UNIVERSITY FOR DEVELOPMENT STUDIES

THE LIVED EXPERIENCES OF WOMEN WITH OBSTETRIC FISTULA IN THE NORTHERN REGION, GHANA: A QUALITATIVE STUDY

AGAMBA SHALINE

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BY

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(MPH MATERNAL AND CHILD HEALTH)

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DECLARATION

I declare that this dissertation, with the exception of quotations and references contained in published works which have been duly acknowledged, is entirely my original work and has not been submitted, either in part or whole, for another degree in this University or elsewhere.

Signature:  Date: 28/06/2024

Name: Agamba Shaline

SUPERVISOR'S DECLARATION

I hereby declare that the preparation of this dissertation was supervised by me following the guidelines on supervision of the dissertation, as laid down by the University for Development Studies.

Signature:  Date: 28/06/2024

Name: Dr. Gilbert Abotisem Abiiro

ABSTRACT

Obstetric fistula is a form of maternal morbidity which can lead to a prolonged disability and poor quality of life. . In this study, the lived experiences of women with obstetric fistula in the Tamale Metropolis were investigated. A qualitative phenomenology design was used to explore the health care needs, treatment challenges, health seeking patterns and socio-cultural consequences of living with obstetric fistula. The study used purposive and snowball sampling techniques to recruit participants. In-depth interviews and key-informant interviews were conducted with eleven obstetric fistula women and three healthcare providers respectively using interview guides. The data was analyzed manually using thematic content analysis. The results showed that improved antenatal care services, access to skilled healthcare practitioners, health facilities and adequate services were the common healthcare needs of the respondents. The treatment challenges reported by the women included financial barriers, repeated/unsuccessful repairs, negative attitude of health professionals, and difficulty coping with postoperative instructions. When seeking treatment for obstetric fistula, the participants tried traditional methods such as spiritual therapies and herbs before finally reporting to the hospital. Extended family members and husbands were found to be the major source of support for women with obstetric fistula in this study. The socio-economic consequence faced by the women were problems with social integration, stigma and psychological trauma, reduced self-esteem, and economic challenges. Some of these difficulties were short-lived especially following corrective surgery while new ones emerged in some cases even after surgery. Therefore, it is critical to give obstetric fistula treatment a top priority and to allocate resources to enhance both the general well-being of women, and the quality and accessibility to fistula treatment. Also, women living with obstetric fistula requires financial support and psychosocial counseling.

DEDICATION

I dedicate this project to my beloved son and husband.

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MAY YOU ALL BE BLESSED BY THE GOOD LORD!!

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LISTS OF ACROYNMS/ABBREVIATIONS

Acronym/Abbreviation	Meaning
ANC	Antenatal Care
DRC	Democratic Republic of Congo
GHS	Ghana Health Service
GSS	Ghana Statistical Service
MoH	Ministry of Health
OPD	Out Patient Department
PMO	Principal Midwifery Officer
PTSD	Post-Traumatic Stress Disorder
RCH	Reproductive and Child Health
SDA	Seventh Day Adventist
SDG	Sustainable Development Goal
SMO	Senior Midwifery Officer
TTH	Tamale Teaching Hospital
UDS	University for Development Studies
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background

Obstetric fistula is a form of maternal morbidity which can lead to a prolonged disability and poor quality of life (Bashah et al., 2018). Research has shown that obstetric fistula is not common in high-income countries owing to an improved obstetric care in these settings in the last century (Polan et al., 2016) contrasting sharply with low- and middle-income countries (LMIC) where obstetric fistula is still prevalent causing both maternal morbidity and mortality (Neogi et al., 2020; Zaghbib et al., 2021). Consequently, obstetric fistula and preventable child-related morbidity and mortality pose great challenges to meeting the Sustainable Development Goal Three (SDG 3) in low- and middle-income countries (Romanzi et al., 2019).

Obstetric fistula occurs through prolonged and abnormal labour where the head or the body of the baby is too large to fit through the pelvis of the mother in a condition known as Cephalo pelvic disproportion (Ryan, 2014). Consequently, pressure is mounted on the tissues as a result of this disproportion and persistent ischemia causing tissue necrosis resulting in the formation of fistula (Ryan, 2014). Moreover, this condition could take place in cases where the baby is in the wrong position or there is an incorrect relationship between the pelvis and the baby even though the baby fits the pelvis. Persistent and unmanageable leaking of feces and/or urine can result in wide-ranging stigmatization of women living with obstetric Fistula (Duko et al., 2021).

