is costly and for that matter they only use it anytime they are able to afford it. This is what participants had to say:

I use nicely scented soap to wash my rags to help remove the odour and apply "turali" (perfume) whenever I am going out. This is however not regular considering the cost of these things and what I earn, I cannot afford it. It is only when my daughter is able to afford it that I use (Bugri Daa)

Awanamas also stated:

I use ordinary soap to wash my things, but whenever my brother sends me some money, I use some to buy perfume and scented soap and use to also give me some nice fragrance. This is however occasional since my brother does not send me money very often.

Lamboya on the other hand expressed her frustration about the use of perfumes this way:

I know there are soaps that one could use to wash the rags and bath to give a nice fragrance which could mask the odour a bit, but I cannot afford it. Sometimes, it becomes difficult

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for me to get even the ordinary soap for washing. Considering what I make for a living as well as caring for my ailing mother, I could not have even been able to get the ordinary soap to wash if not for the benevolence of good Samaritans.

Binaba No.2 also stated:

My husband supports me with the buying of detergents and perfume, so the is what I use to “kill” the smell a bit, but urine has a strong smell that upon all these you can still perceive its odour but probably in a mild form.

**4.2.10 Treatment modalities**

Most of the women interviewed experienced some difficulties accessing treatment for their conditions. These health care access challenges ranged from financial constraints, lack of specialists at health facilities that the women can reach, ignorance and lack of spousal support. Generally, participants noticed the problem for the first time at the hospital following the prolonged labour and delivery. This gave them an opportunity to have it treated early. Nevertheless, majority of the participants only resorted to native treatment after the initial conservative treatment using the Foley's catheter at the hospital failed to correct the problem.

This was because most of them could not afford any repair as some of the men (their husbands) withdrew when the condition became chronic, besides there were no specialists in the region to repair the fistulae hence the need to travel very far for treatment which further compounded the financial burden. Ignorance also played a role in their accessing treatment for the fistulae as some of the participants did not know that there were specialists somewhere who could repair them.

#### 4.2.10.1 Traditional/herbalist

Participants who resorted to this form of treatment recounted their experiences in the following verbatim quotes.

Lamboya stated as follows:

I only underwent local treatment to treat my paralyzed leg, I have not sought any treatment for the fistula because I cannot afford it and the man who should have treated me has run away. I have nobody to help me so I only underwent this form of treatment which also goes with a cost, but that is a bit manageable than the hospital one. Unfortunately, this treatment did not also help.

Similarly, Bugri Daa who had no support from her husband stated:

I have not sought any hospital treatment again ever since I was discharged. The man refused to help me so I tried some native treatment but it did not work. It is only recently, some health workers came and took us to Bolga for free treatment but unfortunately on my part, we were too many for the only surgeon who was repairing the fistulae and therefore we were brought back..

Zambala on the other hand had a different story to give, she narrated:

I underwent native treatment for close to three years; bathing with water that roots have been soaked in for months and drinking some. I was also forbidden to eat meat, fish, eggs, etc. except “dawadawa” that I was allowed to use in preparing my soup. I was also barred from eating or sitting with people for the period I was undergoing the treatment, yet after all these terrible experiences, no cure, so I stopped.

Similarly, Awanamas Setande whose husband could not afford for any orthodox treatment, underwent herbal treatment for three years under similar circumstances. She also narrated hers:

My late husband who was old at the time could not afford any

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treatment for me, so I underwent local treatment for three consecutive years without any improvement. Throughout the three years of treatment, I was forbidden to eat fish, eggs, or meat. I was only allowed to eat “dawadawa”. It was also forbidden for me to talk or eat with people, in fact, I was not allowed near anyone; not even my husband for those three years.

**4.2.10.2 Lack of knowledge about orthodox treatment**

Whereas majority of the participants reported on their inability to afford orthodox treatment, a few of them did not know that it could be treated the orthodox way. For instance, Binaba No.2 who had not attempted treating herself after developing the condition reported as follows:

I have never sought any treatment at any hospital ever since I developed this problem. We (my husband and I) did not know there were bigger doctors elsewhere who could repair this damage. You know we thought the condition was spiritual, so we did not think any hospital treatment could cure it. Therefore, we only sought the native one that did not also help after having to kill goats and sheep to offer sacrifices to the gods.

Binaba No.1 also recounted her ignorance this way:

For me, I have never sought any treatment for it. I never knew it was a disease condition. I thought it was a normal occurrence in women who had delivered per vagina until recently when a health van came announcing at the market square that anyone who had that experience following delivery should come to hospital for operation.

Kpalsako did not also know her condition could be treated until some health workers went to her village on a sensitization programme before she got to know. She however, still needs support to be able to go for repairs as her husband cannot afford. She narrated her experience as follows:

When I was discharged from hospital, I only underwent local treatment for my paralysis. We did not know that the urine

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incontinence could be treated until some nurses from Zebilla hospital came here and took us to Bolga and thence to Accra for the treatment. However, unfortunately on my part, I did not benefit from this free treatment because we were too many for the surgeon and so, some of us were brought back and since then we have not heard from them again.

**4.2.11 Suggestions from participants on ways to improve treatment**

Most of the participants made some suggestions as to how to assist women with this problem. These suggestions bothered on giving assistance in the form of food aid and free repairs so that fistulae victims could live their normal lives again.

**4.2.11.1 Free repairs of obstetric fistulae**

All the participants were of the view that treatment be made free to enable every fistula victim have access to treatment. Stated below are some of the suggestions made. One participant stated:

This is a condition that no woman should be allowed to suffer. If possible it should be prevented and in cases where women get it, they should be treated promptly and free of charge. It is not anything that one should be allowed to live with. There are too many problems associated with it  
(Awanamas)

Binaba No.2 who is particular about cleanliness stated that:

Women should be given assistance such as treating it free, giving detergents and food since it puts a lot out of job.

Zambala also said;

More treatment centres should be opened to cater for women no matter where they come from and treatment must be free so that no matter one's situation one can also get her repaired. The distance of centres also compounds the problem as one would have to travel far for it

Gabulga also suggested:

Also, the men need to be educated as well so that no woman is left in labour for days and where it still occurs, free and prompt treatment should be given. (Gabulga).

#### **4.2.11.2 Food aid to obstetric fistula victims**

Participants also suggested that fistula victims be given some food aid in addition to the free treatment they are advocating for. For instance, Lamboya suggested:

I think it would help us(the fistula victims) a lot if we are given some food aid. The condition puts us out of job thus making living so unbearable for us, especially when the victim is a breadwinner like myself.

Similarly, Awanamas also stated:

Besides treating us free of charge, I think giving us some food aid will also help lift some of the burden on us.

Binaba No. 1 also expressed her views this way:

Giving us some food aid will help us a lot because that is the main reason for us looking for jobs and being discriminated against. I for one sometimes find it difficult to feed my children and this worries me a lot.

