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SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

REINTEGRATION EXPERIENCES AFTER OBSTETRIC FISTULA: A QUALITATIVE STUDY CONDUCTED IN THE CENTRAL REGION

BY

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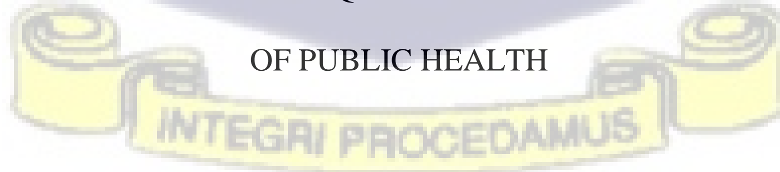
THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH



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DECLARATION

I Millicent Amakye, hereby declare that except for references from other peoples' works which have been duly acknowledged, this dissertation report is my own work carried out at the University of Ghana, Legon under the supervision of Prof. Phyllis Dako-Gyeke. This work has not been submitted in whole or in part for any degree in this or any other University.

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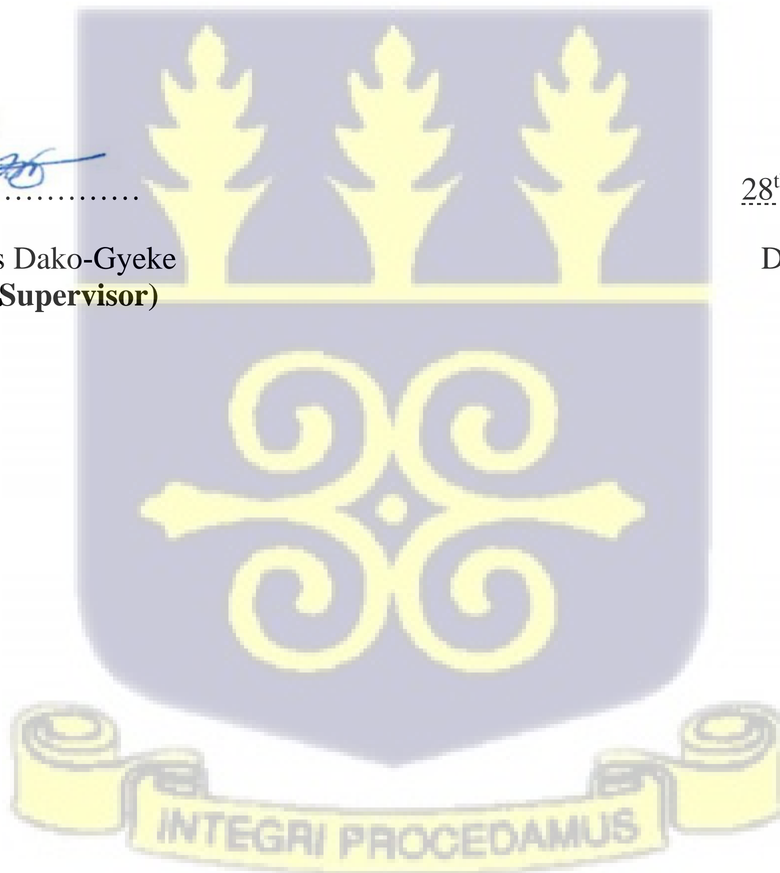

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ABSTRACT

Background: Because of the obstetric fistula, which is largely encountered by marginalized women living in rural and sometimes urban society, many women are currently living in humiliation and seclusion. As a result, the primary goal of this study was to investigate women's reintegration experiences following obstetric fistula treatment.

Methods: The current study employed a qualitative cross-sectional approach. In-depth interviews and focus group discussions were also used to analyse the reintegration of women with fistula repairs using the exploratory descriptive method. Purposive sampling was used to obtain a sample for this study. As a result, 19 people were used in the study. Fifteen (15) women with healed fistulas, three (3) staff members from the fistula centre, and one (1) doctor from Mercy Women's Hospital who was actively involved in the repair. The data were collected through an in-depth interview (IDI), which was directed by an interview guide with open-ended questions.

Results: The majority of the women reported psychological/emotional, social, economic, and marital instability issues, according to the data. In terms of post-fistula repair support, the study found that the majority of participants had help from their family and the government to deal with their problems. The data also revealed that the main services accessible for women after fistula repair were counselling, follow-up, and complication management of the patients' conditions.

Conclusion: According to the study, if the following obstacles are not addressed by providing social support and proper health-care services, women who have had an obstetric fistula repaired will have a difficult time reintegrating into their families and communities. Obstetric fistula, experience, repair, and reintegration are all phrases that come to mind while thinking about obstetric fistula.

Keywords: Obstetric fistula, experience, repair, reintegration

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LIST OF ABBREVIATIONS

CHAG	Christian Health Services Association of Ghana
GHS	Ghana Health Services
GMA	Ghana Medical Association
IDI	In-depth Interview
MoH	Ministry of Health
NMC	Nursing and Midwifery Council
OF	Obstetric Fistula
RVF	Recto-Vaginal Fistula
VVF	Vesicovaginal Fistula
WHO	World Health Organisation

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OPERATIONAL DEFINITIONS OF TERMS

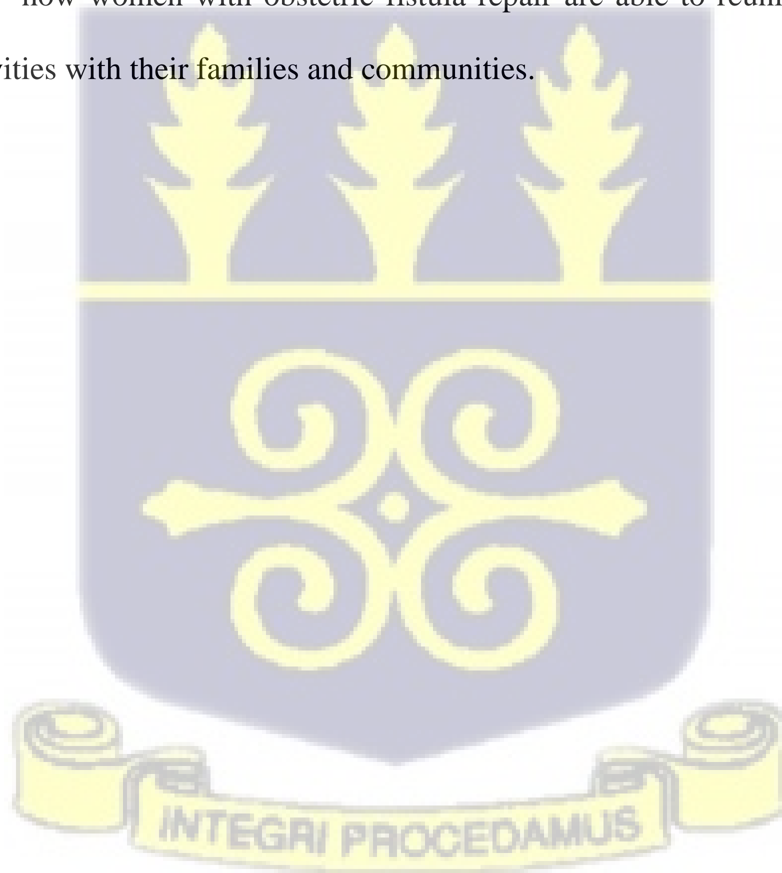
Obstetric fistula: condition in which a hole develops in the birth canal as a result of childbirth. This can be between the vagina and rectum, ureter, or bladder that results in incontinence of urine or faeces.

Experience: An instance of encountering issues associated with obstetric fistula

Psychological experience: A state of joy and ability to gain a sense of control in relation to fears, anxiety, emotions and death as one experiences obstetric fistula.

Social experience: The ability of the individual to enjoy the company of or relate to family, friends or significant others or to partake in leisure and social activities.

Reintegration: how women with obstetric fistula repair are able to reunite and undertake their usual activities with their families and communities.



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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the study

Thousands of women are currently living in shame and seclusion as a result of obstetric fistula, a condition that primarily affects marginalized women in rural and sometimes urban settings (United Nations Population Fund, 2012). According to statistics from 2012, between 50,000 and 10,000 cases of fistula are discovered each year, with the majority of cases occurring in developing countries. Limited access to emergency caesareans, dangerous traditional practices, insufficiently skilled attendants, poverty, insufficient health care systems, and hunger are all factors that contribute to obstetric fistula (United Nations Population Fund, 2012).

Obstetric fistula is defined as an abnormal cavity between a woman's genital tract and her rectum, according to the World Health Organization (2018). Obstructed labor is the main cause of this. Obstetric fistula can be avoided if health care is sought at the right time and treated with proven, cost-effective methods (Geneva Foundation for Medical Education and Research, 2015). Women are reintegrated into society after treatment to resume their usual lives.

Reintegration is defined by Atuhaire, Ojengbede, Mugisha, and Odukogbe (2018) as the acceptance of survivors of obstetric fistula back into their social networks following their traumatic experiences. This makes it easier for them to regain their psychological and emotional equilibrium. Nonetheless, the development of an obstetric fistula can have serious ramifications for women's lives. Wilson (2015) found this in a study on the psychological consequences of obstetric fistula in Tanzanian women. According to the findings, the ladies suffered from post-traumatic stress disorder and depression, which might last a lifetime. This

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was related to the women's high levels of avoidant coping. In addition, in a research conducted by Khisa and Nyamongo (2012) in West Pokot, Kenya, the experiences of women with obstetric fistula after corrective surgery were reviewed. In the study, eight women were interviewed. After obstetric fistula repair, women suffered emotional issues such as low self-worth, humiliation, and psychological trauma, according to the study's findings.

Nyakundi (2015) has performed research at the Kenyatta National Hospital in Nairobi on the dynamics of social reintegration of women after obstetric fistula repair. Twenty professionals and 36 survivors were polled for information. The study's findings revealed that after surgery, the participants sought health services from health facilities, including investigative services (radiography) to determine whether the surgery was successful, community follow-up services, and counseling on how to manage their wounds and what exercises to do to regain their general health.

A study on the reintegration of women after obstetric fistula repair was also undertaken by Jarvis, Richter, and Vallianatos (2017). Data was gathered through interviews with family caregivers of women with Obstetric Fistula. According to the findings of the study, the women were freed from home chores in order to recover adequately after surgery. In addition, several husbands took on home responsibilities to help their spouses.

According to the studies (Wilson, 2015; Khisa & Nyamongo, 2012; Nyankundi, 2015; & Jarvis et al., 2017), women have psychological and social issues as a result of the stigma and humiliation provoked by the behavior of family, friends, and community members during and after obstetric fistula. Thus, comprehensive rehabilitation extends beyond the physical medical care provided to women in hospitals; social, psychological, and social support services, as well as health care, play an important part in restoring the women's overall well-being. As a result, the goal of this study was to learn more about how obstetric fistula impacts women outside of the hospital and following therapy.

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1.2 Problem statement

Obstetric Fistula is almost never seen in developed countries. This suggests that in poor nations like Ghana, obstetric fistula mostly affects women. Every year, between 711 and 1352 cases of obstetric fistula are reported in Ghana, according to the Ghana Health Service (Ghana Health Service, 2015). However, because Ghana lacks a fistula estimating methodology, the numbers provided are not based on a well-known statistical model. Despite the enormity of the problem affecting Ghana, it is clear that sufficient measures have not been taken to address it on a long-term basis. As a result, more research is required to address the problem. Furthermore, the majority of the papers we looked at focused on the experiences of women who had obstetric fistulas (Kabayambi, Matovu, Barageine &Kashesya, 2014; Siddle, Mwambingu, Malinga, & Fiander, 2012; & Gebresilase, 2014).