The ramification of the fistula is not just detrimental to the affected women but to their families as well (Bashah et al., 2018). Other than the medical condition, most affected women are generally shunned from their communities, abandoned, and divorced (Drew et al., 2016). Furthermore,

affected women often remained childless and are criticized by most people in their communities who view the complication as a punishment for a sin committed by these women (Gatwiri, 2018). Such women are often regarded as unhygienic preventing them from taking part in social gatherings and religious activities (Gatwiri, 2018). Improvements in obstetric care such as skilled birth attendance, obstetric care during emergencies, and preparing adequately for birth complications are essential in controlling obstetric fistula. Studies in Ghana have shown that, despite the high antennal clinic attendance of women (97%), much lower cases of assisted delivery have been conducted (74%). For instance, a study in the Central region showed that up to 30% of the women delivered outside the health facility despite high antenatal attendance at the clinic (GSS, GHS, 2015).

Women suffering from fistula often live in a distressful state and have fear for their lives (Barageine et al., 2015). Thus, with respect to fistula, the lived experience refers to the situations or conditions these women go through owing to their fistula condition which could be medical, physical, psychological, or socioeconomic. Moreover, the care approach for women suffering from fistula could be in three forms including awareness (fistula is treatable and preventable), provision of health care needs (surgery, treatment patterns, and treatment challenges), and reintegration of community and family members (Jarvis et al., 2017). Treatment patterns generally refer to the medications, surgical procedures, and conservative treatments which includes modification of diet (Iglay et al., 2022).

Some socio-cultural practices and cultural beliefs have been shown to influence the occurrences of fistula (Mselle & Kohi, 2015a). Factors such as low decision-making power of women, gender inequality, poor economic status, and malnutrition could contribute significantly to fistula among women. For instance, men usually control women in terms of their decision to seek health care

services and mobility to the health care center (Mselle & Kohi, 2015a). Studies have shown that an effective approach to providing care for women with fistula could include reintegration of families and community members, raising awareness, and providing improved obstetric care at the health facilities (El Ayadi et al., 2020; Shallon et al., 2018). Understanding the lived experiences of women suffering from fistula after complicated labour could raise the attention of stakeholders and policy makers in Ghana to help eradicate this devastating complication through an effective health system.

1.2 Problem statement

Globally, between 50,000 and 100,000 women worldwide get obstetric fistulas each year, and more than 2 million women are currently suffering from this complication (Swain, 202; WHO, 2018). Obstetric fistula prevalence has been steadily rising in sub-Saharan Africa, at roughly 10 per 1000 births (Stanton et al., 2007; UNFPA, 2018). Moreover, about 1538 women were reported to suffer from fistula between 2011 and 2014 in Ghana with majority of the cases occurring in Northern Ghana (GHS, 2015). Previous evidence in Ghana revealed a prevalence of obstetric fistula ranging from 1.6 to 1.8 per 1000 births with the Northern region recording the highest prevalence rate (GHS, 2015).

Obstetric fistula has been shown to affect women in terms of their physical, physiological, mental, economic as well as social status. For instance, women living with fistula are often avoided by the community, abandoned by families, divorced, depressed, and constantly criticized by members around them (Iyagba & Briggs, 2021; Sori et al., 2021).

Studies conducted in Ghana have contributed in raising awareness on the detrimental nature of obstetric fistula (Saeed et al., 2014). A prior study assessed the awareness of obstetric fistula.in

terms of risk factors and treatment seeking behaviors (Azanu et al., 2020). Another study explored the knowledge of obstetric fistula among women attending prenatal care services at the clinic (Jarvis et al., 2017). However, little is known regarding the lived experiences of women with obstetric fistula in the Northern Region especially the regional capital. In this regard, this study explored the lived experiences of fistula-affected women in the Tamale Metropolis, Northern Region of Ghana.

1.3 Research questions

1.3.1 Main research question

What are the lived experiences of women with obstetric fistula after a complicated childbirth in the Northern Region, Ghana?

1.3.2 Research questions

- What are the health care needs of women living with obstetric fistula after a complicated childbirth in the Northern Region?
- What are the treatment challenges faced by women living with obstetric fistula after childbirth in the Northern Region?
- What are the health care-seeking patterns of women living with obstetric fistula after childbirth in the northern region?
- What are the socioeconomic consequences of living with obstetric fistula after childbirth in the Northern Region?

1.4 Study objectives

1.4.1 Main objective

The main objective of the present study is to assess the lived experiences of women with obstetric fistula after a complicated childbirth in the Northern Region, Ghana.

