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Psychosocial Effects of Obstetric Fistula on Young Mothers in Western Kenya

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Abstract

Obstetric fistula has remained one of the most devastating complications a woman experiences in the course of delivery in Kenya. Many women suffer long term morbidity and become social outcasts. The aim of this study was to examine the psychosocial consequences of obstetric fistula on young women in the western Kenya region. The study population consisted of women living with obstetric fistula, their families and care givers. The sampling frame consisted of 190 primary respondents. The study adopted a cross-sectional descriptive survey design. The data from the respondents was collected through questionnaires, interview schedules and Focus Group Discussions. The Statistical Package for Social Sciences (SPSS) was used for data analysis. Descriptive statistics such as frequencies, means, percentages and standard deviations were generated for data analysis. The study results show that the main psychological effects of fistula were sadness, shame and loss of self-worth. The study also points at stigmatization, social worthlessness and isolation as the main social effects of fistula. The study recommends addressing negative cultural practices that contribute to obstetric fistula occurrence.

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This includes sensitization of the society about fistula to re-integrate the recovering fistula survivors so as to reduce the associated stigma. Relevant groups and NGOs should offer counselling services to fistula victims on issues that can affect their psychological and social wellbeing.

Key words: Obstetric Fistula; Psychosocial Consequences; Young Women; Western Kenya.

1. Introduction

Most young women, mainly from developing countries are living in shame and isolation because they suffer obstetric fistula. The condition is directly linked to obstructed labour, which lasts several days. Obstructed labour, apart from contributing high mortality rate, is estimated to cause 76% to 97% of all obstetric fistulas [1]. Nigusse and colleagues in *The Causes and Consequences of Obstetric Fistula in Ethiopia* indicate that 95.4% of the fistulas are caused by childbirth. Studies have indicated that coitus, surgery, trauma and other causes constitute only less than five per cent of the cases. The situation is no different in Kenya, where over 90% of all obstetric fistulas are caused by prolonged obstructed labour. Obstructed labour was estimated to be the most disabling maternal health condition ranking 41st in the Global Burden Disease (GBD) in 1990, representing 0.5% of burden of all conditions and 22% of all maternal conditions [2]. Obstetric fistula is by far the most distressing long term condition following obstructed labour. Despite its devastating impact on the lives of women, it is still largely neglected in the third world countries. The myths and misconceptions associated with the condition serve to compound the situation. The condition is considered the poor woman’s burden because it affects some of the most economically marginalized members of the population; mostly young and illiterate women in remote regions of the world.

Obstetric fistula is a medical condition in which a hole develops between the rectum and vagina or between the bladder and vagina, after long obstructed childbirth where emergency medical care is not available [3]. A hole between the urinary bladder and the vagina is known as vesicovaginal fistula whereas a hole between the rectum and the vagina is referred to as rectovaginal fistula [4]. The United Nations Population Fund [5] defines obstetric fistula as a childbirth injury that has been largely neglected, despite the devastating impact it has on the lives of affected women. From the preceding definitions, obstetric fistula is a childbirth injury that occurs to mothers and is associated with prolonged obstructed labour. It is characterized by continuous leakage of urine and/or stool via the birth canal.

Prior to the 19th century, obstetric fistula was considered an incurable condition, but later it was realised that obstetric fistula could be diagnosed and treated [6]. By the first half of 20th century, the maternal mortality rate had substantially reduced in western countries [7]. Today, obstetric fistula is virtually unheard of in western countries. It has also greatly reduced in industrialized nations in Asia and Latin America. However, the condition remains not only prevalent but also a pressing problem in Sub-Saharan Africa. This may be attributed to ignorance, poverty and poor infrastructure. In these countries there is inadequate emergency obstetric care, limited fistula repair services and lack of fistula surgeons to manage the affected women [8]. It is estimated that there are 2 million women living with fistula around the world [9]. The UNPA, 2003 postulated that about 80% of women living with fistula in the East African region lack fistula repair services each year.

In Kenya, the 2014 Kenya Demographic Health Survey estimated that 1% of women of reproductive age have had a fistula in their life. An obstetric fistula needs assessment report by the UNPA indicates that in Kenya, there are 3000 new fistula cases every year; with the treatment capacity for obstetric fistula in Kenya being pegged at a maximum of 1,000 clients per year [10]. However, most importantly, obstetric fistula affects mainly marginalized groups and young uneducated females mostly living in geographically remote settings with limited or no emergency obstetric care services and where fistula care in not a priority.