As a result, this study draws on the perspectives of women who have undergone obstetric repair to provide a unique perspective on life after an obstetric fistula. A systematic review was utilized to assess the reintegration and rehabilitation of women in Sub-Saharan Africa who undergone obstetric fistula repair in a study undertaken by Lombard, St. Jorre, Geddes, Ayadi, and Grant (2015). Data was collected from seven databases and analysed using a thematic analysis. However, this method presents a broad overview of difficulties affecting women in Sub-Saharan Africa and distances itself from the culture-specific issues that affect Ghanaian women's reintegration and rehabilitation experiences. As a result, the goal of this research is to present a comprehensive view of the Ghanaian context. Furthermore, studies conducted in Ghana were difficult to come by the perspectives of women who had obstetric fistula repairs, their family caregivers, and health care practitioners who were involved in the participants' obstetric fistula care or reintegration following repairs. In order to acquire extensive information on primarily the women engaged in obstetric fistula repairs, this study used 15 women who had repairs and three staff members to conduct focus group

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conversations. Because the incidence of obstetric fistula in Ghana is extremely high, studies like the one being conducted now could help to reduce the occurrence of obstetric fistula and give knowledge for use in institutions and by the general public.

1.3 Research questions

1. What are the reintegration challenges women face after OF repair in the Central Region?
2. What are the support systems available for women after OF repair in the Central region?
3. What are the health services available for women after obstetric fistula repair in the Central?

1.4 Study objectives

1.4.1 Main Objective

The general objective of this study was to explore the reintegration experiences of women after Obstetric Fistula repair in Central Region.

1.4.2 Specific objectives

1. To explore the reintegration challenges women face after OF repair in Central region.
2. To identify the support systems available for women after OF repair in Central region.
3. To explore the health services available for women after OF repair in Central region.

1.5 Justification of the study

The reintegration of women after obstetric fistula treatment was explored in this study. Medical superintendents at various hospitals can use the findings to develop more comprehensive measures to easing women's incorporation into their communities. Institutions including the Ministry of Health (MoH), the Ghana Health Service (GHS), the Ghana Medical Association (GMA), and the Nursing and Midwifery Council (NMC) can use the findings to improve medical care and implement more aggressive measures like public health

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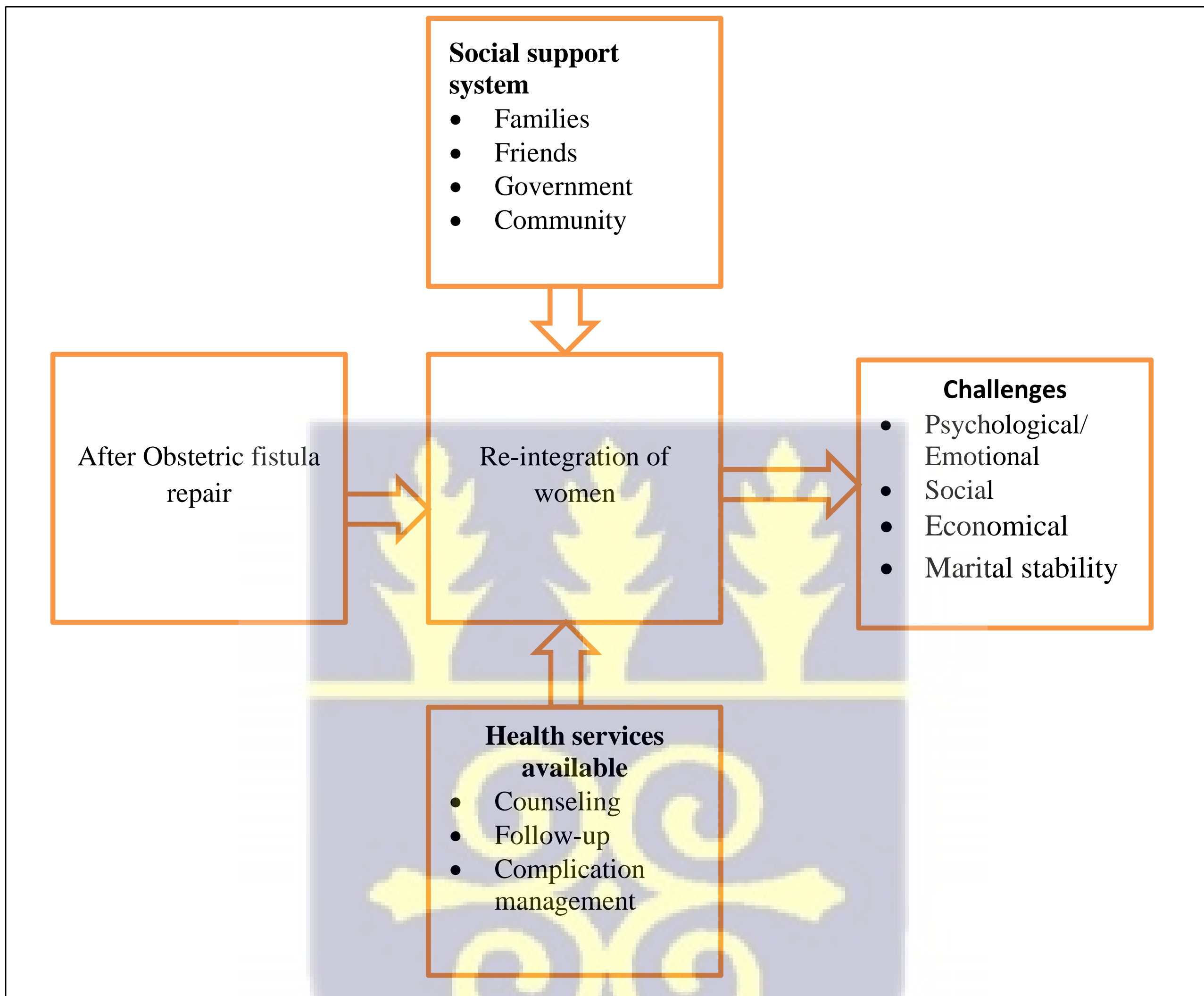
education to combat obstetric fistula. Students and other researchers can also use this research in their academic work and as a foundation for future research.

1.6 Conceptual framework



Adapted from Khisa et al., 2019

Figure 1.1: Conceptual framework on the reintegration experiences after obstetric fistula repair

INTEGRI PROCEDAMUS

Narrative of the conceptual framework

The framework above tries to describe the impact of numerous aspects as well as some of the obstacles involved with women's reintegration after obstetric fistula repair. Obstetric fistula is a common delivery complication that occurs when labor is prolonged and obstructed. Fistula

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brings with it a slew of difficulties, including physical, psychological, and social issues. Obstetric fistula repair appears to be the best option for women who want to start the process of reintegration and normalcy. By definition, reintegration is the process by which a woman with a persistent obstetric fistula returns to her usual life and activities in society. For most fistula patients after corrective surgery, reintegration is a process rather than an instantaneous event.

The process of recovering normalcy is fraught with difficulties, but it is supported by a number of helpful elements. As a result, women's reintegration is influenced by a variety of factors that interact and overlap to define the patient's reintegration outcome along a continuum of reintegration and recovering normalcy, which have been classified as social support and access to health resources.

Families, friends, the government, and the community are examples of social support components that may have a good impact on the reintegration process. Counseling sessions, follow-up care, patient insurance, and complication management are all health-care considerations that may influence the reintegration process. During the reintegration process, women who have had an obstetric fistula repaired may experience various difficulties. Psychological/emotional, social, economic, and marital instability are all possible challenges.

1.7 Organization of the Dissertation

The study contains six chapters: chapter one gives the background into what the study entails, stating what the problem was, further stating objectives for the research which culminated into asking pertinent research questions, justification and the conceptual framework, definition of terms as well as the organisation of the study.

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Chapter two dealt with the literature review on the reintegration experiences of women after obstetric Fistula repair which was retrieved from university repositories, health articles, journals, related books, internet and peer review reports.

Chapter three (3) the study methodology, this chapter focused on the research design, population of study, sample size, sampling technique for selecting the sample size, data source, instruments in data gathering and how the data were analysed. Chapter four of the study comprised analysis of the data. The chapter five (5) discussed the findings of this study. Chapter six dealt with the summary, conclusion and proffer recommendations regarding future studies in similar areas.

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CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The review of literature relevant to the topic is covered in this chapter. This includes elements such as a theoretical overview, an empirical review, and a conclusion that summarizes the entire chapter. The ideas and studies for this project came from internet books, articles, and journals.

2.2 Theoretical Review

Stress and coping in the context of obstetric fistula are often conceptualized using Lazarus and Folkman's transactional stress and coping theory (1984). "A unique relationship between the individual and the environment that is judged by the person as exhausting or exceeding his or her resources and harming his or her well-being" according to the definition of psychological stress by Lazarus and Folkman (1984: p. 19). Both stress reactions and coping efforts are determined by how a person evaluates conditions, according to Lazarus and Folkman (1984). Coping is described as "constantly shifting cognitive and behavioral efforts to manage specific external and/or internal demands that are evaluated as exhausting or beyond the person's resources" in this situational approach (Lazarus & Folkman, 1984: p. 141). It is vital to emphasize that the term 'coping' refers to any efforts to deal with a stressful encounter, regardless of their effectiveness, in order to determine which style of coping is useful for obstetric fistula patients' adjustment (Muthengi, 2018).

Nyankundi (2015) underlines the need of focusing on the specific risks that the patient is facing at the time rather than the sickness as a whole when investigating how patients cope with their condition. Specific stressors experienced by individuals with obstetric fistulas and after repair have been established in keeping with this logic. Survivors of obstetric fistula repair describe emotional anguish as a result of the condition's emotional impact, lifestyle

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changes, dealing with health specialists, spouse reactions, shifts in social roles, return to work, financial issues, and dependency (Salter et al., 2018).

Patients with obstetric fistula have described similar pressures (Sentia, 2016). The disease's interference with personal aspirations (Lopez & Whitehead, 2016) or drug side effects are additional pressures (Lombard et al., 2015). Patients face common stressors such as the death of a loved one or troubles with their children in addition to disease-related pressures (Jarvis et al., 2015). Because perceived stress has been linked to future adverse events and decreased long-term survival in patients with cardiac illness (e.g., Hulley et al., 2017), identifying dispositional coping styles and actual coping mechanisms that support successful adjustment is critical.

General Coping Theory**:** Richard Lazarus and his co-workers leading cognitive-behavioral stress and coping theories can be applied to work contexts as well. It is assumed that a scenario or occurrence is rated negatively as stressful in terms of danger, loss, or harm. Alternatively, the situation or incident could be viewed as a challenge that is neutral or positive. The extent to which something is at stake for the person is referred to as the primary appraisal. A quarrel with a co-worker, for example, may jeopardize an employee's self-esteem, but unemployment is likely to be viewed as a loss of status and income.

The term 'secondary appraisal' refers to the options available to a person in dealing with a problem. Personal attributes such as motivation and views about oneself and the world, as well as coping resources such as financial means, social and problem-solving abilities, personality features, and a pleasant work setting with social support from coworkers and superiors, all play a role (Jarvis et al., 2015). It's vital to remember that primary (demand) evaluation and secondary (resource) appraisal are two parts of the same cognitive process that happen at the same time rather than sequentially (Jarvis et al., 2015).

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In general, two types of coping are distinguished: (1) instrumental, problem-focused coping, which entails attempting to alleviate stress by altering the situation directly, and (2) palliative, emotion-focused coping, which is attempting to manage emotional responses to a stressful situation (Helmenstine, 2018).

Following the completion of the coping attempt, the first stressful incident is'reappraise' along the same lines as the primary appraisal. It's possible that the disagreement with one's coworker has been resolved, or that one has found a new position. In that situation, the reappraisal is positive, and no additional coping attempts are required. However, coping attempts continue if initial coping efforts fail and the situation is reclassified as stressful (Kabayambi et al, 2014).