### **43 CONCLUSION**

Chapter 4 presented the findings of the study with the description of categories and their themes supported with verbatim quotes from the study participants. Chapter 5 will discuss the findings of this study with the existing literature regarding obstetric fistulae.

## CHAPTER FIVE

### DISCUSSION

#### 5.0 INTRODUCTION

The purpose of this study was to explore and document the experiences of women with obstetric fistula in the Bawku East District of the Upper East Region of Ghana. The experiences were critically examined through the conduct of in-depth interviews with ten women who had obstetric vesico-vaginal fistula as a result of complication of labour. These women provided narratives on the major challenges they encounter in their daily lives. In this chapter, the findings of the study drawn from the analysis of the data in chapter four are interpreted and linked to those of other studies in this area. The discussion is done in line with the themes that featured in the analysis.

#### 5.1 CIRCUMSTANCES SURROUNDING PROLONGED LABOUR IN CHILD BIRTH

The history of the respondents revealed that development of the obstetric fistulae was primarily due to prolonged labour. All the deliveries began at home under the supervision of community birth attendants who had very little or no training. It that many of them believed that prolonged labour did not result from poor management but a punishment by the gods for sins committed by the affected women such as infidelity. Some women are denied access to care, or actually harmed, due to cultural beliefs and traditional practices. Some women may live in seclusion and, for many, husbands or other family members, including the mother-in-law" have the responsibility to decide on whether the women should seek health care in pregnancy, or even after prolonged labour (WHO, 2006).

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Many participants had faith in Traditional Birth Attendants and do not attribute their conditions to poorly managed labour under the supervision of the TBAs. They also found their services cheaper and more convenient than professional health practitioners. In Ghana, TBAs contribute immensely in the care of women during pregnancy and delivery in the sub districts and villages where there are no midwives. This has attracted the attention of the United Nations Population Fund (UNPF) (2003) which conducted an evaluation study in Ghana and other African countries such as Uganda, Malawi and Zambia entitled “Traditional Birth Attendants”. The conclusions and recommendations drawn from the evaluation report indicated that, majority of TBAs in Ghana were illiterate and had learned their skills through working with other TBAs. Most TBAs considered themselves as private practitioners who responded to requests for service and received some compensation, mostly in kind. The focus of their work was to assist women during delivery and immediately post-partum. Frequently their assistance also included helping with household chores. Most TBAs went to the woman’s house to deliver although some had arranged a delivery area in their own house or compound.

According to the UNPF (2003), majority of the TBAs interviewed resided in poor rural areas, very distant from health facilities. They often served as a bridge with the formal health system, sometimes accompanying women to health facilities. The report also noted that, most women expressed their preference for TBA’s assistance during delivery. In programmes reviewed in Ghana by the UNFPA, women repeatedly reported reluctance to seek care from health centres. Health staffs were described as impersonal, rude and arrogant. TBAs, knowing that women were poorly treated, sometimes also choose not to refer. If they did, TBAs said that they would lose

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credibility and women would seek assistance of untrained TBAs who, most likely, would not refer them (UNFPA, 1996).

Others also explained that it was due to the fact that many of them were quite young at the time of having their first delivery at age 16 years or less. According to the World Health Organization 2006, the traditional practice of early marriage contributes to a risk of obstructed labour and fistula. In parts of sub-Saharan Africa and South Asia, where obstetric fistula (OF) is most common, women often marry as adolescents, sometimes as young as ten years of age, and many become pregnant immediately thereafter, before their pelvises are fully developed for childbearing (Ekwempu, 1988). In Ethiopia and Nigeria, for example, over 25% of fistula patients had become pregnant before the age of 15, and over 50% had become pregnant before the age of 18 (WHO, 2006).

The unrelenting patronage of traditional birth attendants in certain parts of Ghana including the Upper East Region stems from the long practicing experiences of traditional birth attendants in this part of Ghana and the continued lack of access to health facilities in the region. Hence, the trust of families and communities in traditional birth attendants is never waning. They are easy to find, their presence constitute an aspiration and hope of every pregnant woman in mist of deprived and scarce health resources. Consequently, the continued patronage of the services of traditional birth attendants and the faith in their roles as local midwives.

Similar to these findings, a study done in the Sekyere-West district of the Ashanti Region by Peasah (2003) (unpublished) revealed the following; women preferred to give birth under the traditional birth attendant's supervision to that of the professional birth attendants like the

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midwives, nurses and doctors because they are close to them in terms of distance, familiar and have flexible terms of payment. That is to say, they have the options of either paying in cash or kind in the form of going to work for the traditional birth attendant to defray the debt. Payment could also be deferred, that is client could be cared for on credit to be settled at a later date unlike the hospital situation where the woman is not allowed to go home until her hospital bill is settled (Peasah, 2003; published).

The fact that some other women have had successful delivery under the supervision of unskilled birth attendants reinforces belief that those who suffer prolonged and difficult labour have committed adulterous and infidelity rather than poor management of labour by the unskilled birth attendants. Further research is needed in the belief systems and cultural practices of the people of the Upper East region regarding safe motherhood. The above findings corroborate the findings of Karshima, Kirschner and Arrowsmith (2004) who conducted a study at Evangel Hospital in Jos Plateau State, Nigeria and found that over 96.5 % of fistula cases identified between January' 1992 and June 1999 were associated with prolonged labour.

Similarly, Gbola, (2007) identified factors responsible for vesico - vaginal fistula to include lack of skilled obstetric care providers. He noted that, women who are supervised by skilled professionals such as midwives are very unlikely to develop obstetric fistula, especially where there is access to emergency obstetric care. This is because, women who are supervised by health professionals during labour would be properly monitored with the use of a Partograph, therefore any deviation from normal would be detected early and prompt action taken to avert some of these preventable complications like obstetric fistula. It is for this reason that obstetric fistula is almost non existent in the western world where every woman has access to emergency obstetric

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care (Gbola, 2007). Most of the participants in this study did not know that they had developed obstetric fistula whilst they were in hospital. This is because soon after the delivery they found themselves having indwelling catheters which prevented leakage of urine. However, shortly after the catheter was removed they began to experience urine incontinence. Diagnosis was established after the catheters were removed in the hospital. Initially, health care givers tried to manage the urine incontinence conservatively using indwelling catheters. This prolonged the durations of hospitalization than the average normal time spent in hospital after normal deliveries. The average duration of hospitalization of the respondent after delivery was three months with others being hospitalized for as long as seven months. This also had a negative impact on the participants and their families as their hospital bills accumulated, making it impossible to be settled. Some participants reported having to sell personal belongings in order to settle the bills.