The World Health Organization (WHO) refers to fistula as the single most devastating morbidity of neglected child birth. Indeed, WHO estimates that over 300 million women currently suffer from complications arising from childbirth, with around 20 million new cases arising every year [11]. These complications include vaginal fistula. It is also estimated that about 50,000 to 100,000 women develop obstetric fistula annually with at least 33,000 of these being found in sub-Saharan Africa, Kenya included [12]. Ahmed and Tunçalp [13] estimate that for every maternal death, 20 to 30 women develop serious obstetric complications including fistula. Sadly, an approximately 2 to 3 million women are living with untreated obstetric fistula [14]. A survey done by UNFPA in 2014 in Kenya estimated that there are 3,000 new cases per year, with approximately one to two fistula cases per 1,000 deliveries and only about 7.5% of women with fistula being able to access treatment [15. While it is important to recognize that this data is largely hospital-based and therefore cannot be fully indicative of the magnitude of the problem, the existence of such a high number of obstetric fistula victims highlights the failure of health systems to provide high quality maternal health care including skilled medical attention and timely emergency obstetric care. It is also a reflection of the socio-economic, regional and gender based inequities as well as the patriarchal nature of African societies that hinder women from accessing high quality services. Most cases that occur in rural and marginalized communities and fistula victims are often ostracized [16].

Studies have shown that fistulas are mostly often pregnancy-related (90.4%), followed by pelvic operation related (5.3%), and then by sexual assault (4.3%) [17]. Hysterectomy was at one time the most common gynaecological procedure leading to obstetric fistula [18]. One of the Millennium Development Goals adopted by many countries including Kenya is to improve maternal health [19] but despite its wide adoption of maternal health programmes, women suffer from a wide range of birth complications including obstetric fistula. Although obstetric fistula can be repaired successfully, cultural, religious beliefs, patients' non awareness of availability of treatment facilities, and the cost of the repair have made access to the much needed care unobtainable for many. There is therefore a dire need to sensitize the obstetric fistula victims of this condition on the availability of treatment.

Fistula is a serious condition affecting more than 6 million women annually with over 90 % of these women living in Third World countries [20] with estimated 40,000 women dying annually. Other obstetric fistula associated complications include urinary, faecal or combined incontinence [21], physical and psychosocial morbidity including societal stigmatization [22], divorce and separation [23] loss of income due to difficulty in securing a job or livelihood [24], and reproductive system complications like infertility and amenorrhoea [25].

Apart from surviving the ordeal of obstructed labour, women with obstetric fistula face significant psychosocial challenges [26]. Low self-esteem, feelings of rejection, stress, anxiety, mental health dysfunctions, and posttraumatic stress disorders, loss of dignity and self-worth, loss of sexual pleasure, depression and suicidal thoughts are some psychosocial consequences that can follow this morbidity [27].

In Guinea, a study shows that women who develop obstetric fistula often suffer stigma, abandonment, loss of self-esteem and social isolation [28]. In a study conducted in Nigeria, about 33% of women with obstetric fistulas were depressed and 51% were bitter about life [29]. Divorce is very common immediately a woman is diagnosed with fistula. For example, in a study in Niger among women affected with obstetric fistula, 63% were divorced because of the condition [30]. According to reports in sub-Saharan Africa, more than 50% of women suffering from fistula are divorced by their husbands. Other consequences include severe social stigmatization and loss of support from families and communities.

In another study conducted in Zimbabwe [31], it was found that women with obstetric fistula faced the following psychological problems: helplessness, sadness, suicidal thoughts, stigma and blame, feelings of worthlessness, fear, shame and social withdrawal. In Zambia, a study on women with obstetric fistula receiving care at Monze Hospital revealed that of the 45 women who were no longer living with their husbands, 67% of them stated that this was due to their having fistula. In another study on incidence of depression in women with obstetric fistula in Kenya, depression was present in 72.9% respondents, with 25.7% meeting the criteria for severe depression. From the meta-analysis, in absolute terms, it is estimated that Kenya is one of the countries in Africa that has the largest number of women of reproductive age (15-49 years) who have experienced vaginal fistula symptoms, estimated at between 69,400 and 113,700 [32]. While the figures seem to be quite high, studies determining the psychosocial effects of fistula on young women are elusive and very limited in Kenya. This study set out to bridge this gap.