2.3 Definition of obstetric fistula and repair

Obstetric fistula is most commonly caused by prolonged obstructed labor, which develops as a result of feto-maternal disproportion after delivery, according to Ridder, Badlani, Browning, Singh, Sombie, and Wall (2008). When a part of the baby gets wedged into the pelvis, abnormal communication between the rectum and/or bladder (rectovaginal fistula) and the vagina (vesicovaginal fistula) develops. The blood supply to the tissue is obstructed, and the tissue dies and is shed off, resulting in the fistula. A fistula can also form if a woman has a difficult caesarean section, has a laparotomy, or has forceps administered to her. Rape, sexual abuse, accidents, and other traditional cutting procedures can also result in an obstetric fistula.

Obstetric vesicovaginal fistulae (VVFs) are ischemic necrosis of soft tissue caused by prolonged pressure of the baby's head against the mother's pubic bone, according to the Global Library of Women's Medicine (n.d.). The severity of the harm caused during labor is determined by the length of the labor and the mother's ability to withstand it. However, in many cases, the infant is unable to survive the extended labor, resulting in the mother's

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delivery of a stillborn kid. The most effective way to treat an obstetric fistula is to repair it surgically. In certain circumstances, women are unaware of the availability of treatment or are unable to afford it. As a result, many turn to traditional medicine and healers for help. Despite the fact that obstetric fistula may be repaired, the developing world lacks the necessary technology, personnel, medications, and supplies to care for women with fistula (Women's Dignity Project & Engender-Health, 2006). Despite the low numbers, some women are able to receive health care and have their bodies repaired.

Obstetric fistula repair, according to Debas, Donkor, Gawande, Jamison, Kruk, and Mock (2015), refers to the closure of fistulas using abdominal, vaginal, or combination techniques depending on the location of the fistula. Hancock and Browning (2009) also state that the principle of protecting the ureter, ensuring adequate exposure, detaching the bladder from the vagina around the obstetric fistula, collecting enough bladder after eliminating the scar to facilitate tension-free closure of the defect, and supporting the urethra when deficient are all involved in the repair of obstetric fistulas.

Surgery to repair an obstetric fistula has a reputation for being a difficult procedure in some circumstances, while being quite simple in others. Over 90% of obstetric fistulas, according to highly competent surgeons, can be closed. This percentage, however, includes women who have had a second or third operation. Furthermore, the closure of the fistula does not guarantee that all women who have undergone surgery will be completely dry (Hancock & Browning, 2009).

INTEGRI PROCEDAMUS

2.4 Obstetric Fistula as a Global Burden

Obstetric Fistula (OF) is an irregular opening between a woman's vaginal and bladder, as well as her rectum, through which urine and/or feces stream continuously (WHO, 2016). According to the WHO (2016), over 300 million women worldwide are currently

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experiencing short or long-term issues as a result of pregnancy or childbirth, with roughly 20 million new instances occurring each year. According to the World Health Report (2016), half a million young women die each year as a result of these issues, the majority of whom live in underdeveloped nations.

Obstructed and/or extended labor, as well as poor health-seeking behaviors, inadequate health referral networks, a lack of awareness, bad transportation systems, a shortage of skilled birth attendants, and insufficient obstetric care services, are all contributing factors (GHS, 2015). As a result, those who survive these difficulties are at risk of developing OF. In Asia and Sub-Saharan Africa, more than 2 million young women live with untreated OF, and between 50,000 and 100,000 women worldwide develop obstetric fistula each year (UNFPA, 2016). Over 85 percent of OF cases in underdeveloped nations, according to Waaldijk (2017); Hassan and Ekele (2019), are caused by long obstructed labor. The persistence of obstetric fistula in low-resource settings, according to the WHO (2016), is one of the most visible markers of the vast gap in maternal health care between the industrialized and developing worlds. Ghana is not free from the burden of the OF.

2.5 Obstetric Fistula in Ghana

Between 2011 and 2014, a total of 1,538 patients with vesico-vaginal fistula (VVF) sought treatment in Ghana, with the Northern Region recording the largest number of OF patients (40.1%) (GHS, 2015). Furthermore, according to the GHS Report (2015), each year in Ghana, between 711 and 1,352 new cases of OF emerge. People with the condition are socially isolated, making it difficult to identify them. According to Okoyei et al. (2014), some people believe this is a sexually transmitted disease and/or a divine punishment. OF, which encompasses both vesico-vaginal fistula (VVF) and recto-vaginal fistula (RVF), has been identified as a major but mostly overlooked condition in the field of reproductive health

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(GHS, 2015). The OF is expected to continue as a public health issue in the future, despite the fact that it is preventable (Kalembo & Zgambo, 2016).

2.6 Challenges faced by women living with Obstetric Fistula

Obstetric fistula (OF) is a disorder that occurs when the baby's head is unable to pass through the woman's pelvis due to prolonged obstructed labor. This produces a gap between the bladder and the vaginal entrance, or between the rectum and the vaginal opening. The woman will ooze either feces or urine as a result of this. OF is an issue that affects women of reproductive age all around the world, but especially in developing countries. Over 85 percent of OF cases in underdeveloped nations are caused by protracted obstructed labor (Waaldijk, 2017; Hassan & Ekele, 2019). This could lead to a slew of problems, including the following:

2.6.1 Reintegration challenges faced by women after obstetric fistula repair

Reintegration, according to Salter et al. (2018), can be a significant issue. This refers to a patient's ability to return to a satisfying lifestyle, including home and social activities, in order to achieve a higher quality of life. This includes things like family support, family functioning, sexuality, leisure activity participation, and the capacity to return to work. Low emotional state, insufficient accessibility to community members, and a lack of support from friends and family are all barriers to reintegration. As a result, patients are educated on the difficulties of reintegration in order to help them prepare for and manage the situations they will face after therapy.

Reintegration is defined by Abrams et al. (2010) as the appropriate interventions that help women who have had an obstetric fistula overcome psychological, social, physical, and economic barriers so that they can return to their social networks and communities. The goal of social integration is to break the loop in which a woman's mental and socioeconomic problems are inexorably linked to her physical health. When there is obvious leaking, the

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reintegration process should begin, involving everyone involved in the woman's care. Patients with obstetric fistulas are treated with reintegration and rehabilitation at the same time to help them heal.

Obstetric fistula (OF) is a disorder that occurs when the baby's head is unable to pass through the woman's pelvis due to prolonged obstructed labor. This produces a gap between the bladder and the vaginal entrance, or between the rectum and the vaginal opening. The woman will ooze either feces or urine as a result of this. OF is an issue that affects women of reproductive age all around the world, but especially in developing countries. Over 85 percent of OF cases in underdeveloped nations are caused by protracted obstructed labor (Waaldijk, 2017; Hassan & Ekele, 2019).

2.6.2 The emotional/psychological challenges women face after obstetric fistula repair

Belayihun and Azwihangwisi (2019) conducted a longitudinal study to assess how women's emotions changed after obstetric fistula repairs. Two hundred and nineteen women were chosen and given structured questions to complete. The information was entered into Epi-Data and then uploaded to the Statistical Package for Social Sciences for analysis. Despite having undergone surgery, several women still experienced depression and anxiety, according to the findings of the study. Women who had chronic leaking even after repairs were done were blamed for this.

Emasu et al. (2019) conducted a study in Uganda to look into the reintegration needs of young women who had genitourinary fistula surgery. The participants in the study ranged in age from 14 to 24. The investigation was conducted utilizing semi-structured questions administered by an interviewer. The study's findings revealed that physical capabilities, concerns about future fertility, partner fidelity, and money all contributed to emotional obstacles by increasing participants' anxiety and despair. There was also some insecurity and fear about their future, as well as a reluctance to try to mend their intimate relationships.

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The research (Belayihun & Azwihangwisi, 2019; & Emasu et al., 2019) looked into the emotional issues that women face following obstetric fistula repairs. Despite the fact that the women's sadness and anxiety levels had fallen dramatically, the research revealed that they still experienced depression and anxiety. In addition, some women have been reported to be unwilling to re-establish their intimate relationships while harboring fears and concerns about their future. Both investigations were completed during the last few years and used sufficient sample sizes. As a result, their findings are applicable to a wide range of women with obstetric fistula.

The psychological and sensitive position of women with obstetric fistula repair and those who lament the death of their baby was studied by Ahmed and Holtz (2017) and Blum (2016), who discovered that these women go through the hardship of having to fight for their individual existence. This results in decreased community participation as well as low self-esteem. According to the same authors, around 85 percent of the women who got fistula lost their foetus as a result of the delivery that caused the fistula.

In Nigeria, for example, 33% of OF women who had fistula repair were isolated from their partners, and 51% were unhappy with their lives (Ahmed & Holtz, 2017). The majority of women suffer from low self-esteem and are easily agitated, apprehensive, and angry. These put them through a psychological struggle that is almost always overpowering (Cook et al, 2014). Because of their abandonment by their spouses, families, and communities, these women frequently become socially invisible.

Women who have undergone OF repair have no choice but to cope with their circumstance (Kabayambi et al., 2004). (2014). These coping tactics include just eating and drinking when necessary, washing on a regular basis, using perfume and powder, using calamine lotion to

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sores around the genitals and thighs, and utilizing old shreds of fabric as pads (Ghana Health Service, 2015). These circumstances have an impact on their daily lives.

According to the Ghana Health Service Report (2015), greater incidence of fistula is caused not only by poverty, but also by the impact of specific cultural traditions on women's status, health, and welfare in many developing countries. Giving women a lot of water to drink during labor is one of the harmful cultural practices prevalent in some cultures that put these ladies in psychological danger.

According to Cook et al, (2014), a full bladder has a higher risk of causing a fistula during the baby's eviction. Because accessible care may not be culturally acceptable in some societies, labor may be overly protracted at times. Certain societies, for example, would not allow a male health worker to provide care to a pregnant woman in labor (Cook et al, 2014).

2.6.3 The social challenges that confront women after obstetric fistula repair

Drew, Wilkinson, Nundwe, Moyo, Mataya, Mwale, and Tang (2016) conducted a study in Lilongwe, Malawi, to evaluate the long-term results for women following obstetric fistula repair. Twenty people were chosen for in-depth interviews as part of the study. Content analysis was used to code and analyze the interviews. The findings of the study revealed that the majority of women (85 percent) had trouble conceiving after surgery, which upset their community members. In addition, when it was discovered that their uterus had been removed, leaving them unable to produce children, some respondents were abandoned by their husbands.

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Muthengi (2018) investigated the success of the integration technique among obstetric fistula survivors in Kisii County. Twenty-two women were purposefully sampled in the Kisii Teaching and Referral Hospital in Kisii County for the study. Data was gathered through in-

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depth interviews, key informant interviews, case narratives, and secondary sources, and processed using content and thematic analysis, as well as Nvivo data analysis software.

The survivors were socially isolated from the community and family members, according to the study's findings. Furthermore, it was discovered that the majority of the women had lost their social links in the community as a result of the fistula, making it difficult for them to reintegrate into society. In addition, some members of their community believed they had not been healed as they claimed. As a result, they were labelled as misfits and witches, which lingered even after the repairs.

The research mentioned (Drew et al., 2016; & Muthengi, 2018) looked on the social issues that women faced following obstetric fistula repairs. According to the findings of the study, some of the women were upset by their community members because they were unable to conceive following fistula repairs and were abandoned by their spouses in cases where their uterus had been removed. Furthermore, the majority of women had severed social links with their neighbors and found it difficult to rebuild relationships, while others were still labeled as misfits or witches.