1.4.2 Specific objectives

- To identify the health care needs of women living with obstetric fistula after a complicated childbirth in the Northern Region
- To explore the treatment challenges faced by women living with obstetric fistula after childbirth in the Northern Region
- To explores the treatment-seeking pattern of women living with obstetric fistula after childbirth in the Northern Region
- To explore the socioeconomic consequence of women living with obstetric fistula after childbirth in the Northern Region

1.5 Significance of the study

The importance of improving obstetric care among women in Ghana cannot be overemphasized. However, most people have some misconception regarding obstetric fistula which is treatable as well as preventable. Fistula-affected women are often neglected in most communities with people perceiving the complication to be a curse or a punishment of those women. High cases of fistula have been reported in the northern part of Ghana. In order to meet the SDG3 which aims at reducing global maternal mortality among mothers by the year 2030, the policy makers and stakeholders in the society need to be well informed about the devastating life experiences of women with fistula after childbirth. This may enable these important stakeholders to intervene in providing a lasting solution to this preventable complication. Moreover, the outcome of this

research may contribute to enhancing the maternal health services delivered at various healthcare facilities in the Northern Region.

The findings of this study may serve as an important source of knowledge regarding the experiences of women living with obstetric fistula which may aid in enhancing delivery programs targeted to these women. Additionally, this study's findings may aid in fostering behavioral change concerning the condition these women face. The study's findings may help develop strategies to encourage victims of obstetric fistula together with their families on ways to seek access to repair services of fistula in order to mitigate the problem. Finally, this study may be stepping stone and baseline for other researches that will be conducted in the future.

1.6 Organization of the study

The current study is organized into six chapters. The first chapter (introduction) comprised the study background, the problem statement, and research questions, study objectives, and the significance of the study. The second chapter focused on the review of relevant literature concerning the topic and the conceptual framework of the study. The third section presents the methodology of the study. This section covers the study region, study design, study population, sampling size, sampling strategy, data gathering procedure, data collection tools, data management, data analysis, and ethical considerations. The fourth section presents the results both in tables and graphical formats. Presentation of the results and comparison with previous literature is presented in the chapter five of this research. Finally, the last section presents the general conclusion, summarizing the major findings, and the study recommendation.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section of the thesis presents a review of the conceptual, theoretical, and empirical literature on the lived experiences of women with obstetric fistula. The present review is structured according to maternal health, the concept and types of fistulae, lived experiences with obstetric fistula, factors associated with obstetric fistula, transactional model of stress and coping, stigma theory, the theory of ecological system, health care needs of women living with obstetric fistula, treatment challenges of women with obstetric fistula, socio-cultural/economic experiences of women with obstetric fistula, summary of the review findings and the conceptual framework of the study. Online databases were used to retrieve relevant materials on these topics. These databases included Google Scholar, PubMed, and EBSCO Host. The key terms used in the search engines comprised several combinations of fistula, obstetric health, and reproductive health.

2.2 Maternal health

2.2.1 The concept of maternal health

According to the WHO (2023), "maternal health" is a term that describes the condition of women before, during, and after childbirth. The stages of maternal healthcare include pre-conception, early pregnancy services, antenatal care, delivery care, and postnatal care. Every stage ought to be positive to ensure that both the mother and her unborn child enjoy the best possible health and well-being (Lotto et al., 2023).

2.2.2 Pre-conception and early pregnancy services

Some of the services the woman should get access to during the pre-conception period are advice and counseling concerning alcohol consumption, smoking cessation, and dietary advice (Taneja et al., 2020). Other services include the consumption of folic acid to control neural tube defects (Chandra-Mouli et al., 2013). Furthermore, women having medical problems, poor obstetric history, and family history of relevant serious sicknesses benefit from the services of early pregnancy (Chandra-Mouli et al., 2013). Early pregnancy service focus on any untoward symptoms including abdominal pain, bleeding and arranges appropriate treatment and investigations (Chandra-Mouli et al., 2013).

