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Exploring the Psychosocial Effects of Obstetric Fistula among Women in Kenya

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ABSTRACT

Women in the global south continue to experience the pain of Obstetric Fistula (OF), despite the increased use of new technology in the health sector. Obstetric Fistula is a medical condition in which a hole develops between the rectum and vagina (recto-vaginal fistula) or between the bladder and vagina (vesico-vaginal fistula) after a long and obstructed childbirth where medical care is not available. The World Health Organization shows that 50,000 to 100,000 women globally develop obstetric fistula each year. In the SubSaharanAfrica, about two million women have the condition with about 75000 new cases developing yearly. In Kenya, approximately 1% of women suffer from chronic illness due unavailable medical care. This causes untold suffering and stigma among the affected women. This paper attempts to examine the persistent occurrence of the condition among the affected women, the psychosocial effects and the strategies the Kenyan government has put in place to eradicate it. This paper is based on a systematic review of the past literatures that examined the psychosocial effects of OF. The studies analysed are both qualitative and mixed method primary studies**.** The paper found out that the psychological effects are real and traumatizing in the sense that victims lack control over body functions, leading to anxiety, low self-esteem and depression. The affected women are mainly young girls and women who are illiterate, poor with little or no access to obstetric care, compounded by weak referral systems.The paper recommends the need for more awareness to be created especially on community perceptions, put and enhance the structures in place to facilitate access to health care. A

strong emphasis on the urgent need to develop a positive attitude towards those affected is critical for reintegration. A collaborative approach that involves the community; medical institutions and development partners should be adopted to enhance effective sustainable solutions.

Keywords; Obstetric Fistula, Psychosocial Effects, Women, Communities, Kenya.

1.0 INTRODUCTION

Globally, Obstetric Fistula (OF) afflicts women from settings with limited resources. Studies indicate that approximately 3.5 million women suffer from the condition with at least 50,000 up to a possible 130, 000 new cases that emerge yearly especially in South Asia and Sub Saharan Africa (Adler, Ronsmans, C, Calvert, C. & Filippi, 2013). About one million women live with Fistula in Nigeria and 1/1000 births are complicated by OF in Kenya and Nigeria as well (Wall, Wilkinson and Arrowsmith, Miller 2005). Although research shows that Uganda and Ethiopia have the largest number of women who have suffered OF, developed countries have managed to eradicate it totally (Maheu et al. 2015). The current study attempts to explore the persistent occurrence, the psychosocial effects often ignored and the strategies that have been put in place to eradicate OF condition.

The developing countries especially the global south have unique characteristics that predispose young women to OF. African women naturally have narrower pelvises putting them at risk during childbirth in addition to poor nutrition that further causes stunted pelvic growth (Adler et al 2013, Wall, L. et al 2008). The natural condition is exuberated by socio cultural factors such as early marriage and Female Genital Cutting (FGC), putting the young women at risk. Early marriage has health implications on the young brides, approximately 800 women die from preventable diseases related to pregnancy and are predisposed to OF. The married girls are under pressure to seal the marriage by giving birth (UNFPA, 2012). Research consistently shows that countries where the mean age at marriage is 15 or below, such as Nigeria, Ethiopia and Bangladesh, display high rates of fistula. Most women who were affected by fistula were found to be shorter, weigh less, have less education and of lower socioeconomic status than women who had given birth without complications. Some communities have cultural barriers such belief in evil spirits, traditional healers and diviners that hinder women from seeking medical care while in others a woman is not allowed to access healthcare without the husband's permission (Wall, 2008, Mulleta, 2006).

Additional findings link OF to poverty, where women who have no access to medical care are adversely affected. In the Sub Saharan Africa, one of the poorest countries is Malawi, living below US$2 poverty line (World Bank Group 2018). About 80 per cent of the population in Malawi live in rural areas, where poverty, distance and poor infrastructure make it difficult for people to access health care services (National Statistical Office [NSO] and ICF 2017). Maternal mortality is still among the highest in the region at 439 per 100,000 live births (NSO and ICF 2017). Obstetric fistula has been one of the neglected conditions in Malawi, receiving attention only after the launch of the End Fistula Campaign by the United Nations Fund for Population Activities (UNFPA) in 2003 (UNFPA and Engender Health 2003).

2.0 METHODOLOGY

Secondary sources of literature have been used in this paper. The Search, Appraisal, Synthesis and Analysis (SALSA) approach was adopted to review the literature. The method guided in identifying the most relevant information. About 40 articles were reviewed guided by key words.