Further, the identification of prolonged labour and poor management of labour as the main factor in the development of obstetric fistula in this study sharply contradicts the findings of Muleta et al (2008) who found that only one third of cases of obstetric fistula in rural Ethiopia are attributable to poor management of labour. This finding however supports the findings of Muleta et al (2005) who made the following observation that:

- All obstetric fistulae were due to prolonged labour of more than one day duration and duration of up to eight days;
- Home delivery was more common in untreated fistulae patients compared with that of treated ones in hospitals;

- High proportions of untreated fistula patients did not visit the health institutions at all for difficult or prolonged labour;
- The time elapse before visiting health institutions for treatment was much higher for untreated patients compared to treated patients; and
- The most common reasons for not visiting health institutions when labour was prolonged was inaccessibility of health services and financial difficulties, lack of information, lack of transport or motorable roads linking the communities with the main health facilities.

## **5.2 REASONS FOR NON ATTENDANCE FOR HOSPITAL DELIVERY**

Findings of the study showed that women in labour were faced with some challenges which tend to make them labour at home rather than go to a health facility. It was found that almost all the women interviewed expressed the desire to have skilled care during labour but due to some challenges they were confronted with, could not and had to go through difficult times. These challenges, according to them bothered on accessibility to healthcare services, including lack of health facilities, long distance of walk, transportation difficulties and financial constraints. The role of the husband in deciding on the choice of birthing place was also another challenge experienced by the participants.

The study participants indicated that the distance to the nearest health facility was too long and impossible to make on foot. Also due to the inaccessible nature of some of the health facilities coupled with unavailability of transport, women have no option but to try delivering their babies at home with the assistance of traditional midwives shrouded in various beliefs and practices

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regarding delivery. This finding supports that of Turan et al (2007) who in their study found that woman who developed obstetric fistula invariably delivered at home due to lack of emergency obstetric care with distance and transportation difficulties as key factors.

Also it was found out that roads leading to the communities with health facilities were in deplorable states or non-existent. Thus walking was the only choice of accessing a health facility. Accruing monies to attend hospital for services or child birth was made impossible for these women who were mostly petty traders and peasant farmers. This corroborates the findings of Islam and Begum (1992) that lack of transportation and long distance of walk to health facilities as major causes of low patronage of health facilities among women during pregnancy, labour and delivery'. Consequently, pregnant women in these rural areas often do not attend antenatal clinic for monitoring and resort to traditional birth attendants during labour, posing a lot of risk to both the mother and baby as any potential health problem could become fatal due to lack of monitoring and prompt management.

Another challenge expressed by the participants was the role of their husbands in deciding where they should have their babies. Concerning this, it was noticed that the participants had very little or no say as far as major decision making such as choice of birth place was concerned. Here, the participants wished they were sent to hospital during labour but since their husbands did not give the go ahead, they were helpless as their voices were not heard. They could not also go to the hospital without their husbands' consent because it is their husbands that will pay the transportation cost and the hospital bill.

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Financial constraints was another factor that hinders the participants from accessing skilled care during labour. As has been documented by earlier studies such as Molzan Turan, Johnson, Lake and Polan (2007) and Women's Dignity Project and Engender Health (2007), most of the participants were poor and for that matter, could not afford for hospital delivery. For instance most of the participants stated that they would have gone first for hospital care when they were in labour if they had the financial capability. For instance, some participants reported how helpless they were while the men went about their sacrifices.

The participants were also concerned about the length of stay in the hospital and the consequent accumulation of the bills to be paid in the mix of poverty and unemployment. Hence, the duration of stay in the hospital in itself is a contributory factor to non attendance.

**53 DIAGNOSIS / DURATION OF STAY IN HOSPITAL**

Hospital attendance for labour and delivery was found to be a last resort after home management of labour had failed. Most of the participants were in labour for a minimum of three days and maximum of four days.

The diagnosis of obstetric fistulae was made in the hospital shortly after participants had eventually delivered. However, most of them were managed conservatively using the Foley's catheter which prolonged their stay in hospital. This resulted in accumulation of hospital bills which affected victims could not pay. Hence their further detention in the hospital. The duration of fistula patients' in hospital after diagnosis ranged between three months and one year.



#### 5.4 PSYCHOSOCIAL EXPERIENCES OF WOMEN WITH OBSTETRIC FISTULA

Women with obstetric fistula were found to suffer negative psychosocial experiences for as long as the condition persisted. The impact of these experiences were devastating to the extent that they were unable to continue their jobs, trades or farming activities which were their sources of livelihood.

Psychologically, the women with obstetric fistula reported suffering perpetual worry, family and self isolation. These stemmed from the odour that emanated from them due to urine incontinence. The odour also made them to feel unworthy and unfit to be in the company of friends and others in society as a whole. This compelled them to isolate themselves from other people including those who did not feel the same way about them.

Similar psychological experiences have been noted by Mafakhkharul and Begum (2007) in their case study of patients with vesico - vaginal fistula to assess the psychosocial effects of the condition on them. They identified psychosocial problems such as feeling of embarrassment in the midst of others. Fasakin (2007) also identified psychological experiences of women with obstetric fistula to include social isolation and worry over stigmatization.

Women with obstetric fistula were also found to experience negative social experiences such as stigmatization, isolation, neglect and ostracism in this current study as confirmed by Mafakhkharul, Begum and Fasakin (2007). These experiences impacted greatly on the participants' performance of their jobs and the everyday activities that earn them livelihood and pride of a woman. Stigmatization was both felt and perceived and mostly associated with neighbours, friends, business colleagues and family members. Fear of stigma also resulted in

isolation in order to avoid embarrassment and humiliation. Another significant negative social experience reported by the women was discrimination in the form of loss of job and refusal to offer jobs to them because of their condition.

Negative social experiences of women with obstetric fistulae is widespread across west Africa and other parts of the African continent as similar findings have been documented by Muleta et al (2008) in their cross sectional study to assess the health and social problems encountered by untreated and treated obstetric fistula patients in Rural Ethiopia. According to the findings of these researchers, women with obstetric fistula faced social problems such as divorce or abandonment, by husbands or family members, discrimination, isolation, avoidance of friends and stigmatization in society. In the words of Ahmed and Holtz (2006), women affected with obstetric fistula were the most dispossessed, outcast and powerless group of women in the world. Further research and interventions are needed in the field of obstetric medicine to put smiles on the faces of Ghanaian women affected and devastated through the process of becoming a mother.

#### **5.4.1 Emotional problems encountered by women with obstetric fistula**

Emotional problems of women with obstetric fistulae were found to arise out of frustration and feelings of powerlessness and hopelessness. Most of them expressed displeasure about the way they were treated, especially the negative social and psychological experiences they suffered from their family members, friends and loved ones who should have been their source of emotional support in this condition. Abandonment also evoked profound emotions and memories of the good old days when they were well and enjoyed happy relationships with their husbands, families and friends. This finding is in line with what Banda, (2007) found. In his study, some participants became so emotional about their situation that some decided to go and live near a

cemetery where they were completely out of reach of those who always cause them emotional pain. In the current study the participants were very emotional and some exhibited their emotional pain by cursing their partners whom they believe contributed indirectly to their predicaments for abandoning them.