2.6.4 Economic Challenges

Obstetric fistula repair imposes huge financial costs on victims and their families, in addition to the mental suffering it causes. According to Kazaura et al, women living with OF repair are difficult to discover due to a lack of funds or a draining of limited resources, a lack of family support, and a great distance to health facilities (2019). Due to the vexing challenges associated with faecal or urine incontinence, delaying OF repair may also expose patients to a lowered social, mental, medical, and emotional status.

This could lead to social retreat or marginalization, as well as poverty (Murray et al, 2016). It has been reported that marriages have broken down as a result of having OF or repair

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(Kabayambi et al., 2014). Furthermore, the loss of children, isolation, and a lack of productive job are all significant issues that add to the stress level of afflicted women and may lead to identity loss (Mselle et al, 2017). Families, in addition to the particular women, may face stigma as a result of the lady's OF status, even after she has been repaired. This is referred to as caregiver stigma (Kabayambi et al, 2014; Jarvis et al, 2017).

2.6.5 Marital instability

Women's experiences were frequently recounted shortly after surgery, and they frequently underlined the negative marital aspects of reintegration. Women, for example, stated that despite being cured of their ailment, they were not allowed to cook or serve guests in their homes since the condition was seen to be filthy, sinful, and spreadable through food preparation (Khisa & Nyamongo, 2018). Furthermore, the desire to avoid past traumas of shame and prejudice was frequently perceived as a barrier to women reintegrating into their communities (Gebresilase, 2014; Khisa & Nyamongo, 2018).

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Husbands' assistance is critical in assisting women in reintegrating back into their lives prior to the onset of OF (Donnelly et al., 2016). This is especially true in Ghana, where family is a basic and highly cherished institution, and the

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extended family serves as a support network that is both accountable for and compelled to help one another (Tettey, Puplampu, & Berman, 2017). It's crucial to understand how a woman's return following OF repair affects her marriage because the marriage can have an impact on her health, welfare, and effective reintegration (Bowen, 2016).

Understanding a husband's perspective and the level of assistance he can provide is especially crucial because Ghanaian men traditionally play a vital role in health and health care decision-making (Ganle & Dery, 2015). Few research has looked into family caregivers' experiences and how they manage the reintegration process (Pope, Bangser, & Requejo, 2017; Yeakey et al., 2016).

2.7 The social support systems available for women after OF repair

Pope, Bangser, and Requejo (2010) conducted research to determine the difficulties and enabling factors that women faced during their reintegration into society following obstetric fistula repairs. In Tanzania's Mwanza region, seventy-one women were questioned. According to the findings of the study, the majority of the women were able to resume their typical economic and social activities prior to the emergence of fistula. This occurred,

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however, after a period of time. In addition, the women's relatives were found to be supportive of their recovery and use of the healthcare centers for postoperative treatment.

In a study conducted by Dennis et al. (2016), the experiences of social support among women who underwent obstetric fistula repair surgery in Tanzania were studied. In-depth interviews and cross-sectional surveys were analyzed using a mixed-methods approach.

The findings revealed that the women's spouses aided their recovery following surgery by assisting them in sticking to their medical regimen. Supportive spouses were also shown to be willing to compromise their short-term sexual desire in order to help their partner heal. Women received tangible, financial, and emotional assistance from other members of their family, including siblings, children, and parents after OF repair.

The cited studies (Pope et al., 2010; Dennis et al., 2016) looked into the social support systems available to women following fistula repair. The study's findings revealed that the women's spouses and family members provide financial, emotional, and tangible assistance. In addition, the women's relatives were found to be supportive of their rehabilitation and attendance at postoperative health care programs. The study used a mixed-method strategy to collect data from women and their families, which is noteworthy. In comparison, this study collects data from women and health practitioners involved in their care using just the qualitative method.

This study is part of a wider critical case study that examines reintegration experiences. To this purpose, the findings relating to the experience of women undergoing OF repair in Central Ghana are highlighted. Testimony on the roles and responsibilities of mothers can educate decision-makers, opinion leaders, health-care providers, and the general public about the critical role that family members play in assisting women in reintegrating back into their homes following OF repair.

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2.8 The health services available for women after obstetric fistula repair

Ayadi et al. (2018) evaluated rehabilitation and reintegration programming as an adjuvant to fistula surgery in a study. The study followed the standards for systematic reviews and meta-analyses. The search was conducted using nine databases from the public health, social science, and biomedical sectors. The findings of the study revealed that women who had obstetric fistula repairs had access to services such as counseling, physical therapy, follow-up, and skills training.

Degge, Hayter, and Laurenson (2018) investigated the integrated evaluation of women with obstetric fistula and other treatment experiences in a study. Searches were conducted using databases such as CINHAL, Psych INFO, MEDLINE, and Academic Search Premier. A qualitative study of 21 women was conducted. Women were also given post-repair rehabilitation counseling, literacy training, seed grants, and health education in their communities, according to the findings.

The studies (Ayadi et al., 2018; & Degge et al., 2018) were carried out to evaluate the health services offered to women following obstetric fistula repair. Following fistula treatment, women were offered counseling, physical therapy, skills training, seed grants, and literacy programs, according to the findings. Nonetheless, these findings were derived from secondary sources, lowering their applicability and dependability for the study.

According to Ahmed and Holtz (2007), 80% of women who acquire fistulas get chronic skin problems as a result of urine irritation. According to Okoye et al. (2014), OF repair women may experience amenorrhea, vaginal stenosis, childlessness, bladder calculi, infection, and foot-drop as a result of neurological impairments, but they lack the resources to address these issues. Because of their constant urine incontinence and scratching, these ladies develop sores and ulcers on their thighs.

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Furthermore, according to Kabayambi et al. (2014), the women and their caregivers highlighted provider harm and neglect as reasons of several of the medical care issues. The link between OF and medical injury is true (Wall, 2006). Despite the involvement of health personnel, the most common cause of OF is obstructed labor and labor delay (Keri et al, 2010; WHO, 2012). These findings demonstrate the need for increased community awareness of the causes and prevention, as well as assistance for women undergoing OF repair and other labor-related problems.

However, the fundamental cause could be an inadequate health-care system (Murk, 2009). Shyness and financial difficulties were listed as the main reasons why women with fistula hesitate to seek medical assistance, according to the Ghana Health Service Report (2015). To avoid embarrassment and discrimination against their family, OF women may not be able to obtain medical care from their in-laws. Some in-laws thought OF was a disease that should be kept hidden (Ghana Health Service, 2015).

2.9 Conclusion

The goal of this study was to assess women's integrating experiences following obstetric fistula repair. Debas et al. (2015) define obstetric fistula repair as the closure of fistulas via vaginal, abdominal, or combination techniques. Women are reintegrated into their communities after renovations are completed. Reintegration refers to the interventions that help survivors of obstetric fistula overcome social, physical, psychological, and economic barriers so they can return to their social relationships and communities (Abrams et al., 2010).

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Depression and anxiety are two mental issues that women suffer after fistula treatment (Belayihun et al., 2019). Women's social issues include being abandoned by their husbands and being pressured by their community to have children (Drew et al., 2016). Furthermore,

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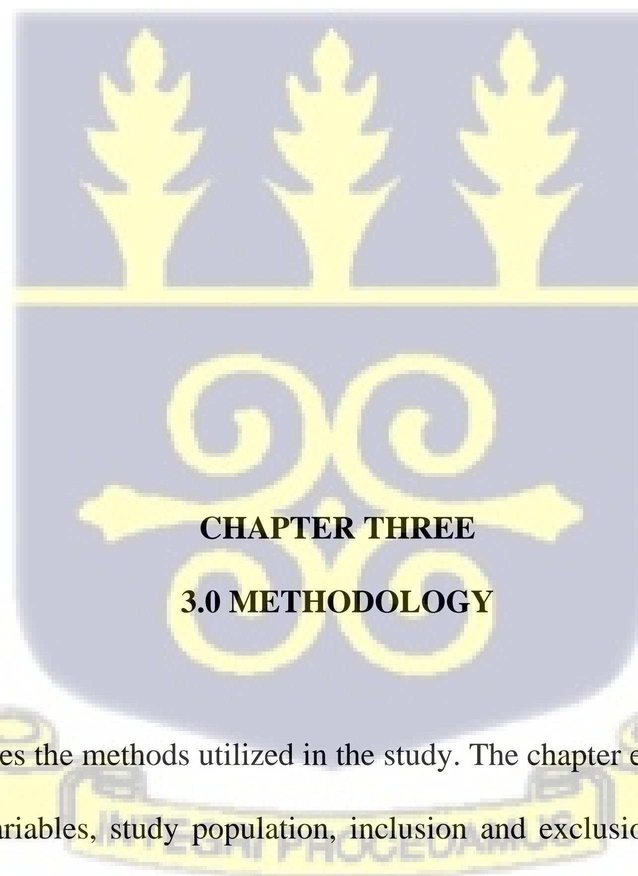
according to Pope et al., (2010), the women's families and communities provided as social support systems for them and assisted them in their recovery. Counselling, skills training, and physical rehabilitation were among the health interventions accessible to women after obstetric repair, according to Ayadi et al. (2008). The next chapters go through numerous topics that are important to this research.



CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter addresses the methods utilized in the study. The chapter entails the study design, study area, study variables, study population, inclusion and exclusion criteria, sample size and sampling techniques, data collection tools, data collection methods, quality control, data analysis procedure, ethical considerations, data storage and management

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3.2 Study design

A qualitative cross-sectional study was used for this study. Also, the exploratory descriptive design was applied through the use of in-depth interviews and focus group discussion to assess the reintegration of women with after fistula repairs. According to Sentia (2016), a cross-sectional study refers to a type of observational study that is applied at the same time among participants to determine exposures and outcomes. Also, data are gathered for the cross-sectional study using qualitative methods such as unstructured interviews. The cross-sectional approach provides data on the current occurrences in a specific population and does not seek to manipulate variables (Cherry, 2019). Hence, the utilization of a qualitative cross-sectional design will allow the researcher to gather data on women who have been reintegrated into society after obstetric fistula repairs without any interference.

3.3 Study Area

The Ghana Maternal Health Survey asserts that 0.9 % of women in Ghana suffer from fistula (Ghana Statistical Service, 2018). The study used Mankessim within the Mfantseman Municipal Area, Central Region as the location for the study. As recorded in the 2010 population housing census, the Mfantseman Municipality records 144,332 inhabitants, with 45 per cent being males and 55 per cent being females. Mankessim registers the highest number of people among other communities, recording 5,048 inhabitants (Ghana Statistical Service, 2014). Thus, Mankessim served as a suitable location to gather data for the study. This enabled the researcher to gather information from the fistula repair centre in Mercy Women's Catholic Hospital located in Mankessim, Central Region and the patients who had used this centre for their repairs.

Mercy Women's Hospital was utilized since it is the main fistula treatment centre in the Central Region (Diallo, 2019). The Catholic Archdiocese of Cape Coast established Mercy Women's Catholic Hospital in Mankessim in 2003 to primarily repair clients who have

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developed Obstetric Fistula condition as a result of child birth and to provide effective maternal health to curb the increasing levels of maternal mortality. Mercy Women's Hospital started full operations in 2010. In 2012, the hospital was upgraded into a primary hospital status providing other services like the Diagnostic services, Eye clinic, Accident and Emergency services as well as other special services like Physiotherapy with an approximated total bed capacity of 150. Since its inception, the focus of the hospital has been on obstetric fistula and maternal & child and general hospital services.