2. Objectives of the study

The following are the two objectives addresses in this paper:

i. To determine the social effects of obstetric fistula on young women in the western Kenya region.
ii. To determine the psychological effects of obstetric fistula on young women in western Kenya.

3. Research methodology

The study population consisted of women that are living with obstetric fistula, their families and care givers. The sampling frame consisted of 190 primary respondents consisting of fistula survivors aged between 15-24 years from Kakamega, Bungoma, Trans Nzoia, West Pokot, Kisii and Migori Counties of Kenya. The secondary respondents included 60 older fistula survivors aged above 25 years - ten from each county - and 60 Fistula survivors' significant others. The significant others were their husbands, parents or siblings. The study adopted a cross-sectional descriptive survey design. The data from the respondents was collected through questionnaires, interview schedules and Focus Group Discussions (FGDs). The Statistical Package for Social Sciences (SPSS) was used for data analysis. The descriptive statistics such as frequencies, means, percentages and standard deviations were used in data analysis. All the participants were informed about the purpose of the study and assured of confidentiality and of the fact that the findings would not be used in such a way as to harm them.

Their participation was voluntary and without expectation of any rewards. None of the respondents was denied services for refusing to participate. A written informed consent was signed by all the respondents before they could take part in the study.

4. Results and Discussion

The study sought to establish the distribution of respondents by age in the study areas and the results generated as in table 1 below.

Table 1: Distribution of Respondents by Age

Status	**<15yrs**	**15-18yrs**	**19-21yrs**	**22-24yrs**	**>24yrs**	**Total**	**%**
Single	4	26	40	33	5	108	57
Married	0	13	22	13	8	56	29
Divorced	2	5	4	18	1	26	14
Total	**6**	**44**	**66**	**64**	**14**	**190**	

From the results in table it was noted that the youngest client was aged 13 years old with the oldest being 26 years old. It was also noted that majority of the respondents were single (accounting for 57% of the respondents) while those who were married accounted for about 29%. The remaining 14% of the respondents were already divorced at the time of this study. On investigating the cause of divorce, it was noted that 18 out of the 26 respondents (or 73% of the divorced respondents) were divorced due to their obstetric fistula condition.

A review of existing literature indicates that in Kenya, obstetric fistula is a big problem even though the actual prevalence and incidence remain unknown. Its prevalence is not well quantified from a medical point of view, particularly amongst the poor women. In Kenya, the UNFPA estimates that there are 3000 new fistula cases every year, whereas the 2014 Kenya Demographic Health Survey indicates that 1% of women have ever had fistula. There are areas in the country where the problem of obstetric fistula has not received enough attention. Additionally, this study established that the real status of affected women is not well known in the community. The study therefore concurs with most reviewed literature studies, which agree that obstetric fistula is a highly prevalent condition with most of those who are suffering from it being silent about it because of the stigmatization that comes with the disease. The study additionally identifies the condition's impact on the client's emotional wellbeing and the mitigating measures. There is need to sensitise communities about this condition so that they can help the fistula clients to open up about their situation, cope with it, and seek medical attention.

The first objective of this study was to determine the social effects of obstetric fistula on young women in the western Kenya region. To achieve this objective, the respondents were requested to complete a questionnaire. Their responses were scored and results computed to establish the social effects the victims underwent as a result of Obstetric Fistula. The results are represented in table 2 below:

The study sought to find out the social effect of obstetric fistula from the clients perspective. The respondents were asked to select to list all the social effects they had as a result of obstetric fistula.

Table 2: Social Effects arising from Suffering from Obstetric Fistula

Effects of Suffering from Obstetric Fistula	Frequency	Percentage
Stigmatization	174	35
Social inferiority	56	11
Socially worthless	144	29
Divorce	25	5
Isolation	98	20
Total	**497**	**100**

From table 2 above, 497 responses were generated from this question. Stigmatization (35%), social worthlessness (29%) and isolation (20%) are seen as leading among the social effects of obstetric fistula. Judging from the number of responses in relation to the number of participants, it is clear that most of the participants were socially affected in more than one way. It is valid therefore to conclude that a fistula survivor first experiences self-stigma which makes her to be isolated. This comes with the feeling of worthless and acts as worthless leading to total isolation by the community.