What these participants are going through calls for very strong emotional support from their husbands and loved ones for them to feel loved, but in most cases, it is rather the partners who abandon or shun their company. The situation becomes even unbearable when the particular victim has no living children and is again abandoned/neglected by her husband or even divorced. The participants were not only suffering emotionally, but the pain and discomfort from physical injuries and maladies were most disheartening.

## **5.5 PHYSICAL PROBLEMS ENCOUNTERED BY WOMEN WITH OBSTETRIC FISTULA**

Physical problems suffered by the women as a result of obstetric fistula were common among all the participants. The most common ones included genital sores, intermittent abdominal pains, menstrual changes and genital tract infections. The genital sores resulted from constant irritation of the urethra and vagina by acid from the frequent leakage of urine and the perpetual wetting of the perineum whilst intermittent abdominal pain and urinary tract infection were caused by infection. Menstrual changes reported include amenorrhea and discomfort. Other physical problems reported were foot drop, perineal sores, itching and vulva discomfort.

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Physical problems of women with obstetric fistula have also been identified by other researchers.

According to Mafakhkharal and Begum (2007) Bangladeshi women with obstetric fistula reported physical problems such as constant feeling of being unwell, dyspareunia, local pain and fever. Also. Gbola (2007) reported that the plight of victims of vesico - vaginal fistula in Nigeria was found to be sorrowful as they suffered severe pain and bleeding, injuries and infections of the vagina, urethra, bladder and incontinence of urine. Similarly, Arrowsmith et al (2003) reported of physical injuries including sores, frequent urinary tract infections and foot drop which were also found in the current study. The frequent development of genital sores is due to the constant wetness of the genital area by urine which is irritable to the skin. This causes itching and excoriation of the skin around the area and when the victims scratch, then the sores result, and like a vicious cycle, continuous exposure of these sores to the constant dripping of urine and general unhygienic nature of the area by the rags that these victims use, the sores hardly heal. Expectantly, the presence of physical injuries resulted in strained relationship amongst the participants and their sexual partners.

**5.6 EFFECTS OF OBSTETRIC FISTULA ON MARITAL RELATIONSHIP / SEX LIFE**

The study discovered that women with obstetric fistula did not enjoy their marital and conjugal relationships and sexual life as they did before the development of the condition. Most of the women in the study reported bitter experiences mainly due to neglect and or abandonment. They did not also have conjugal relationships with their husbands. A few of them however reported having emotional support and financial support from their husbands.

The literature on marital and sexual relationships of women with obstetric fistulae was consistent with the findings of this study. As Gbola (2007) reported in a study conducted in Nigeria.

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married women who sustained obstetric fistulae were abandoned by their husbands and families and never shared bed with their husbands or have sexual intercourse with them because their husbands refused to let them get closer to them. They were also prevented from serving their husbands meals or washing their clothes. Although some of the husbands were supportive, many family members and members of the community were unsupportive.

The current study findings confirm that of Muleta et al (2008) who found that in-laws and extended family members of husbands were most unsupportive and encouraged the husband to abandon his wife. Similar findings have been made by Kadir, Iliyasu and Umar (2003) who report from a study on the medical and social consequences of fistula among patients presenting with vesico - vaginal fistula at a large referral centre in Kano, Northern Nigeria. The researchers also found that affected women were considered to have brought shame and dishonor to themselves and their families and where they managed to avoid not being divorced by the husband they often lost any form of support from their husbands who tend to marry second or more other wives.

The researchers also found that women with obstetric fistula commonly suffered divorce and/or abandonment by their husbands. For couples who divorced because of the fistula, the decision was usually made on the part of the husband who left the wife and when divorce occurred, some women remained single without an intimate partner. Those who were afraid of their ex-husbands' reactions rejected male advances. Other women, who wanted to remarry, experienced stigma and could not find a partner who would accept their condition.

Furthermore, regarding the opinion of relatives about divorce of the affected women, Kadir, Iliyasu and Umar (2003) reported that female relatives encouraged the husbands to take a second

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wife due to the woman's condition. This in the view of the current researcher was a strategy aimed at preserving the husband's financial support and responsibility to his wife while ensuring that his sexual and other needs were met. Future research should be conducted about Men's perspectives on their marital relationships with wives who sustain obstetric fistulae.

**5.7 SOCIO-ECONOMIC IMPACT OF OBSTETRIC FISTULA**

The participants of the current study reported socio- economic problems such as loss of job due to discrimination and inability to continue their own trades due to physical injuries and debilitation. Those who remained in business could only do mainly petty trading. They also lost their customers and co - traders due to odour whilst others suffered open verbal abuse, stigmatization and mockery. This social antagonism forced most of the participants to recoil in their jobs.

Job losses meant little or no income which rendered them unable to afford even basic needs such as food, soap or clothing. They could neither afford sanitary pads to contain the urine and hence they resorted to the use of rags which were less effective and made them to have odour. Many of the respondents lamented their inability to afford detergents and scented soap and deodorants sprays to mask the odour due to their very low income levels. The financial burden of the women was also compounded with cost of frequent health care for the management of the frequent genitourinary infections.

Kabir, Iliyasu, Abubakar and Umar (2003) observed that women with obstetric fistula are incapable of working because they were shunned by society. Similarly, Judo and Sadauki (2002) in a cross sectional survey of consecutive obstetric fistula patients who reported for repair in the

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Murtala Mohammed specialist Hospital in Nigeria reported that most of the women were not gainfully employed and even those with identifiable source of income were mainly in low earning menial jobs. They also found out that most of them lived by themselves, support themselves, and are self employed but they declined to disclose the nature of the trades. The socio economic impact of the condition also negatively affected the finances of their families. The participants of the current study lamented that their families suffer hardships as most of them contributed significantly to the up keep of the family. Also, families who had to pay money for the discharge of women detained in hospital after treatment for non payment of hospital bills lost income. Women with obstetric fistula do not have access to basic social amenities such as good water, food and health services.

**5.8 FAMILY SOCIAL SUPPORT SYSTEM AND COPING STRATEGIES**

Despite reported neglect by spouses and family members, the family system was still the most reliable source of social support. Children of the women were particularly supportive to the extent of washing their clothes for them and assisting them to maintain their personal hygiene. In general, family support was limited to the provision of basic needs such as food, detergents and clothes as well as accompanying them to go to the hospital. The latter was not common because of limited family income. The least supportive family members were the husbands as some did not offer any support although the condition resulted from mutually concerned pregnancy.