The hospital is run under the National Catholic Health Service, Ghana (NCHS) and registered with the Health Facility and Regulatory Agency (HEFRA), Accra and a member of the Christian Health Services Association of Ghana (CHAG), under the Ministry of Health of Ghana. The hospital also serves as the referral centre for most of the hospitals and clinics dotted in and around Mankessim. Currently, Mercy Women's hospital has a total staff strength of two hundred and thirty nine (239) with four (4) doctors, two (2) of whom are Specialists. There are one hundred and twenty-eight (128) nursing staff, and twenty (20) midwives (Ghana Health Service, 2015).

The Fistula unit has a forty – five bed capacity ward with a spacious Out Patients Department (OPD), a laboratory, consulting, examination rooms and pharmacy. The Fistula unit receives team of specialists from Korle Bu Teaching Hospital, Accra and occasionally from Komfo Anokye Teaching Hospital, Kumasi every quarter in a year for repairs. The unit's theatre has a two bed operating tables, recovery and changing rooms for both males and females. There is a complete patient's relatives' hostel which serves as an accommodation facility and a pre – admission facility for patients affected with fistula at the unit. Between 2011 and 2014, One hundred and ninety women were recorded to have had their obstetric fistula repaired in the Central Region. This represents 17.7 per cent of the national population and makes it the third-highest rate in the country (Ghana Health Service, 2015).

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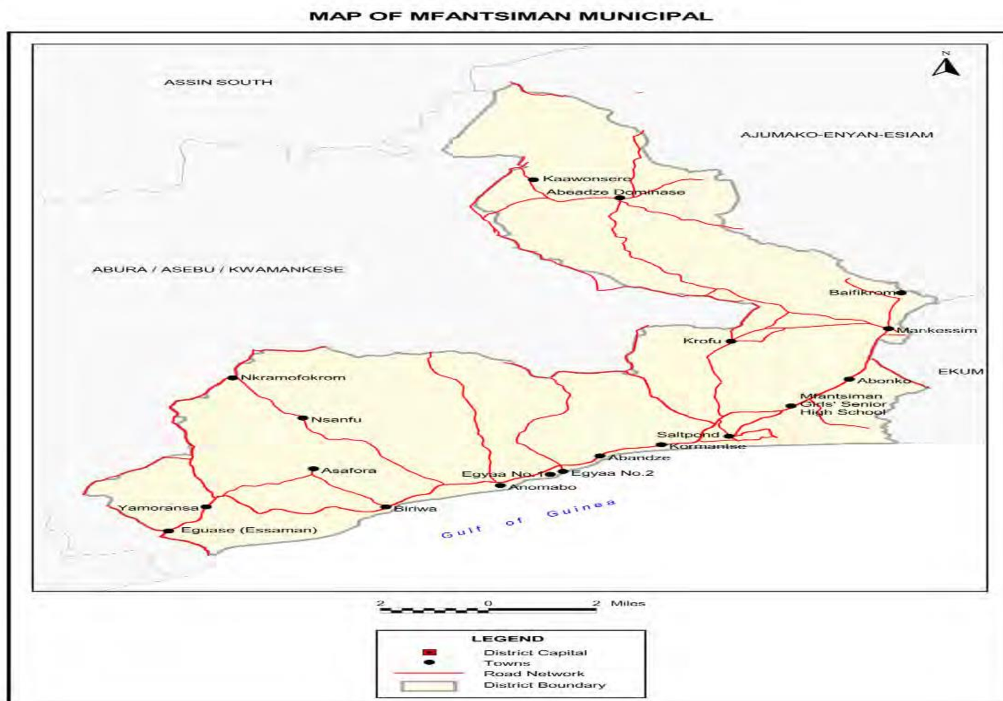

Figure 2: Source: Ghana Statistical Service, (2014)

3.4 Themes explored

Themes are features of participant's accounts characterising particular perceptions or experiences that the researcher sees as relevant to the research question. Coding is the process of identifying themes in accounts and attaching labels or codes to index or number them. In order to bring to light the reintegration experiences of women after fistula repair, the following five themes were generated and explored. The first theme explored the emotional and psychological experiences of the women after the repair. The next theme also explored the social ordeals that the mothers encountered even after the repair. The third theme explored the social support systems available for the women during the reintegration process. The fourth theme also unravelled the health support systems and services available for the women during and after the repair and the final theme also explored the financial cost incurred by the women in the process of seeking health.

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3.5 Study Population

According to Hanlon and Larget (2011), a population refers to the entirety of units and individuals who are of interest to a study. Therefore, this study utilized women who have had obstetric fistula repairs in the Mercy Women's Catholic Hospital located in Mankessim with the following inclusion and exclusion criteria:

3.6 Inclusion and exclusion criteria

As stated by Hulley, Cummings, Browner, Grady and Newmann (2007), the inclusion criteria refer to primary features of the target population that are relevant to the research question. Also, the exclusion criteria refer to the characteristics of identified subsets of the populations that can meet the inclusion criteria of the study, yet exhibit features that affect the realization of the objectives of the study.

Thus, the inclusion criteria comprised of females:

i. Who had fistula repair at the Mercy Women's Hospital 6 months ago and beyond
ii. Aged between 15 and 49 years
iii. Reside in the Central Region
iv. Willing to partake in the interview and be recorded
v. Accessible to be contacted through a functioning number

Also, the exclusion criteria entailed:

i. Women who have had surgery in less than 6 months
ii. Women who are 50 years or older
iii. Women who do not live in the Central Region
iv. Those who are not mentally sound
v. Those who had their fistula repair done in centres apart from the Mercy Women's Hospital

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3.7 Sample size

The number of research participants who were utilized was determined by the saturation point following an appropriate number of participants and data collected. As reported by Faulkner and Trotter (2017), saturation refers to the stage when new information cannot be obtained in data analysis of research, thereby creating redundancy that suggests that data collection may end. Therefore, a sample size of 19 was utilized. Sixteen (16) women who have had obstetric fistula repair and three (3) staff at the Fistula unit at the Mercy women's Hospital were interviewed using the In-depth interview (IDI).

3.8 Sampling techniques

This study used purposive sampling technique to obtain participants for the study. Purposive sampling refers to a strategy that is used to choose research participants using specified characteristics that are essential to the research question. This occurs when participants have the required experience or knowledge needed for the study (Lopez, Whitehead, 2013). In this study, information on the records of women who have had the obstetric fistula repair was taken and the inclusion and exclusion criteria were applied. Those mothers who had contacts were called on phone and those willing to partake in the research were chosen after an in-depth explanation had been given.

3.9 Data collection tools

According to Boyce and Neale (2006), in-depth interview is defined by the use of research techniques that involve the research carrying out thorough interviews with a small number of participants to investigate their views on a specific programme, situation or idea. Thus, the study was conducted using focus group discussions and in-depth interviews. The processes were guided by interview guide in the study. The interview guide contains questions or topics that are intended to be investigated during the course of the interview (Boyce & Neale, 2006). Open-ended questions were utilized in a semi-structured interview guide prepared for the

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study. The interview guide was partitioned in two sections, namely; Section A and B. Section A entailed questions that collected socio-demographic information of the participants whilst Section B comprised questions that addressed the research objectives.

3.10 Data collection methods

Firstly, letters were sent to the management of Mercy Women's Hospital. When permission was granted, informed consent was obtained from all selected participants. Additionally, interviews were conducted by the researcher within 20 minutes per session over a period of 21 days. The interview was recorded to help in appropriate transcription.

3.11 Quality control

Lavrakas (2008) states that quality control refers to the process and efforts that researchers implement to ensure the accuracy and quality of data being collected for a specific study. This enables the researcher to monitor suitable interviewer behaviour, sample management systems and other quality-control factors of the research process that influence the quality of data. Thus, pilot study was conducted to enhance the quality of data of the study. According to Bloor and Wood (2006), Piloting is the fulfilment of preliminary research before the main study is conducted. This allows the researcher to modify research tools, timing, research design and other central factors.

3.12 Pretesting

At the Mankessim Government Hospital in Central Region, pre-testing of the research data collection instruments took place. The pre-test facility was situated outside the study area, but in terms of personnel, facilities given to clients and the configuration of the wards, it had similar characteristics. The pre-testing helped classify certain difficulties that were linked to the understanding of the respondents. The researcher pre-tested the interview on three (3) health workers and three (3) patients for reliability of the instruments.

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3.13 Data analysis procedure

Data were analysed using content and thematic analysis. Interview recordings were transcribed verbatim. The transcribed work was read several times to identify key concepts. Codes were developed for identified key concepts which were then grouped into themes. Data were analysed according to the themes that emerged. Tape recorders were used for recording the conversation between researcher and the participants. All the questions were fully attended to but when participants were not comfortable answering a question it was skipped to the next one. Where the participants did not fully understand a question, the researcher repeated the same question to ensure proper grasp of what the question was all about. The audio-tapes were listened to over and again and transcribed verbatim. Thematic Content Analysis (TCA) was employed for analysing the data. Thematic Content Analysis (TCA) is a descriptive presentation of qualitative data (Anderson, 2017). This method involves looking across all the data to identify the main themes that summarize all the views you have collected (Anderson, 2017).

3.14 Ethical considerations

Authorization was acquired from the Ghana Health Service Ethics Review Committee. Following this, an introductory letter from the Department of Social and Behavioural Sciences (SOBS) of the School of Public Health (SPH) was submitted to the Central Region Health Directorate to facilitate preliminary interactions with the medical superintendent and other essential hospital authorities to obtain permission before commencing the study. Participants were assured of anonymity and confidentiality throughout the study as stipulated in the informed consents presented to them.

Additionally, the participants were guaranteed their safety and with no likelihood of posing harm to well-being. Nonetheless, the benefits of the study were explained and its relation to other women in similar circumstances. Furthermore, study participants were adequately

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informed about the research and their entitlement to withdraw from the study at any stage of the study when any form of distress was observed.

3.15 Data storage and management

The tape recorder utilized was checked to ensure its functioning during the course of the interviews. Furthermore, notes were taken to record essential portions of the interviews and important observations perceived in the sessions. All participants were provided identification numbers starting from 01 to 17. The transcripts of the study were saved on an external drive to avert data loss. The tape recorder, audio recordings and back up data were deposited in a safe that can only be accessed by the researcher and supervisor. Data were destroyed after five years of collection when no longer required.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the qualitative data which were collected using in-depth interviews on nineteen (19) participants. Sixteen (16) women who have had obstetric fistula repair and three (3) staff at the Fistula unit at the Mercy women's Hospital. The interviews centred primarily on obstetric fistula repair of patients. The first section of the results presents the background characteristics of the participants. The subsequent results are presented according to the stated objectives of this study. Major themes that emerged in this section include emotional and psychological experiences of patients, social experiences/support and

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health service available Overall, three (3) main themes and eleven (11) subthemes emerged. The academic supervisor for this study served as a co-coder. The presentations of the results are supported by verbatim quotes of the respondents' responses using pseudonyms (Refer Table 4.1 for themes and subthemes of the study).

Table 4.1: Major and subthemes from the data

Main themes	Subthemes
1. Reintegration challenges	Psychological/emotional Social Economical Marital instability
2. Social support	Family Government Community
3. Health service available	Counselled after repair Follow-up services Complication management

4.2 Background characteristics

From table 4.2, the study used nineteen (19) participants. Most of the participants were within the age range of 34-49years. Also, most of the participants were married. Most of them had SHS their highest educational. Again, more than half of the participants were traders and delivered their last babies at the health facilities.