2.2.3 Antenatal care

The WHO defined antenatal care as the care which is given by skilled health-care professionals to pregnant women and adolescent girls to ensure the best health conditions for both baby and mother during pregnancy (WHO, 2016). The components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion (WHO, 2016). The WHO has recommended a new ANC model of attaining at least eight ANC contacts, on the basis of recent evidence that indicates improvements in health outcomes and an increased likelihood when receiving effective maternal health interventions under the new ANC model compared to four focus ANC model. It is believed that the recommendation will help to lower perinatal mortality and enhance women's healthcare experiences (Raïssa Kourouma et al., 2021; WHO, 2016). The recommendations include universal and context-specific interventions. The recommended interventions span five categories: routine antenatal nutrition, maternal and fetal assessment, preventive measures, interventions for management of common physiologic symptoms in pregnancy, and health system-level interventions to improve the

utilization and quality of ANC (WHO, 2016). Some of the recommendations for the WHO for routine ANC are gynecological examination, urine test, laboratory investigations, advice on emergencies, birth preparedness, delivery, and lactation; education concerning delivery and recognizing warning signs; supplementation of iron and folic acid, immunization of tetanus toxoid (WHO, 2003).

2.2.4 Delivery Care

For women who have uncomplicated pregnancy and child birth, routine care is provided to them at the community level. Some of the basic care services given at the delivery period include active management of the third stage of labor; early cord clamping; clean birthing technique; essential newborn care; controlled cord traction; oxytocic on the birth of the anterior shoulder (WHO, 2003).

2.2.5 Postnatal care period

Postnatal care is the care a mother receives for a period of six weeks since the time of delivery (Iddrisu et al., 2019). Postpartum period is the period that starts from one hour after the delivery of placenta and up to the end of six weeks after delivery. Given the high rate of maternal and infant deaths during this period, it is a crucial moment in the lives of expectant mothers and their newborn children. Thus, the WHO recommends four postnatal care contacts that a mother is supposed to receive. When giving birth at home, the first postnatal contact should occur as soon as feasible within 24 hours of the birth, but for an easy vaginal delivery in a medical facility, healthy mothers and babies are expected to receive care for at least 24 hours following delivery (Jones et al., 2021). The subsequent three care contacts should be received on the 3rd day (48–72 hours), between the 7th and 14th day after birth, and the 6th week after birth (WHO, 2014).

2.3 Fistula

2.3.1 Concept and types of fistulas

Conceptually, fistula is defined as any unnatural connection that occurs between two or more body cavities and/or between a body cavity and the surface of the skin (Polan et al., 2016). Among a few examples, fistulas can occur between the skin surface and the gut or between the vagina and the rectum (Polan et al., 2016). They develop when internal sores brought on by inflammation become so bad that they carve out a tunnel in the tissues of the body (WHO, 2021). Fistulas can be brought on by several conditions/ailments, such as surgery, Crohn's disease, and abscesses (Nalubwama et al., 2020). The location of the fistula predicts the signs and symptoms it will come with. For instance, a fistula between the colon and the bladder might result in red or murky urine as well as urinary tract infections (Maheu-Giroux et al., 2015).

Basically, four different kinds of fistulas exist which are categorized based on where they occur (WHO, 2018). These are:

- ***Enterocutaneous fistulas:*** This is a form of fistula that extends form the intestines to the skin. This type of fistula may be a complication of a surgical procedure or as a result of a chronic disease. One way to think of it is as a path that runs from the colon through the surgical site and finally to the skin.
- ***Enteroenteric or enterocolic fistula:*** This type of abnormal communication involves the small or large intestines.
- ***Enterovesicular fistula:*** This form of fistula leads to the bladder. Frequent urinary tract infections or the flow of gas from the urethra during urination may be caused by these fistulas.

- ***Enterovaginal fistula.*** This is a fistula that connects to the vagina and is more common among mothers. In other literature, enterovaginal fistula is referred to as obstetric fistula which is among the leading complications associated with pregnancy and child birth (WHO, 2018).

2.3.2 Obstetric fistula

Several literatures have proposed varying definitions to the concept of obstetric fistula which literally mean the same thing. For instance, Tebeu et al. (2012) defined it as an abnormal connection/hole that exists between the vaginal tract of a woman and either her digestive or urinary system. Also, according to Kimani et al. (2014) obstetric fistula is an improper connection made between the vagina and the bladder or rectum (Kimani et al., 2014). Lyimo and Mosha (2019) elaborated that majority of gynecological fistulas are caused by protracted or obstructed labor. In the interest of this research, obstetric fistula is conceptualized as a form of maternal morbidity involving a hole in the vaginal tract of the woman as a result of obstructed or protracted labor which can lead to a prolonged disability and poor quality of life.

Literature has shown that, the oldest known instance of an obstetric fistula was discovered in an Egyptian mummy from the Eleventh Dynasty named Henhenit in 2050 BC, and it appeared that she had a vesico-vaginal fistula (Polan et al., 2016). Avicenna, a Persian Physician, discovered and outlined the connection between the emergence of fistula and obstructed labor in 1037 AD (Zacharin, 2000). But today, there are several women living with this condition in both low-and-middle income countries.