On coping strategies, it was observed that the women adopted similar strategies to control odour and maintain cleanliness. Most of them used old rags as pads. They expressed their desire to keep these clean but they were unable to do so because they could not afford detergents.

According Gbola (2007) women with obstetric fistula adapted ways of preventing embarrassment and humiliation by begging for alms and forming associations with other patients in the spirit of self support; others console themselves psychologically by developing faith in God and devotion to Christian religious activities.

### **5.9 ATTEMPTS AT TREATMENT / HEALTH SEEKING BEHAVIOURS**

Most of the women had tried both traditional and orthodox medical treatment of their conditions since they were discharged from the hospital. According to them the first attempt at treatment began in the hospital after it was found that they could not control the urinary pattern; they were catheterized and given drugs for some time. But this initial treatment was unsuccessful and hence they were discharged in the state of urine incontinence. Majority of them began their search for cure a few days after they got home from hospital trying both herbal, faith healing and medical treatment whenever possible but they could not get the much needed cure. The search for a cure was abandoned by majority of the participants when their husband upon realizing that the condition had become chronic abandoned them. According to Muleta et al 2008, treatment of fistula was generally accepted by participants to be helpful in improving their status in their families and communities. However, it was still difficult for some women to fully enjoy family and community life because of stigmatization. Most of the treated women complained of stigmatization and avoidance of friends and relatives even after treatment.

### **5.10 SUGGESTIONS FROM PARTICIPANTS ON WAYS TO IMPROVE TREATMENT**

The respondents gave various suggestions on how obstetric fistulae could be prevented as well as support of those who are living with the condition. These are as follows:

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- > Provision of free treatment and free supply of food, detergents, jobs and other basic needs to women with obstetric fistula
- > Establishment of more treatment centres to improve access to care and reduce travelling distance to centres for medical care
- > Education of women and their husbands on the causes, and prevention of the condition and the need to attend prenatal and antenatal clinics for proper management of pregnancies, labour and delivery

Regarding ways of improving management of obstetric fistula, Ahmed and Holtz, 2006 stresses that there is an urgent need for medical attention for women with the condition not only from charitable perspective but also in terms of human rights and social justice.

## CHAPTER SIX

### SUMMARY AND CONCLUSION

#### 6.0 INTRODUCTION

This is the concluding chapter of the study which comprises a summary of conclusions drawn from the findings and discussion of the study and an account of the researcher's personal and field experiences. The implications of the findings of the study to nursing research, administration, practice and education have also been presented and recommendations made to guide future researchers, policy makers and nurse managements on issues relating to the causes, prevention, effects and management of obstetric fistulae.

#### 6.1 SUMMARY

Obstetric fistula is a hole (or "false communication") that forms between the bladder and the vagina (known as a vesico-vaginal fistula, or VVF) or between the rectum and the vagina (a recto-vaginal fistula, or RVF) during prolonged and obstructed labour. According to Women's Dignity Project and Engender Health, 2006, the persistent pressure on the soft tissues around the vagina, bladder and/or the rectum by the fetal skull/presenting part cuts off blood supply to the tissues, causing them to disintegrate (ischemic necrosis). A hole is then left, and urine and/or feces leak continuously and uncontrollably from the vagina.

The World Health Organization estimates that, globally, over 300 million women currently suffer from short- or long-term complications arising from pregnancy or childbirth, with around 20 million new cases arising every year. Problems include infertility, severe anaemia, uterine prolapses and vaginal fistulae. Worldwide, obstructed labour occurs in an estimated 5% of life

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births and accounts for 8% of maternal deaths. Adolescent girls are particularly susceptible to obstructed labour, because their pelvises are not fully developed (WHO, 2006).

The findings of this study as well as those of other researchers of obstetric fistulae indicate that, despite the devastating impact of obstetric fistula on the lives of affected women, obstetric fistula remains largely neglected in the developing world. It has remained a hidden condition, affecting mainly the most marginalized members of the population whose socio economic condition are characterized by poverty, illiteracy and ignorance (Molzan Turan, Johnson and Lake Polan, 2007 and Women's Dignity Project & Engender Health, 2007). Most of the girls and women live in remote regions of the world. The study also revealed that most of the victims got married or were forced into marriage at ages as low as 16 years during which the anatomical structures of the female reproductive system have not developed enough to withstand the pressure and stress of pregnancy, labour and delivery.

It is worth noting that factors contributing to the development of obstetric fistula such as early pregnancy, poor nutrition before and after pregnancy and prolonged labour are largely unknown to the victims and their families as well as the communities at large. Most of the women in this study for instance attributed their conditions to curses or effects of procedures done in hospital during labour and delivery. Ironically most of the deliveries that resulted in the fistulas were initiated at home and supervised by untrained birth attendants for a minimum of three days before they were taken to hospital as a last resort.

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On a global scale, the continued incidence of obstetric fistula in low-resource settings is one of the most visible indicators of the enormous gaps in maternal health care between the developed and developing world. Obstetric fistula still exists because health care systems fail to provide accessible, quality maternal health care, including family planning, skilled birth attendance, and basic and emergency obstetric care, and affordable treatment of fistula. In addition, social systems are failing to provide a safety net for girls and women (WHO, 2006)

The plight of women with obstetric fistula was found by this study and others in the literature to be pathetic and dehumanizing. According to the WHO, (2006), millions of girls and young women in developing countries such as Ghana, Nigeria, Tanzania and Kenya are living in shame and isolation, often abandoned by their husbands and excluded by their families and communities. They usually live in abject poverty, shunned or blamed by society and, unable to earn money, many fall deeper into poverty and further despair. This study found out that the victims lost their jobs, husbands, and did not get any jobs to do even if they tried to do any. Their husbands in most cases married again and did not allow them to live with them in the same room nor have sex with them. The women harbored deep emotional sentiments because the development of the conditions was due to complications which arose during childbirth; a decision they mutually reached with their husbands for the benefits of their families and society at large. They were also devastated by the loss of their babies who died in most cases adding to their depression, pain and suffering.

The psychosocial and economic impact of the victims of obstetric fistula was compounded with the health impact of the condition. Most of the women interviewed specifically mentioned that

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their health had changed negatively because they felt sick or had pain. They indicated having sores around their genitals as a result of fistula. Other health problems identified included foot drop, feeling tired, weak and uncomfortable.

Accessibility to hospital care during pregnancy and delivery was poor. Most of the women interviewed indicated lack of money for transportation to hospital for antenatal care as a major problem. Though most of them had attended antenatal clinics, they were not consistent and when they went into labour, their husbands and families preferred home delivery to hospital delivery since the former was less expensive

Also the study revealed that accessibility to treatment was a major problem; there was no treatment centre around the District where most of the women came from. The initial hospital intervention was mainly catheterization after delivery and medications given against infection and to relieve pain. Awareness of the availability of treatment centres were not immediately known and when they were later known, they were found to be far from them making it difficult to travel there. Even those who were able to travel to treatment centres did not receive repair until after several months. Since majority of them could not afford the cost of treatment, they had to wait for about a year later to have access to free treatment.