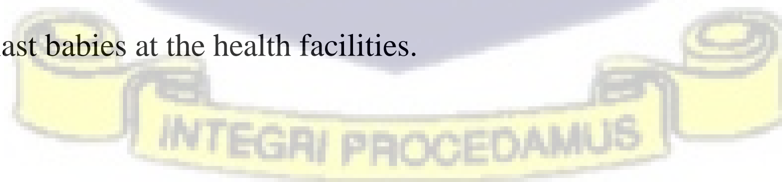

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Table 4.2: Demographic characteristics of the participants

Pseudonym	Age	Edu Level	Marital status	Occupation	No of children	Religion	Place of last delivery
P1	34	SHS	Married	Nurse	3	Christian	Health facility
P2	33	No education	Married	Nurse	2	Muslim	Home
P3	35	SHS	Married	Nurse	3	Muslim	Home
P4	37	SHS	Married	Unemployed	4	Muslim	Home
P5	49	Primary	Married	Unemployed	3	Muslim	Health facility
P6	49	Primary	Married	Trading	4	Muslim	Health facility
P7	45	Tertiary	Married	Unemployed	3	Christian	Health facility
P8	34	SHS	Married	Trading	2	Christian	Health facility
P9	33	SHS	Married	Trading	1	Christian	Health facility
P10	31	Primary	Single	Unemployed	1	Christian	Health facility
P11	43	SHS	Married	Artisan	4	Christian	Health facility
P12	45	SHS	Married	Trading	3	Christian	Health facility
P13	41	Tertiary	Married	Trading	4	Christian	Health facility
P14	39	SHS	Married	Trading	3	Christian	Health facility
P15	37	SHS	Single	Trading	2	Christian	Home
P16	42	SHS	Divorced	Unemployed	4	Christian	Health facility
P17	38	Primary	Married	Trading	3	Christian	Health facility
P18	35	No education	Married	Trading	1	Christian	Health facility
P19	39	No education	Married	Trading	3	Christian	Health facility

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4.3 Challenges faced by women during reintegration

This theme presents the findings on the challenges faced by women during the integration after obstetric fistula repair. The challenges included emotional/psychological, social, economic and marriage instability. To address this objective or major theme, subthemes were identified following the data analysis on the challenges faced by patients.

4.3.1 Psychological/emotional challenge after obstetric fistula repair

Findings of the study showed that, most of the participants had psychological/emotional challenges after obstetric fistula repair. Majority of the participants stated not been able to lift heavy objects, sexual abstinence and stigmatisation as major challenges they faced after the surgery that gave them psychological/emotional stress. Also, most of the participants were able to recognised these challenges even though it might not be obvious especially the stigmatisation in the communities. However, some participants were of the view that, challenges were based on the individuals' socio-economic status and their communities.

"When we talk about obstetric fistula, it means a lot because of its associated challenges that the body goes through such as discrimination in the community, no one wants to come closer to you if only they know of your condition they sometimes pinch their noses when closer …" (P2).

"My challenge, the challenge I have about obstetric fistula is that, most of the patients who are with this condition are rejected by the community because it is a chronic condition and difficult to treat without surgery, some also experience damage to organ that needs management, and each of them has its own challenges…" (P5).

"I'm not able to lift heavy objects after the surgery because I am afraid of complications so I always go by what the nurses tell me however, it becomes a challenge when my husband is not around to help me undertake some difficult tasks…" (P8).

Others also referred to the challenge as not been able to have sex with their husbands as a result of the repair and sometimes the smell emanating from the vagina that relates to the

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leakage of faeces into the vagina. The research showed that, most participants knew that the inability to have sex was caused by the involvement of the vaginal walls.

"…When we talk about sex, we talk about the vagina. So anything related to damage to this area where the penis will pass, even though some psychological issues may trigger some discomfort still the vagina is involved, because when we talk about the sex, the whole system, your brain is part and the nerves are also part of it so it works in that manner…" (P1).

"…I think sex is erm, a physiological sensation that relates to the nervous system and most importantly the vagina and it is also the feeling that a person may express. Only the one who is... the one experiencing it who can tell you. And managing patients' sexual issues in this uncomfortable condition is very important" (P2).

"…I know for sexual management [clears throat]. When one is in pain, the person may not feel for it... as any other condition, the patient may not be able to verbalise it due to shyness, but from facial expression and other things, you can know that the person is not comfortable during the act…" (P3).

i. Community integration

From the analysis, it was realised that most of the participants (11) had challenge with the community integration after the obstetric fistula whilst few did not. Those who had this challenge had it through complications such as infection and gaping after the fistula repair went through psychological/emotional stress during the reintegration process.

"…Yeah, I had an infection one week after the surgery and it was terrible, faeces was passing through my vagina and was very offensive, yes very offensive, my husband and myself were worried it will lead to different condition like destroying my womb and other organs…" (P17).

"Yes. I had that challenge; I was finding it difficult to even go to church and other social gatherings because I didn't want people to know about my condition even some of my closed relative did not want to come to me saying I was smelling…" (P18).

"As part of our community integration I tried to visit my friends and family members so I will not be isolated but it wasn't easy at all especially for those who knew of my condition…" (P12).

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ii. Fear of recurrence

The emotional/psychological experiences identified by the participants included fear of recurrence of the obstetric fistula in the future. This fear resulted in changes in the patients' emotional/psychological status. This was stated by most of the participants. A medication (pharmacological treatment) was part of the methods adopted by the participants to manage this fear since most of the complications were prevented by the administration of medication after the surgery. Most of the participants (14) had knowledge about the recurrence of the condition if care was not taken. In serious cases patients were counselled to adhere to the treatment protocols of the condition.

"In cases of this fear, I take my medication as prescribed to prevent the recurrence of the condition since we were told it could happen again anytime we are going to deliver so the only to do was to take the medications to heal the wound properly…" (P5).

"As you know, as patients, it's all about taking your medications to avoid recurrence and other complications. I normally experience bleeding per vaginum and headache. We're lucky if we are able to verbalise, yes. But sometimes, those who can't verbalise, are left untreated and feel helpless..." (P4).

"…The fear of recurrence of the condition is what we use medications to manage depending on the severity and the patient's experience. If you fail to take good care of yourself the condition can recur which is always serious than the previous one…" (P2).

iii. Afraid of being operated again

This is one of the strategies participants adopted in the management of their obstetric fistula with the fear of being operated upon again. The majority of the participants used this as motivation to continue with their prescribed treatment. They went for wound dressing as scheduled, took medication and nutritious diet to aid in wound healing were some of the strategies adopted by the patients to prevent subsequent surgeries. The findings showed that emotional and psychological challenges were not based on the obstetric fistula alone but its

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management and prevention of more surgeries for the same condition. This was captured in the narration of most of the participants:

"Yes, there was an instance that a friend had two surgeries before the condition was repaired since then, I have the notion that I can be operated upon again which sometimes depends on the doctor who will perform the operation, some will do it well others too I don't know will do it anyhow…" (P1).

"…Okay so for instance when a patient complains of pain during sex, they assume that the operation didn't go well and sometimes too least discharge from the vagina is associated with the repaired fistula which could be different condition all together…" (P16).

"So in case of any small issue after the surgery it should be reported immediately to the hospital for prompt action otherwise it will bring major problem which may call for second operation…" (P10).

Patients described their psychological experience as sadness and fear of unknown.

A patient shared her experience;

> *"……I felt very sad especially when they didn't know what was happening initially. Every test they took in relation to my condition was negative so they could not tell the actual cause of my condition…" (P19).*
>
> *"……I get emotional distress and sadness about my condition because I don't know the outcome of the disease, 'hmm' what will happen in future 'mpo' I don't know. ".....I get emotional distress sometimes but the lord has always been my support" (P5).*

4.4 Social challenges of women after OF repair

The second theme of the study was to explore the social experiences of patients with obstetric fistula repair. Following the data analysis, the study identified three significant sub-themes to achieve the stated objective. In short, the social experience of patients was categorized into three broad sub-themes: treatment before and after, relationship with family members and interest of giving birth again. The treatment before and after repair included loss of job, social isolation and lack of support. These were the challenges the patients experienced in relation to their society

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or community. This is how the disease influenced the social activities of the participants in quest to care for themselves after the surgery.

i. Loss of job

The treatment brought the patients' normal living activities to a standstill and unable to perform social activities that hitherto were performing.

"I have suspended work because of this condition. I want to take care of myself to a level where I can go to work on my own without having to worry so much…" (P11).

"A lot of challenges, when I came to the hospital for the operation, you see I couldn't sell my yam, a lot of it went bad so the profit margin is small. When I come here, the drug I buy sometimes cost me more than GHS 200 or GHS 300 so it really affects me, but I do my best so that I will be healed (P14).

ii. Social isolation

Some of the patients isolated themselves from some social activities due to their condition. This was as a result of constant care that the patients required to keep themselves neat.

A patient had this to say:

"…My husband most of the time leave me alone to attend to other activities and I don't have anyone to care for me in his absence. He engages me in conversations when we are together. I hardly talk about the condition in the presence of other family members not that I don't want them to know but because I don't want them to spread the diagnosis to their friends" (P2).

Another patient added *"…eeerrh hummm! It is a strange condition. I don't want people to know about his condition, so I have limited my interaction with friends and other people…" (P11).*

"…Now that they have lifted the ban on church, I am yet to attend church. I used to attend church regularly before the COVID issue started, it is not about the condition that is why I'm indoors but due to the COVID-19" (P5).

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4.5 Economic challenges

Most of the participants enunciated that they had economic challenges since they did not receive any financial support for family members. Others also had some support from NGOs and government for their treatment.

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"I went for review for three times, it was on my third time that I was asked not to come again. I stay far from here so lorry fare is too much, the hospital and the staff also helped me in terms of money after my discharge…" (P6).

After the surgery the hospital staff gave me transportation fee because I didn't have any money on me and my husband too didn't have any…" (P5).

"The treatment of obstetric fistula is costly and the poor stand the risk of complicating their conditions" (P8). Another patient also stated *"…I don't get any support from the government apart from the National Health Insurance, my brother and sister have really been the helpers but they got tired along the way so I have taken upon myself everything" (P9).*

4.6 Marriage instability

Participants expressed their views regarding how fistula has affected their relationship with their husbands or partners. Some of them recounted with pain how they were abandoned by their married partners without social and financial support. For example:

"The man with whom I had that baby who caused this problem left me. Then this present one when he realized I have this condition, he never came back. When I told him I was pregnant, he told me he is not ready for any child. He does not support me financially at all" (P6).

"That man I do not know where he is; about twenty-five years. He left me immediately I developed the condition. As husband and wife, we were supposed to be happy together with the birth of our child, but here no, the baby died. I developed this terrible condition. I am supposed to go through it alone. I only pray to God someday I shall be cured of this condition. I have never set my eyes on him again" (P13).

"This was my second pregnancy so I knew labour had started, but my mother-in-law advised me not to rush to the hospital. I delayed at home. The next morning when I could not bear the pains any longer, I informed my husband and he brought me to the hospital. At the hospital, the midwife who examined me told me she did not hear my baby's heart beat due to the labour pains. I did not believe her but after about 20 minutes I delivered and my baby did not cry. After three days, I realize I do not have the urge to urinate by myself. I informed my husband and that was the beginning of my plight. For twelve years now, I do not know where he is. He never supports me" (P4).

"After losing my baby, as if that is not enough my husband also divorced me as though I caused the death of our child. He has even left the community maybe because he does not even want people to be seeing him as my former husband. Because that was my first

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pregnancy, I have not been able to get pregnant again; I am now seen as a hopeless person. I do not know where he is now" (P12).

However, there were a few, who receive support from their husbands and partners. This category of women expressed their experiences in the following comments:

"He supports me a lot but we do not stay together again. We separated when I developed this condition but he is around and he asks about me. He gives me words of encouragement and he has even promised to support me financially during my surgery" (P10).

"He is still around me. He never left me and I think he is a good man because a lot of men cannot do what he has done so I always pray to become well again and make him happy" (P15).