It was very interesting to note that the demographics showed 14% of the participants as having been divorced whereas only 5% of the responses cited having been socially affected by divorce. This could be because the clients were affected in so many ways that they had to focus on the way most important for them. 'My own mother was so ashamed of me, she wanted me to hide in the kitchen; I wasn't allowed to participate in any domestic work or even greet visitors. That was more disturbing than being chased away by my husband,' Said Anne, when asked about her feeling on divorce.

For the fistula clients who went back to their family of origin after the divorce, the study sought to find out how they were received by their families. It was observed that 20% of the respondents were positively received by their families whereas 80% had challenges with members of their families. Relationships with their sister in-laws seemed to be more strained compared to relationships with other members of the family. In the FGDs, the respondents concurred that when effects of fistula disabled them from participating in such chores as cooking during social functions, they were rendered totally inadequate and this reduced their dignity greatly and increased social isolation and stigmatization. This is in agreement with many studies proving that in nearly all cases, many women afflicted with fistula are divorced or separated. They also found that the rates of separation increased the longer a woman lives with fistula, especially if she remains childless [33].

Similar studies show that fistula comes with a lot of stigma. For instance the smelly nature of vesico-vaginal fistula exposes its victims to mistreatment and stigma, leading them to be ostracized by their relatives and community. In many cases family members do not like sharing food with women with vesico-vaginal fistula at family events [34]. In Kenya for instance, the lives of women with fistula are devastating. A similar situation is reported in a study [35] in Kaptembwa –Nakuru, Kenya. The study concluded that the foul odour emanating from affected women leads to humiliation and severe social-cultural stigmatization and isolation.

The second objective of the study was to determine the psychological effects of obstetric fistula on young women in the western Kenya region. To achieve this objective, the respondents were requested to complete a questionnaire that had multiple choices. They were required to tick all that was applicable hence they could have more than one response. Their responses were scored and results computed to establish the psychological effects the victims underwent as a result of Obstetric Fistula. The results are represented in table 3 below:

Table 3: Psychological Effects arising from Suffering from Obstetric Fistula

Effects of Suffering from Obstetric Fistula	Frequency	Percentage
Hopelessness	52	10
Sadness	162	33
Suicidal ideation	5	1
Loss of self-worth	116	23
Shame	23	5
Social withdrawal	139	28
Total	**497**	**100**

The study results in table 3 above show that most victims (33%) experienced sadness, followed by shame (28%) and then loss of self-worth (23%) as psychological effects of fistula. Although suicidal ideation had a small percentage, as a psychological effect, it is an indication of the magnitude of the problem of fistula among young women. This result corroborates the study [36] conducted in Zimbabwe. It revealed that women with obstetric fistula faced the following psychological problems: helplessness, sadness, suicidal thoughts, stigma and blame, feelings of worthlessness, fear, shame and social withdrawal. Similarly the results also agree with another study in Kaptembwa –Nakuru, Kenya, which revealed that loneliness, separation and despair were the major effects of fistula among the victims [37]. Other than collaborating finding from this gives insights on how family members are affected by fistula survivors. The strained relationship between the survivor and her family members shows how those family members feel about the client's situation. This, therefore, indicates that the fight against fistula cannot be won unless it is addressed by a comprehensive and holistic strategy targeting the client, her family and immediate community members with effective and structured psychosocial support services.

5. Conclusions and Recommendations

5.1 Conclusions

Obstetric fistula has remained one of the most devastating complications for one to experience in the course of delivery in Kenya. With many mothers not having access to skilled delivery, the incidences of obstetric fistula may be higher than expected given the rampant prevalence of acute poverty and low literacy levels in western Kenya. Many of these women suffer long term morbidity and often become social outcasts in their societies. They experience psychological consequences such as sadness, shame, loss of self-worth and suicidal tendencies. Socially, they suffer from stigmatization, social worthlessness and social isolation. They are simply social outcasts in their communities.

5.2 Recommendations

i. There is need to address negative cultural practices that contribute to obstetric fistula. Communities should be sensitised about fistula to re-integrate fistula victims or survivors in order to reduce the stigma and improve the support structure for fistula survivors.
ii. Organisations implementing fistula interventions should offer effective psychosocial support services to fistula clients who should include counselling services and skills / vocational training sessions to fistula victims and survivors on issue that can affect their mental and social well-being.
iii. The government should encourage male involvement in fistula repair and management as they exert a huge influence in the health matters of women.

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