In view of the above, there is the urgent need first to create awareness and knowledge of the risk factors and prevention of obstetric fistula. This requires the collective effort of health professionals, the Ministries of Health and Information and the Ghana Health Service. Policy document on prevention as well as management of obstetric fistulas should be formulated and

implemented. Also comprehensive and accessible care should be given to all women before, during pregnancy and delivery to prevent complications of labour such as obstruction that can result in obstetric fistulas. Families with women living with obstetric fistulas in particular should be involved in health education and counseling sessions to enable them accept and support the victims to enhance their quality of life. For those who live with the fistula, more treatment centres should be developed especially in the rural and economically disadvantaged areas to improve accessibility to treatment.

## **6.2 PERSONAL EXPERIENCES**

The study on experiences of women with obstetric fistulas was characterized by challenges and difficulties from the literature search through to data collection analysis and compilation of the work piece. Ten w'omen were interviewed, eight at home and two at the Presbyterian Hospital, Bawku. Women with fistula were identified by health data in the Bolgatanga Hospital where most of the women had reported for treatment. Their residential addresses were taken from their folders. A public health nurse assisted the researcher to trace the first four participants who also provided residential details of others for the researcher to locate them. All the women lived in villages in the Bawku West District at various locations that were wide apart. Accessibility to some of the villages was hindered by poor means of transportation and lack of clear directions to specific houses of participants. This was compounded by the lack of taxis to charter to these areas. This prolonged the duration of the interviews because it was not possible to interview more than one person in a day. The researcher also experienced problems of accommodation since she was not living in the district. Limited resources did not permit hotel accommodation.

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The researcher had to live with friends and contend with the prevailing conditions there such as lack of privacy, mosquito bites.

All participants were receptive and appreciative to be interviewed. Participants were recruited individually by explaining the purpose of the study, its benefits. They were clearly told that participation in the study was purely their personal decision and they could decline to participate before or anytime during the study. They were then asked to participate in the study. The women, who were interested, were made to sign an informed consent form to participate in the study. The interviews focused on understanding their perspectives on the pregnancy that resulted in the fistula and the personal, social, and economic impact of fistula on their lives. They also were asked about the coping strategies they employed to deal with the impact of the fistula and their recommendations for ways to prevent or treat fistula.

There was no language barrier as all participants spoke Kusaal, which the researcher understands. However it was quite difficult finding a location for the interviews. Participants preferred that interviews were done in their room because they did not want other people to see them because of stigmatization. Sometimes interviews were deferred several times for lack of suitable places. The researcher had to hire motors and pay riders as well in order for them to send her to these remote areas because there were either no other means of transport due to lack of access roads, or the only lorry to the place goes there only on the place's market days (every three days) and stays overnight to wait for the traders (who are his main passengers) so that they can sell their wares and the next day, he brings them back to the district capital. This made it difficult for the researcher to go with this truck as she had no place to stay overnight to wait for

this truck since it is the only means to the place. Sometimes the researcher had to travel from Bawku to Kumasi where she lives, to visit the family mobilize funds to cover these field expenses including food and make follow up visits.

### **6.3 IMPLICATIONS FOR NURSING EDUCATION**

The findings of the study have identified gaps in health education of rural people on the causes, effects and management of obstetric fistulas. Nursing and Midwifery curricula should be designed to include comprehensive obstetric care of women. Also midwives and public health nurses should benefit from in service and regular training to upgrade their knowledge of managing women during pregnancy, labour and delivery. Training of traditional birth attendants is also essential and should cover many of these untrained women who continue to be the preferred choice of rural women during labour and delivery mainly due to reasons such as poor access to health facilities, poverty and ignorance. Nursing curricula must also focus on imparting knowledge of the social, cultural and demographic characteristics of the women, families and communities in which they work to enable them give care without offending or disregarding their cultures and tradition as this may let them shun the services they have been trained to do.

### **6.4 IMPLICATIONS FOR NURSING ADMINISTRATION**

Nurses and midwives are core stakeholders in the fight against obstetric fistula. Monitoring of incidence of obstetric fistula should be regulated by nurse administrators and public health offices to determine the extent of the problem. Places with high incidence should be the target of health delivery policies that border on management of obstetric care. Evaluation and follow up services by nurse administrators should be monitored in places where obstetric care policies have

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been implemented to determine the effect of the policies on the health of women who receive the services rendered. Policy reviews should be carried out where the impact of obstetric services do not improve outcome of pregnancy labour and delivery.

The study found out that husbands and family members had great influence on the decision of women during pregnancy, labour and delivery, nurse - leaders should therefore liaise with the families of women before and during pregnancy to encourage them to support them to attend antenatal clinics and report to hospital during labour. To ensure this, nurse administrators should demand report of home visits by public health nurses and midwives with evidence of family involvement during interactions at these visits. Nurse Managers should ensure that compilation of field data on obstetric fistula should be done regularly and reported to the regional and national levels by nurse administrators for appropriate actions to be taken

**6.5 IMPLICATIONS FOR CLINICAL PRACTICE**

The role of nurses in delivery of obstetric services cannot be overemphasized; the study revealed that many women with obstetric fistula did not know that prolonged and obstructed labour could result in obstetric fistulas. This points to a gap in health education especially of women and families in rural areas. Nurses working with pregnant women can fill this gap by intensifying education of women about obstetric health. Also the attitude of nurses towards women in the hospital should be cordial, friendly and caring. This will motivate women to make the health care setting their first contact for obstetric services. Those living with obstetric fistulas even need more care and professional supports from nurses to enable them feel comfortable worthy and confident of their human dignity.

Skills in counseling and care of women requiring obstetric services should be imparted to nurses in the field such as midwives and public health nurses to enable them give efficient care. Logistics such as means of transportation and basic health assessment tools should be provided for nurses to enhance wide coverage of women who need obstetric services. More nurses should be trained as specialists in giving obstetric care services to ease stress and burn outs that may hinder their efficiency

#### **6.6 IMPLICATIONS FOR RESEARCH**

In determining the problem of obstetric fistula in Ghana and the challenges of women with obstetric fistula, more Researches are still required to know the incidence and prevalence of obstetric fistula as data on these are nonexistent or not accurate other areas of concern that need research include factors that contribute to obstetric fistula development such as early marriages (women getting married below 16 years), prolonged and obstructed labour and reasons for non attendance of antenatal care.

#### **6.7 Recommendations**

The findings reveal negative experiences of women living with obstetric fistula; a condition that is both preventable and therefore suggest the following action to ensure that no girl or woman develops obstetric fistula during childbirth or is forced to live with the lifelong consequences of obstetric fistula.