4.7 Social support systems for women after OF repair

To answer the second research objective — the social support systems for women after obstetric fistula. Most of the participants had support from their families and the government to deal with their challenges. Support systems are ways adopted by patients with obstetric fistula repair to reduce their burden of the condition on them. The subthemes that were derived were social support and economic support.

i. Social support

Social support that was identified during the study included the family of the women as well as Clinical Psychologists and Social workers from the repair centre. It was shown in the findings that social support either from close family members or friends helped relieved or reduced the patients' burden. It was also revealed that patients who received social support lived good life than those without any support because the mere presence of their relatives made them happy and instilled confidence in them that they would get well one day.

> *"...Me for instance when I was in labor without my sister, like I would have cried enough so it does help yes, it really helped when you have your family around, you know that home support is really good" (P7).*

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"…Mm, social support... when I see that my relatives are coming, I feel happy. And sometimes, I can tell my relatives what I'm going through and the relatives will console me so I think it helps us" (P12).

"…So patients in comparison with the ones that receive more friends and family coming to visit us as to those who don't have people coming to visit them, the once who don't have people coming to visit them they are a bit tensed every time they are trying to manage something…" (P115).

ii. Relationship with family members

Unhealthy relationship with family members and other close ones also increased patients social challenges as one patient stated;

"...I was admitted here and I called the father and he said when we are discharged, I should call him to send us money but there was no response when I called hmm" (P14).

'My parents and family are Jehovah witnesses and so they didn't approve of a blood transfusion when I needed blood but I went ahead and allowed for the transfusion and since they don't approve of that, they have not helped in any way. I attend Thy Glory Church where blood transfusion is allowed" (P7).

4.8 Health services available

Monitoring patients ensured that the patients adhered to the treatment regimen for example taken of drugs, observing personal cleanliness and going for regular medical check up to prevent complications. The facility monitored the condition of their patients most especially on the issue of complications through the following subthemes; counselling after repair, follow-up and complication management of the patients' conditions.

i. Counselling

Some participants also described counselling unit as one of the services available to help deal with their challenges. Some of these strategies included problem solving, where patients try to deal with their problems on their own with the help of the health workers.

"Some people have their own way of solving their problems, even if they're in pain. Like most of them, they have faecal discharge so when they come, whatever you'll do for them, they see the value. So some of them will say, I put pad or I visit the washroom frequently" (P3).

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"Sometimes the patient will tell you, "Oh, Aunty Nurse, I think it would help me if you take me through counselling because there are so many information received."(P1).

"Ah well, when you come, you talk about problem solving, I had a... one of my patients who, ah. This patient will say she is suffering and I will take her the counselling unit" (P2).

"After surgery we educate them not to lift heavy items after the fistula surgery and also cannot give birth per vagina unless caesarean section" (P3).

ii. Follow-up services

Some of the participants spoke about the fact when the patients were discharged they had the opportunity for follow-up and this helped them to overcome complications. Some of the patients also failed to come for the follow-up not want the nurses to know what was wrong with them sometimes hence they avoided the nurses as well as other family members.

"A period of three months is given to them to come for the next visit, after the last review and the patient is ok we advice them to take care" (P1).

"She came for review three times weekly and the hospital took the bill for the CS" (P1).

iii. Management of complications

Most of the participants indicated that the health system had a good effect on them before, during and after the surgery thereby preventing complications. The ability to communicate clearly might be as a result of platform provided by the facility. Some were able to communicate to the nurses during vital signs taking when the nurses were with the patients alone. In fact it was seen that most of the patients felt safe and comfortable when the nurses and other medical staff were around them during the surgery and after the repair.

"After the surgery some of the patients stay at hospital for two to three weeks for them to be taking care of with any bill for them to pay. The hospital is doing well in for helping the needy patients in this area" (P3).

"The health system success rate is high and depends on the type of fistula you have and the number of years you have lived with the fistula and we are trying to find out if nutrition also helps in the repair after discharge" (P2).

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"After the operation the doctor bought food and provisions for the patient and was advised to take good care of herself else the condition will come again" (P1).

"The hospital and the staff also helped some of the patients in terms of money after discharge so the hospital has great effects on the wellbeing of the patients" (P3).

4.9 Summary

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

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CHAPTER FIVE

5.0 DISCUSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study as related to the objectives relevant to the reintegration experiences of women after obstetric fistula repair into a more comprehensible description. This work provides a broader and deeper understanding regarding the reintegration experiences of women after obstetric fistula repair. The major themes are discussed while inculcating the subthemes in the discussions as they are directly linked.

5.2 Challenges faced by women during reintegration

This theme presented the findings on the challenges women faced during the integration process after obstetric fistula repair. The challenges included emotional/psychological, social, economic and marriage instability.

5.2.1 Psychological/emotional challenge

Findings of the study showed that, most of the participants had psychological/emotional challenges after obstetric fistula repair. They had this challenge as a result of inability to lift things themselves, sexual abstinence and afraid of been operated again and stigmatisation during the community reintegration. The results are supported by another study, which revealed that obstetric fistula repair is predominantly followed by psychological stress during the reintegration process (Abrams *et al*, 2010). Additionally, most of the participants (11) had psychological/emotional challenge with the community integration after the obstetric fistula repair. Those who had this challenge had it through complications such as infection and gaping after the fistula repair and went through psychological/emotional trauma. This is consistent with findings that in developing countries, some women still encountered depression and anxiety even though they had undergone an operation. This was attributed to

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women who experienced persistent leaking even after repairs were made (Belayihun & Azwihangwisi, 2019).

Emasu et al. (2019) in their study also found that physical capabilities, issues on future fertility, the fidelity of partners and also income created emotional and psychological challenges by building their anxieties and depression. There was also some insecurity and fearfulness about their future and unwillingness to attempt to restore intimate relationships.

The studies stated (Belayihun & Azwihangwisi, 2019; & Emasu et al. 2019) were conducted to investigate the emotional challenges of women after obstetric fistula repairs. The results of the studies indicated that the women encountered depression and anxiety even though their intensity had decreased significantly. Also, some women were observed to have an unwillingness to restore their intimate relationships whilst nurturing insecurities and fearfulness about their future. Both studies were conducted in recent years and utilized adequate sample sizes for their studies. Hence, their results are relevant and relatable to the current study.

Contrary to the findings by Kabayambi et al. (2014) women with OF repair are left with no choice than to cope with their situation. These coping strategies comprise eating and drinking only when it is needed, bathing regularly, using perfume and powder, putting calamine lotion on the sores surrounding the genitals and thighs, and using old pieces of cloth that are torn into shreds as pads to reduce the psychological impact of the condition. This, considering the fact that many of the women had their deliveries and repairs in hospital but developed the OF and other complications, suggests that there could be gaps in the healthcare delivery systems such as not being attended to by a skilled health professional. This means that access to a hospital or healthcare facilities per se is not enough. Instead, access to skilled maternal care during antenatal care and labour as well as repair could prevent the development of psychological/emotional challenges after the fistula repair.

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5.2.2 Social challenges

The second subtheme of the study was to explore the social experiences of patients with obstetric fistula repair. Following the data analysis, the results revealed that most of the women loss their jobs, social isolation and lack of support. These were the challenges the patients experienced in relation to their society or community. This is in line with the study conducted by Nundwe, Moyo, Mataya, Mwale, and Tang (2016) where the results of the study showed that women were frustrated by their community members due to the difficulty to conceive after surgery. Also, some respondents were abandoned by their husbands when it was revealed that their uterus had been removed, hence, making them unable to have children.

Also, similar findings were found by Muthengi (2018), his findings of the study indicated that the survivors faced social segregation from the community and family members. Also, it was observed that majority of the women had lost their social relationships in the community due to the fistula, hence, it was difficult to reintegrate into the community because of their broken ties. Furthermore, some members of their community believed that they had not been cured as they proclaimed. Therefore, they were branded as outcasts and witches, which still persisted after repairs.

Furthermore, the study (Drew et al., 2016) was carried out to investigate the social challenges that affected women after obstetric fistula repairs. The results of the study revealed that some of the women were frustrated by their community members due to their inability to conceive after fistula repairs had been undertaken and abandoned by their partners in cases where their uterus had been removed. Moreover, the majority of women had broken their social ties with their community members and found it difficult to restore relationships whilst others were still branded as outcasts and witches. The increased social challenges even after the repair might be due to the fact that health professionals fail to sensitise the community members as

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well as the patients' close relatives on the causes, prevention and treatment of the obstetric fistula. Consistent education perhaps could reduce these challenges if not eradicated entirely.

5.2.3 Economic challenges

The findings showed that most of the participants enunciated that they had economic challenges since they did not receive any financial support from family members though others had some support from NGOs and government for their treatment. This supports Kazaura et al. (2019) findings that obstetric fistula repair levies enormous monetary burdens on sufferers and their families. Lack of cash or draining of scanty resources, lack of family backing, and long distance to health facilities were some of the reasons why women living with OF repair are not easy to improve their financial status. Also, the postponement of OF repair may equally expose patients to a diminished social, mental, medical, and emotional status due to the spiteful difficulties accompanying the faecal or urine incontinence.

The findings also corroborate with Khisa *et al.* (2016), also found that a combination of issues ranging from stigma, isolation, financial difficulties due to diminished employability led to erosion of self-worth in women living with fistula and in many cases, led to psychological distress resulting in suicidal tendencies. The social life of women in that study was found to be poor. Many of them reported isolating themselves in order to avoid being stigmatized by people and the larger society. This experience is common with women living with fistula across many parts of the globe.

Poverty among women with fistula repair may suggest why some develop complications after the repair because they are not able to buy the recommended medications, nutrition and other personal requirements. Financial constraints could also lead poor personal and environmental hygiene of the women after the fistula repair resulting in the body odour.

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5.2.4 Marital instability

Participants expressed their views regarding how fistula has affected their relationship with their husbands or partners. Some of them recounted with pain how they were abandoned by their married partners without social and financial support. The findings are in line with Murray et al. (2016) who state that marital instability after fistula repair ultimately leads to social withdrawal or exclusion and poverty. The breakdown of marriages due to having OF or repair has been reported (Kabayambi et al., 2014). In addition, loss of children, seclusion, and lack of gainful employment are protuberant challenges, which increase the stress level for the affected women and could lead to loss of identity and marriage (Mselle et al, 2017). Beyond the individual woman, the families may also experience stigma due to the status of the woman with OF even after repair. In-laws who are badly affected by the condition of the woman call for the break of the marriage.

Husbands' support is essential in this case to assist women in reintegrating to their lives they had prior to the development of obstetric fistula repair. This is particularly true in Ghana where family is a fundamental and highly valued institution and where the extended family functions as a support group responsible for and obligated to assist each other (Tettey, Puplampu, & Berman, 2017). It is, therefore, important to understand how marriage is affected by a woman's return after OF repair because the marriage can influence a woman's health, welfare, and successful reintegration (Bowen, 2016). Understanding a husband's perception and the level of support he can provide is particularly important because culturally Ghanaian men play a key role in decision-making about health and health care (Ganle & Dery, 2015). Contrary, few studies address the experiences of family caregivers and how they manage the reintegration process in the marriage (Pope, Bangser, & Requejo, 2017; Yeakey et al., 2016).

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5.3 The social support systems available for women after obstetric fistula repair

The second objective sought to find the social supports available to women after obstetric fistula repair. The findings showed that social support either from close family members or friends, government helped relieved or reduced the patients' burden which was not there for them. It was also revealed that patients who received social support lived good life than those without any support because the mere presence of their relatives made them happy and instilled confidence in them that they would get well one day. Contrary to this finding by Pope, Bangser and Requejo (2010), their findings of the study showed that the majority of the women were able to continue their normal economic and social activities they were engaged in before the occurrence of fistula. However, this took place after a period of time. Also, the families of the women were noted to be supportive of the women in their recovery and utilization of the healthcare centres for postoperative care.