2.3.3 Prevalence of obstetric fistula

In a global meta-analysis of nineteen studies, Adler et al., (2013) noted in a population-based research that, the overall prevalence of fistula per 1000 women of reproductive age was 0.29 in

all geographical areas (Adler et al., 2013). When the authors separated the population by regions, they discovered that 1.57 per 1000 women of reproductive age in South Asia and sub-Saharan Africa, 1.60 per 1000 women in sub-Saharan Africa, and 1.20 per 1000 women in South Asia had obstetric fistula. In another clinically reviewed paper comprising 19 published articles from Africa and the Middle East on general fistula cases, it was found that, 79.4% to 100% of reported fistulas were obstetrical (Tebeu et al., 2012). Out of this proportion, 1% to 8% were accounted for by rectovaginal fistulae, 79% to 100% by vesicovaginal fistulae and 1% to 23% by both rectovaginal and vesicovaginal fistulae (Tebeu et al., 2012).

2.4 Lived experiences of women with obstetric fistula

2.4.1 Physical consequence

Women living with fistula have been reported to face physical challenges such as medical and emotional problems which are as a result of incontinence including smells, genital sores, wounds, discomfort, pain, foot drop, and exhaustion (Hurissa et al., 2022). Studies have revealed that women with obstetric fistula are not able to afford medical fees or hygiene keeping supplies and thus, they sooth their sores using herbs (El Ayadi et al., 2019). In controlling the leakage, some of them prevent themselves from feeding like they used to feed before the period of fistula, and this leads to loss in weight (Bangser et al., 2011). Furthermore, obstetric fistula victims tend to bath consistently in an attempt to control the discomfort, smell and to stay hygienic. Hence, some of them get bored of bathing repeatedly (Mselle & Kohi, 2015).

In a qualitative investigation into the real-life experiences of Zimbabwean women, one participant narrated that *"In order to control the flow of the urine, I used old cloths. I am very uncomfortable because I am always wet. I got sores and feel itchiness on my thighs as a result of the wetness. Most of the time, the lesions become very painful deep in my wounds"* (Peta et al., 2017).

Resultantly, walking exercises were limited by the women because it might worsen the sores and wounds. The study further reported that some women experienced urinary tract infections frequently. In a different survey, another survivor of this menace asserted that *"Owing to the continuous wetness I experienced, my vulva was bruised. I halted visiting the church and other gatherings since I could not walk due to the wounds on my thighs and vulva"* (Bryan, 2011).

2.4.2 Psychosocial experiences

According to integrative review of the literature on the lived experiences of women with obstetric fistula, the most extensively cited challenges were the psychosocial challenges associated with obstetric fistula, especially stigma, loss of status, and physical isolation (Barageine et al., 2015; Changole et al., 2017). The consistent flow of faeces and/or urine insinuates unpleasant smell and wetness which could repulse their spouses, families and community members (Changole et al., 2017).

According to Siddle et al. (2013), the unpleasant smell and wetness that obstetric fistula women go through has super distressing impact on their psychosocial experiences. Such victims are being insulted, shunned, and excluded from societal activities (Mwini-Nyaledzigbor et al., 2013). In their explorative study, Farid et al. (2013) established that many muslim women were being secluded from participating in religious matters including entering the place of worship (Farid et al., 2013). Furthermore, some women showed symptoms of depression, suicidal thoughts, and worthlessness due to the way they are being handled by their peers (Changole et al., 2017). According to Gebresilase (2014), in most cases, their ability to perform everyday tasks and fulfill their roles as wives is hindered by their negative body image, which ultimately has a substantial effect on their relationships and causes them to lose their independence (Gebresilase, 2014). As a result, members of the family suffers psychological stress concerning the plight of their wives or daughters.

One may argue that corrective surgery could put an end to most if these stressors. Meanwhile, according to a Kenyan research, women in West Pokot who underwent corrective surgery still reported ongoing issues such as separation and divorce, infertility, stigma, loneliness, shame, the diminished feeling of value, misperceptions of others, psychological trauma, and unemployment (Khisa & Nyamongo, 2012). With the widespread consensus that a fistula has adverse social and psychological consequences as a result of its physical manifestations and the fact that they are constantly noticed for leaking urine and odor, there is also evidence in other low-income settings in Africa and Asia (Mwini-Nyaledzigbor et al., 2013).