2.1 RESULTS

Studies show that women adversely affected by Obstetric Fistula had less education, lower socioeconomic status, weigh less, shorter, majority live in rural areas where poverty and poor infrastructure is a challenge in accessing health care facilities World Bank (2018).

3.0 PSYCHOSOCIAL EFFECTS OF OBSTETRIC FISTULA

Among the West Pokot in Kenya, one out of every 1000 women suffer from OF, the most affected being young girls and women who are illiterate, poor with little or no access to obstetric care, compounded by weak referral systems (McFadden, et al.2011). The women who suffer from Obstetric Fistula experience rejection, seclusion from the family, stigma, loss of social network and support (Khisa et al, 2019; Kabir, 2004). Besides, the affected marital relationships lead to divorce or separation. The smell of urine and feaces predispose the woman to social isolation, abandonment and divorce (Khisa, 2010; Yeakey et al, 2009). This is exuberated by the loss of the foetus, which has a potential of reducing the woman's chances of bearing children especially in societies where children seal the marriage (Yeakey et al. 2009, Miller et al 2005; Curdie, Moffat and Jones, 2018). The psychological effects are real and traumatizing in the sense that victims lack control over body functions, leading to anxiety, low self-esteem and depression (Wall 2006). Many women manifest feelings of hopelessness about their status and are not empowered to seek treatment. They are desperate, anxious and sad about the uncertainty of the future (Siddle, Mwambingu, Malinga and Fiander, 2013).

A study carried out in Nigeria shows that about 33% of women suffering from Fistula suffered depression, while 51% were angry with life. There was reported low self-esteem, stress and anxiety. The support provided by the husband is noted, the study showed that women who received such support were optimistic about life (Kabir, et al 2004).

Obstetric fistula has serious economic repercussions for affected women and their families. Studies show that the cost of treating Obstretic Fistula is high, it includes time taken away from income generating activities to seek medical attention, inability to work because of poor health and stigma and the need to constantly observe hygiene. This strains family resources and a potential cause of financial hardship, disagreements and lack of support that causes poverty (Ahmed and Holtz 2007). Women in Kenya too go through feelings of shame and severe disruption of their economic, physical, psychological and social lives and have to deal with moral and hygiene challenges (Khisa et. al, 2019).

In order to end Obstetric Fistula, several strategies have been put in place at the global, regional and national levels. The aim of the 2030 Agenda for Sustainable Development is to change the world by realizing 17 sustainable development goals. It pledges to achieve gender equality and securing health and well being for all, ending poverty and eradicating obstetric fistula. It is important to note that various interventions have been put in place.

3.1 INTERVENTIONS AT THE GLOBAL AND REGIONAL LEVEL

The aim of Global Strategy for Women's, Children's and Adolescents' Health (2016–

2030) is to end fistula. Its main goal is to end preventable maternal and newborn mortality, reduce the rate of global maternal mortality to less than 70 per 100,000 live births and to support countries in implementing the goals. Through the operational framework adopted by the sixty- ninth World Health Assembly in 2016, it emphasizes the significance of developing a sustainable, health financing, evidence-based strategy, strengthening health systems and building strategic multisectoral partnerships (United Nations, 2018).

In 2015, the World Health Assembly adopted a resolution on "Strengthening emergency and essential surgical care and anaesthesia as an element of universal health coverage, calling for access to emergency and essential surgery for all, including the prevention and treatment of obstetric fistula. During the 2015 meeting in Geneva of the World Health Organization (WHO) Global Initiative for Emergency and Essential Surgical Care in Geneva, a blueprint towards the implementation of the resolution was drafted. Following up on the resolution at the recent seventieth World Health Assembly held in 2018, a two-year report was presented and a decision adopted calling for continued reporting at least every two years (Fistula Foundation, 2016 annual report)

Regionally, the African Union task force for maternal, newborn and child health required Heads of State and Government to declare the ending of obstetric fistula and female genital mutilation in 2018. The task force advocated for the usage of advocacy platforms and reporting mechanisms, which involved Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa and campaigns against child marriage to increase accountability on continental commitments and speed up the eradication of female genital mutilation and fistula (United Nations, 2018)).

3.2 INTERVENTIONS IN KENYA

Nationally, countries are making advancement in reducing maternal and newborn mortality and morbidity (WHO, 2015). Kenya too has adopted several steps towards the elimination of obstetric fistula through the introduction of The Kenya National Obstetric Fistula Training Curriculum for Health Care Workers, which was adopted in 2006 through funding and technical support from United Nations Population Fund (UNFPA). In Kenya, this service is provided in Kenyatta National Hospital, Cherangany Nursing Home, Women and Development Against Distress in Africa (WADADIA) in West Pokot, Mt. Elgon and Siaya, Jaramogi Oginga Odinga Teaching and Referral Hospital (formerly known as Nyanza Provincial General Hospital) in Kisumu, Gynocare Fistula Centre in Eldoret and jamaa Mission Hospital (Mogambi, 2016).