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1. The Ghana Health Service should formulate and implement health education policies and programs to address the problem of low awareness and knowledge of risks of fistula, its impact on the individuals and society at large and availability of treatment services
2. The Ghana Health Services should provide adequate training of obstetric care services providers (i.e. as midwives, doctors, and obstetricians/ gynecologists), build more health facilities and ensure the availability of, supplies, and equipment so every woman can have access to emergency obstetric care as well as high-quality and consistent reproductive health care services.
3. Pre-natal clinics should be established for physical assessment of women and girls before pregnancy in order to identify those at risk early and plan their care for pregnancy and labour.
4. Government and NGOs interested in improving obstetric services to women should provide quality fistula repair service centres and ensure that such services are available and accessible to women in worst affected areas at no cost or highly subsidized cost.
5. Advocacy, support, and reintegration efforts should be instituted to reduce the emotional and economic impacts of fistula on victims through establishment of fistula support and counseling centres and associations for victims to identify themselves with as well as provision of food aid.

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6. Government and research institutions should sponsor researches on obstetric fistula to be conducted in the rural areas to identify the causes of fistula and needs of women living with the condition and make appropriate recommendations to address them
  
7. Women with fistula should be helped to form identifiable groups through which outreach for financial and other support systems can be channeled.

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**Experiences of Women with Obstetric Fistula****APPENDIX - A**

## Background information form

Pseudo. Participant name.....

Age.....

Ethnicity.....

Religion.....

Marital status.....

Number of deliveries..... Number of children alive.....

Occupation:

Previous.....

Current.....

Educational Level.....

Hometown.....

Languages Spoken.....

Antenatal attendance.....

Place of birth.....

Duration of labour.....

**APPENDIX - B****Participant Information Sheet**

Project title: Experiences of women with obstetric fistula in Bawku East District

Name of researcher: Alice Abokai Agana

Telephone number: 0245447164

I am an M'Phil Nursing student of the School of Nursing, University of Ghana, carrying out this research. The purpose of it is to shed light on what the obstetric fistula patients go through as a result of their condition and how they to cope with it.

There is no reward either in cash or kind, however it is envisaged that the findings will go a long way to influence measures taken in terms of its prevention and care and also add to knowledge base in that area.

Having an obstetric fistula is all it takes to qualify to take part in the study regardless of age, marital status, duration of the problem etc. You have a free will to decide whether to partake in study or not, and if you agree to take part, your co-operation will be needed. You will have to give a written consent by either signing or thumb printing one after you have clearly understood its content.

You will be interviewed in your own language or the one you feel most comfortable with, and the interview will centre on your experiences with obstetric fistula and the strategies you devised to cope with the condition. There are no right or wrong answers; hence you are free to express yourself in whatever way you wish. The interview will last for about 45 minutes to one hour and will be scheduled at your convenience. It will also be tape-recorded. The interview sessions will be at most twice, that is in the event that the researcher did not get a clear understanding of what was said during the first interview.

me conversation; also your name will not be mentioned during the time the interview is being recorded and any personal information about you as well. Documents that may bear your name such as the agreement form will be handled by the researcher and her supervisors only and these will be kept under lock and only used for further studies after further ethical clearance. You are also free to ask me whatever you do not understand for clarification. You may contact the under listed person to know more about my study in case of any uneventualities.

1. Dr Francis Antoh, Lecturer, School of Nursing, University of Ghana, Legon Telephone

number: 0244577063

2. Prudence Portia Mwinituo (Mrs), Lecturer, School of Nursing, University of Ghana,

Legon Telephone number: 0271821385

**Experiences of Women with Obstetric Fistula****APPENDIX - C Individual Consent Form**

PROJECT TITLE: Experiences of women with obstetric fistulae in the Bawku East District

RESEARCHER: Alice Abokai Agana

Telephone number: 0245447164

I am a graduate student of the School of Nursing, University of Ghana. I am carrying out this research study and I would like you to take part in the study. We know that in bringing forth children, there can be complications associated with it and one of these complications is obstetric fistula. Obstetric fistula is an abnormal communication between a woman's birth passage (most often the vagina) and the urinary tract or between the vagina and the rectum resulting in uncontrollable leakage of urine and/or faeces. For a woman to have an obstetric fistula with urine and stool passing through unnatural passages messes her up which is an uncomfortable situation in any woman's life.

PURPOSE OF THE STUDY: This study seeks to document what happens to women who have developed obstetric fistulae in their daily life.

BENEFITS: By doing this study, nurses and other people will know more about the condition so that measures can be taken to improve upon obstetric care as well as prevent future occurrence of the condition.

METHODS: If you are a woman with obstetric fistula, you are invited to take part in this study. If you agree to do this, your consent will be needed. You can do this in writing by signing or putting your thumbprint on a consent form. I will ask you questions and you will answer in your

**Experiences of Women with Obstetric Fistula**

own words. There is no wrong or right answer. We will talk for about 45 minutes to one hour at a place of your choice and out of other people's reach. Later, we may talk again. The reason for this is to make sure I understand what you said.

**CONFIDENTIALITY** (nobody will know): Each talk will be tape-recorded. I will protect your privacy. You can choose where we should talk. No one else will know what you say. A number instead of your name will be used on anything that is written about our talk.

**BENEFITS:** Being part of the study may not help you but may teach you about how to care for yourself.

**HARM:** There is no direct physical harm if you take part in this study. However, you may start to feel bad when talking about your experiences. The researcher will talk to you about these feelings and help you find any help you need when available.

**VOLUNTARY PARTICIPATION:**

Participation in this study is voluntary and so if you do not like to take part it is alright. You will not lose anything or services that you are entitled to because you refuse to be part of the study. If you join the study and latter you decide you no longer want to be in the study, you can stop just by telling me. It will not affect the care that you get. It is estimated that about twenty participants would be interviewed over a period of about three months. You would therefore be part of the study for this number of months.

**Experiences of Women with Obstetric Fistula****USE OF YOUR INFORMATION:**

The tape-recordings of our talk may be used for research or for teaching of others or writing about obstetric fistula. Anything that says who you are will not be used when this happens. What you say may be used in the report. Your name and anything that might show who you are will be removed. You can always ask me questions about the study. You can contact the following persons at the School of Nursing, University of Ghana, Legon or me if you have any questions to ask about the study.

**CONTACT PERSONS:**

If you need any information, please contact the following:

Dr Francis Anto (Head of Research & Administration Department), School of Nursing, University of Ghana, P. O. Box 43, Legon. 0244577063

Mrs Prudence Portia Mwinituo-Nyaledzigbor (Supervisor), School of Nursing, University' of Ghana, P. O. Box 43, Legon. Telephone number: 0271821385

Rev Dr Samuel Ayete-Nyampong (NMIMR-IRB, Chairman), Noguchi Memorial Institute for Medical Research, University of Ghana, Legon. Telephone number: 0208152360

I confirm that I have read the information explaining the nature, conduct, benefits and risks of the research project. I am aware that results of the study, including personal details will be anonymously processed into a research report. I have been given the chance to ask questions and feel that all my questions have been answered. I know that my participation is entirely voluntary.