Similar findings were seen in Dennis et al. (2016), partners of the women facilitated their recovery after repairs by helping them comply with their medical regiment. It was also observed that supportive spouses were prepared to sacrifice their short-term sexual desire to enable their partner's healing. Also, from other members of their family such as siblings, children and parents, women were assisted with tangible, financial and emotional support. Furthermore, the studies cited (Pope et al. 2010; Dennis et al., 2016) investigated the social support systems that were available to women after fistula repair. The results of the study indicated that the partners and family members of the women provide financial, emotional and tangible support. Also, the families of the women were noted to be supportive in terms of

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recovery and the attendance of health care programmes for postoperative care. Notably, a mixed-method design was utilized in the study to gather data from women and their families.

The social support system in this study was not encouraging since some of the husbands even left their wives as a result of the obstetric fistula and its repair. Women who lacked the social support ended up going through serious psychological/emotional stress during the reintegration stage.

5.4 Health services available for women after OF repair

Monitoring patients ensured that the patients adhered to the treatment regimen for example taken of drugs, observing personal cleanliness and going for regular medical check up to prevent complications. The facility monitored the condition of their patients most especially on the issue of complications through the following subthemes; counselling after repair, follow-up and complication management of the patients' conditions. The findings showed that most participants described counselling as one of the services available to help deal with their challenges. Also, it was revealed that when the patients were discharged, they had the opportunity for follow-up and this helped them to overcome complications. The results again showed that most of the participants indicated that the health system had a good effect on them before, during and after the surgery thereby preventing complications.

These findings corroborate with study by Ayadi et al. (2018) whose results showed that services such as counselling, physical therapy and follow-up were available for women after obstetric fistula repairs. Additionally, the findings support Degge, Hayter and Laurenson (2018) who conducted a study to investigate the integrative review of women living with obstetric fistula and other treatment experiences. The findings showed that women were provided with post-repair rehabilitation counselling, literacy classes, provided with seed grants and health education in their communities.

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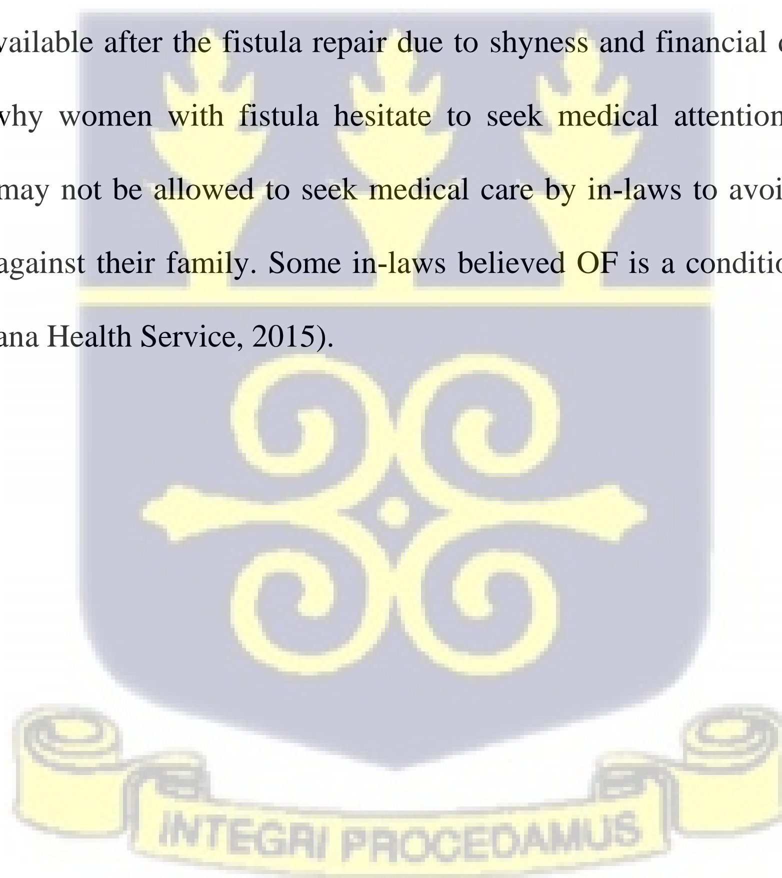
Contrary to the findings, Okoye et al. (2014) observed that OF repair women may develop amenorrhea, vaginal stenosis, childlessness, bladder calculi, infection and foot-drop, which are caused by neurological injuries but lack resources to deal with these challenges. Furthermore, according to Kabayambi et al, (2014) injury by providers and negligence were cited by the women and their caretakers among the perceived causes of some of the medical care challenges.

These show that there is the need for further sensitization of health facilities on the support the women with OF repair and other labour-related complications require. The underlying reason however could be the ineffective health care system to deal with women after fistula repair. Apart from the facility's challenges the individual patients sometimes fail to utilise the opportunities available after the fistula repair due to shyness and financial difficulties as the main reasons why women with fistula hesitate to seek medical attention. Also, obstetric fistula women may not be allowed to seek medical care by in-laws to avoid the stigma and discrimination against their family. Some in-laws believed OF is a condition that should be kept secret (Ghana Health Service, 2015).



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CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter presents a summary of the study findings, conclusions and recommendations needed to help women after obstetric fistula repair integrate well in their families and the community at large in the Central Region.

6.2 Summary of the study

The study looked at the reintegration experiences of women after obstetric fistula repair in the Central region. The explored three objectives as follows: the reintegration challenges women face after OF repair, support systems available for women after OF repair and health services available for women after OF repair. The study adopted a purposive sampling technique to select the participants for the study. Nineteen participants were used (sixteen women with fistula repair and three health workers). The study utilized semi-structured interview guide. Data were analysed using thematic analysis and the following findings emerged from the study:

On challenges faced by the women after obstetric fistula repair, the findings revealed that most of the women had psychological/emotional, social, economic and marital instability challenges.

Again, on support available for women after fistula repair, the study revealed that most of the participants had support from their families and the government to deal with their challenges.

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Furthermore, on health services available for women after the obstetric fistula repair, the findings showed that the facilities had counselling after repair, follow-up and complication management of the patients' conditions the main services available for the women after fistula repair.

6.3 Conclusions

Women who develop obstetric fistula during delivery experience challenges in quest to reintegrate themselves into their communities after repair. The challenges revealed in the study included psychological/emotional, social, economic and marital instability.

Also, social support to the women after obstetric fistula repair from families, husbands, communities and government was poor. Additionally, the health services available for the women after fistula repair were not enough to help in the reintegration processes of the women.

The study concludes that if the above challenges are not addressed by providing social support and adequate health facilities' services, women after obstetric fistula repair will find it very difficult to reintegrate themselves into their families and communities.

6.4 Recommendations

Based on the findings, the following recommendations are made:

6.4.1 Government

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Given the neglected nature of fistula, the Government of Ghana should consider fistula as a societal problem, which needs social intervention. Government should provide free medical care for women living with fistula. This will enable women with the condition who are hiding and are unable to meet the cost of treatment have access to health care services. The

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government should also support women with fistula financially to enable them meet the financial responsibilities of managing and repair of the condition.

6.4.2 Ministry of Health

The Ministry of Health (MOH) should take deliberate steps to train surgeons and midwives for posting across the country to provide requisite care to pregnant women. The MOH should also create health care facilities with the needed equipment, staff facilities with adequate and skilful doctors and nurses to treat women who develop fistula with surgical repairs across the country. Policies should also be developed by the MOH on education and awareness creation about fistula.

6.4.3 Ghana health service

As the policy implementation agency of the MOH, the Ghana Health Service should ensure that pregnant women are cared for by skilled health care professionals at all hospitals and healthcare facilities across the country. Ideally, a better education in maternity care and a more effective prenatal care could help avoid the problems of fistula in the majority of cases. Health promotion and education should be carried out frequently in all communities to educate women on the risk factors of fistula and hygienic practices fistula patient should adopt. Clinical Psychologists can be made available at district Hospitals and patients can be referred to them free.

6.4.4 Civil society organizations and philanthropists

Civil society organizations must support government efforts by reaching out to women with fistula in order to support them to receive surgical repairs for their condition. Sensitization and awareness creation should also be undertaken to educate women and young girls on the

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risk factors of fistula as well as support the women after the fistula repair for reintegration into the communities.

6.4.5 Areas for Further Research

The study could be replicated in different region to confirm or refute the findings of this study.

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APPENDIX 1: STUDY TOOL (INTERVIEW GUIDE)

I am conducting a study on reintegration experiences after obstetric fistula: A qualitative study conducted in the Central Region of Ghana in your community in partial fulfilment for the award of Master of Public Health at the University of Ghana, School of Public Health. You have therefore been selected to participate in the study.

I would be grateful if you could give your frank response to the attached questionnaire which has been designed to collect data for the study. Please be informed that the information you would give would be used for academic purposes only and would be treated with utmost confidentiality. You are therefore guaranteed complete anonymity and no identification of information is requested or will be transmitted with your responses and participation is voluntary.

Thank you for your co-operation.

SECTION A: DEMOGRAPHICS

The following questions ask about demographic characteristics (your age, where you live, whom you live with and how you live)

1. How old are you? A. 15-30 [ ] B. 31-49 [ ]
2. What is the highest educational level you have completed? A. Primary [ ] B. JHS [ ] C. SHS [ ] D. Tertiary [ ] E. No Formal Education [ ]
3. What is your marital status? A. Single [ ] B. Married [ ] C. Divorced [ ] D. Widowed [ ]
4. What is your occupation? …………………………………..
5. How many children do you have? ……………………………
6. What is your Religion?...
7. Where did you deliver your last baby?...

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SECTION B: EMOTIONAL AND PSYCHOLOGICAL EXPERIENCES

14. What challenges do you face after the fistula repair?..........

15. How do you see yourself after the surgery?.......

16. Was there any fear of reoccurrence of the condition after the surgery?

17. Are you afraid of being operated upon again?

SECTION C: SOCIAL EXPERIENCES/SUPPORT

18. Is there any difference between how people treated you before and now?

19. How is your relationship with your family, husband, neigbours and church?

20. Is there any interest of giving birth again after this repair?

21. Is there any social and economic support from an external agency or group?

SECTION D: HEALTH SERVICES AVAILABLE

22. How were you counselled after the repair of the fistula?

23. Tell me about the follow up services available to you after the repair?

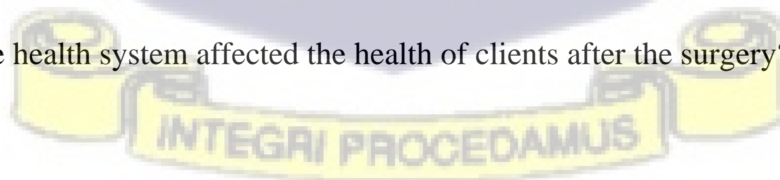
24. How has the health system affected your health after the surgery?

SECTION E: HEALTH SERVICES AVAILABLE (HEALTH WORHERS)

25. How do you counsel clients after the repair of the fistula?

26. Tell me about the follow up services available to clients after the repair?

27. How has the health system affected the health of clients after the surgery?



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APPENDIX II: ETHICAL APPROVAL LETTER

In case of reply the number and date of this Letter should be quoted.

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org
26th July, 2021

My Ref. GHS/RDD/ERC/Admin/App /21/296
Your Ref. No.

Millicent Amakye
Department of Social and Behavioural Sciences University of Ghana,
Post Office Box LG 13, Accra Ghana

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 058/05/21**
Project Title	Reintegration Experiences after Obstetric Fistula: A Qualitative Research in the Central Region.
Approval Date	26th July, 2021
Expiry Date	25th July, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
Dr. James Akazili
(Head, Ethics & Research Management Department)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

INTEGRI PROCEDAMUS