Other initiatives have been implemented in collaboration with the international partners like UNFPA. Working with Direct Relief International (DRI) and the Fistula Foundation, the Global Fistula Map provides information on the state of fistula treatment capacity around the world. DRI uses mapping technology and Geographic Information System (GIS) tools in Western Kenya to explain the spatial distribution and key characteristics of women receiving fistula treatment. The map locates the patients and where additional outreach and resources for treatment are as well as the use of mobile phones. In 2010 Women and Health Alliance International (WAHA), distributed 10 all-terrain motorbikes ambulances in Kenya to help in the prevention and treatment of obstetric fistula. Another Campaign Partner, One by One in Kenya has developed a network of fistula survivors and community volunteers to educate their own communities about fistula and bring fistula patients in for

care and provide reintegration support for women when they return home following treatment (United Nations, 2012)

Despite the efforts that have been put in place, evidence from the field shows there is need to make follow up on obstetric fistula clients after treatment and discharge and to address the issues that emerge thereafter (Corodhia, 2015). In addition, Khisa et. al (2019) in the study of 'A grounded theory of regaining normalcy and reintegration of women with obstetric fistula in Kenya' suggests the need for a model of care that involves social, psychological, economic and physical elements of care after surgery and discharge.

Since Obstetric Fistula exposes women to poverty, illiteracy and sociocultural factors, there is need to promote girl child education. Studies show that in Nigeria, illiteracy contributed to 96% of cases, while in Cameroon 81% of patients who lacked formal education were affected by Obstetric Fistula (Pearson, DeBernis, and Shoo, 2009).

Creating awareness and giving education to the local community on the social cultural factors and psychosocial effects reduces OF and facilitates the rolling out of community programs tailored to meet the needs of the community. Research shows that patients who have been treated have acted as community advocates for Fistula in Kenya and other countries (Wegner et al, 2007).

The efforts to eradicate Fistula will not be effective without looking at the Psycho social scars that the affected women have gone through.

Women who suffer from low self esteem, anxiety and depression require psychological help in the form of counselling for self development. The process of counselling helps the women to rediscover their strengths and appreciate themselves again.

Khisa (2015) in the study among the Pokot of Kenya found out that women benefit from counselling that focusses on getting back to normalcy, possible return to fertility or dealing with permanent infertility and couple counselling. In addition, access to information, education and communication on lifestyle change such as exercises, adequate intake of water and improved nutrition is important. This implies that the intervention should be tailored to meet the needs of the affected women.

Relating to the above, family and community support is critical for healing and integration. Women come from a social environment and they need to be settled back to their previous gender roles. A study conducted in Tanzania shows that 68% of women who had gone through surgery found support from the family. Consequently, they were able to fit in, started businesses and felt a sense of belonging. They were mainly supported by the members of the natal family (Pope, Bangser, & Requejo, 2011).

Training and equipping women with skills enhances their economic empowerment and independence. In Kenya, a study among the West Pokot shows that 22% of women did not go back to work after surgery whereas 75% went back to their previous work (Khisa, 2015, Pope et al 2011, Nielsen et al. 2009). This shows that empowering women boosts their self esteem, and they are not considered a burden to the family. The need for promotion of sexual of sexual and reproductive rights remains and should be enhanced by county governments (Kimani,Ogutu and Kibe, 2014)

4.0 CONCLUSION AND RECOMMENDATIONS.

The various interventions are commendable. However, more needs to be done to deal with the psychosocial scars that the women have gone through.

The study recommends women to have access to information, knowledge about Fistula care and treatment. The National government should provide support to the county governments to strengthen and equip the health care systems with a view to cater for the needs of Fistula survivors.

It is also important to understand the psychosocial needs of women and that of the community, this will facilitate the interventions that are tailored to meet the needs of the affected women which include psychosocial support in form of counselling and continuous linkage of OF survivors to social support programmes for effective rehabilitation. Family and community support are critical for healing and integration.

As mentioned above, the paper further recommends training and equipping women with skills to enhance their economic empowerment and independence. The education of the girl child should be strengthened. This is due to the fact that OF can be prevented by avoiding early and teenage pregnancies and discouraging harmful sociocultural practices such as Female Genital Cutting and Early Marriage. The fistula survivors should be encouraged and equipped with skills to act as community advocates.

In conclusion, a collaborative effort between the community and all the stakeholders should be adopted for sustainable solutions.

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