I also know that I can withdraw my consent at any time and that will have no consequences for medical care. I declare myself prepared to participate in this study.

**Experiences of Women with Obstetric Fistula**

Client's name..... Signature

..... Date .....

I have read/ explained the study to the participant in a language that she understands well. I  
believe she has understood the information.

..... Signature of Researcher

Date.....

**APPENDIX - D**

## Interview Guide

1. Could you tell me all about yourself?
2. How would you describe your reproductive history with reference to your condition?
3. Please tell me about your everyday experiences with an obstetric fistula
  - How will you describe your type of fistula?
  - How does it feel like to have an obstetric fistula?
4. Please tell me all about your partner's reactions towards you since you had the fistula
  - What other health problems do you encounter/
  - Tell me your every day experiences as a woman with this problem
  - Tell me about your ability to do work with the fistula
5. Tell me some of the challenges you face as a result of your condition
  - Regarding your work
  - Regarding you and your husband's sexual relationship
  - Your relationship with friends and family members
  - What treatment have you undergone so far regarding the fistula?
6. How has your condition affected your social life?
  - Meeting people in gatherings eg. Funeral, marriage ceremonies etc.
  - What are the attitudes of friends and family members towards you?

**Experiences of Women with Obstetric Fistula**

- Tell me the family roles you used to play and now
7. How do you cope with the condition?
- Could you describe your worries and anxieties about this condition?
  - Stigmatization and discrimination
  - Isolation
  - Marital problems

**Experiences of Women with Obstetric Fistula****APPENDIX F: LETTER TO BOLGATANGA REGIONAL / BAWKU HOSPITALS**

School of Nursing

University of Ghana

P. O. Box 43

Legon

The Medical Superintendant

Bolgatanga Regional Hospital

P. O. Box ...

Bolgatanga

Dear Sir/Madam,

APPLICATION FOR SITE APPROVAL TO CONDUCT A RESEARCH PROJECT AT THE  
MATERNITY UNIT

Title of Project: Experiences of women with obstetric fistulae in the Bawku East District

Researcher: Alice Abokai Agana

This letter is to request your permission and assistance in accessing obstetric fistulae patients in the Maternity for data collection in a research project on aspects of obstetric fistula. An M'Phil research student at the School of Nursing, University of Ghana, Legon, will conduct the research. She is a midwife and currently a tutor at Nursing/Midwifery Training College, Kumasi.

The Institutional Review Board (IRB) of the Noguchi Memorial Institute has approved the research proposal for Medical Research and the College of Health Sciences, University of

**Experiences of Women with Obstetric Fistula**

Ghana, Legon. The participants will be women who have obstetric fistulae. Data collection will involve interviews with the women with obstetric fistula at a location of their choice. I kindly request your assistance in helping the researcher to access the fistulae patients and if required, providing her with a room where she can conduct interviews.

Attached is a copy of information sheet that will be given to prospective participants and an approval letter from the IRB. Thanks for your prompt consideration on this matter.

Yours faithfully,

Dr Francis Anto (Head of Research, Education and Administration)

School of Nursing

University of Ghana

Legon.

CC

The Deputy Director of Nursing Services (DDNS) In-Charge

Bolgatanga Regional Hospital

Bolgatanga

The Principal Nursing Officer In-Charge (Maternity Unit)

Bolgatanga Regional Hospital

Bolgatanga.

**APPENDIX -F DEMOGRAPHIC CHARACTERISTICS TABLE**

No	Pseudonym Participant Name	Age	Ethnicity	No. of Del.	No. of Chn. alive	Religion	Marital Status	Previous Occupation	Current Occupation	Dura. Of Labour	Place Of Lab.	ANC attendant
1.	Bugri	20	Busanga	5	2	Moslem	Married	Cooked Rice vendor	Onion Seller	3days	Home	2 Visits
2	Puyanga	65	Kusasi	11	4	Trad. Believer	Widow	Pito Brewer	Nil	3 days	Home	Nil
3	Kpalsako	30	Kusasi	6	4	Trad. Believer	Married	Pito Brewer	Shea Butter Seller	4days	Home	Nil
4	Awanamas Setande	40	Kusasi	1	Nil	Trad. Believer	Widow	Local gin seller	Nil	4days	Home	Nil
5	Lamboya	Does not know	Kusasi	3	Nil	Trad. Believer	Divorced	Cooked rice vendor	Nil	3days	Home	Nil
6	Zambala	63	Busanga	6	4	Moslem	Married	Cocoa farmer	Peasant Farmer	3days	Home	Nil
7	Bugri Daa	40	Kusasi	4	2	Moslem	Separated	Rice Seller	Nil	3days	Home	3 Visits
8	Binaba 1	70	Kusasi	5	3	Trad. Believer	Married	Millet Seller	Petty Trading	3days	Home	Nil fl 51
9	Binaba 2	Does Not know	Talensi	3	2	Trad. Believer	Married	Kulikuli (groundnut Cake) Seller	Nil	3davs	Home	Nil ! I
10	Gabulga	30	Kusasi	2	Nil	Trad. Believer	Divorced	Trader Cloth seller	Peasant fanner	3dnvs	Home	Nil

# **NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH INSTITUTIONAL REVIEW BOARD**

(UNIVERSITY OF GHANA)

Phone: +(233) 21 500374 /501178  
Fax:+(233) 21 502182  
Email: Director@noguchi.mimcom.net  
Telex No: 2556 UGL GH



P.O. Box LG581  
Legon  
Ghana

Mv Ref. No: DF.22

12<sup>th</sup> November, 2008

Your Ref. No:

## **ETHICAL CLEARANCE**

**FEDERALWIDE ASSURANCE FWA 00001824**

**IRB 0001276**

**NMIMR-IRB CPN 010/08-09**

**IORG 0000908**

On 12<sup>th</sup> November 2008, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB), at a full board meeting reviewed and approved your protocol titled:

**TITLE OF PROTOCOL** : **Experiences of women with obstetric fistula in the Bawku East District of the Upper East Region**

**PRINCIPAL INVESTIGATOR :** **Alice Abokai Agana(Student)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 11<sup>th</sup> November, 2009. You are to submit annual reports for continuing review.

Signature of Chairman: .....  
r^ Rev. Dr. Samuel Ayete-Nyampong  
**(NMIMR - IRB, Chairman)**

cc: Professor Alexander K.Nyarko  
Director, Noguchi Memorial Institute  
for Medical Research, University of Ghana, Legon