In Western Kenya, Mohameda et al. (2016) explored the psychosocial effects of obstetric fistula on young mothers, the main psychological impacts of obstetric fistula were despair, embarrassment, and loss of self-worth. Their study highlighted social worthlessness, isolation, and stigmatization as the primary social consequences of obstetric fistula (Mohameda et al., 2016). Furthermore, Bashah and co (2018) noted that women with obstetric fistula frequently deal with detrimental mental health issues including despair, sentiments of dependence, helplessness, fear of the future, loss of dignity and post-traumatic stress disorder (PTSD). These frequently come about as a result of the condition's stress, lack of support, social shame, economic incapacity, ignorance of fistula treatment options, remarks and responses from others, and the perceived sense of pessimism (Bashah et al., 2018).

Compared with almost two-third of women who had advanced pelvic organ prolapse, an Ethiopian research found that nearly every woman with obstetric fistula are depressed (Zeleke et al., 2013). Likewise, in comparison to other women visiting a gynecology clinic for various gynecological disorders, a different study indicated that obstetric fistula patients had considerably greater rates of PTSD, depression, physiological issues, and unhealthy coping mechanisms (Wilson et al.,

2015). Moreover, depression is reported to be more prevalent in older women, divorcees, unemployed people, people who perceive their fistula as a serious problem, people who lack social support, and those who have had a fistula for longer than three months (Mohameda et al., 2016; Zeleke et al., 2013).

2.4.3 Marital disruptions, sexual and reproductive life

Literature have shown that, the development of obstetric fistula in majority of the cases could lead to rejections, divorce and complete separation from family members (Bashah et al., 2019; Mwini-Nyaledzigbor et al., 2013). Since obstetric fistula reportedly affects intimate relationships between couples, it is therefore a substantial contributor to marital disruptions (Mwini-Nyaledzigbor et al., 2013). In certain polygamous situations, women suffering from obstetric fistula were still living with their spouses though without having any sexual relationship with them (Mwini-Nyaledzigbor et al., 2013). Most of the sexual problems associated with this menace are as a result of dyspareunia, together with incontinence, soiling and odors (Anzaku et al., 2017). Also, women who still had sexual relations with their spouses cited challenges of disgrace from leakages, whereas others perceived it as torturous (Blum, 2012). Moreover, Mwini-Nyaledzigbor et al. (2013) revealed that soreness, genital itch, burning sensation, as well as the appearance of blood and pus in urines could be other physiological symptoms affecting such women. Studies have reported that most husbands helped their spouses in handling their fistula challenges (Donnelly et al., 2015; Landry et al., 2013b). Similarly, a study in the Southern part of Nigeria found that majority of women suffering obstetric fistula problems continued to stay in harmony with their husbands (Umoiyoho et al., 2011). In another study, the presence of children was another crucial element which ensured marital stability (Turan et al., 2007).

In other settings, victims of obstetric fistula are normally regarded as "useless beings" since they are not able to discharge the roles which are expected from them by the family. Hence, they are usually abandoned or neglected. In a qualitative study, an obstetric fistula survivor lamented that she was not treated well by the husband: *"He neglected me and threw out all of my belongings. Since I had fistula to date, we have not been living as couples"* (Mselle et al., 2011). Even after a successful repair of obstetric fistula, various socio-cultural elements still stand as barriers to reuniting such women with the their community (Hurissa et al., 2022). Moreover, married women with obstetric fistula are frequently taken back to their parents' house where they are not permitted to cook, take part in social activities, or participate in religious ceremonies until they are healed. In some situations, such women are forced to sign divorce forms as a woman with tears over her face recounts; *"My husband informed me that I have to sign the divorce letter. He gave me some of our family property and sent me off..."* (Animut et al., 2019). Conversely, a research conducted in Malawi found that survivors of obstetric fistula, especially those who got divorced due to the condition, easily get remarried after a successful repair (Yeakey et al., 2009).

2.4.4 Mental health consequences of women

Studies in the literature have demonstrated that women living with obstetric fistula are affected by mental health problems including loss of dignity, inability to seek care, and lack of support (Duko et al., 2021). According to a study conducted in sub-Saharan Africa, feelings of dependency, fear of future life, and loss of hope, were highlighted as mental health challenges faced by obstetric fistula women (Bashah et al., 2018; Mutabazi-Mwesigire et al., 2014). The mental health problems suffered by victims of obstetric fistula are linked to various interrelated factors including lack of family care and support, economical and physical incapability to seek care, and poor understanding concerning fistula treatment and care (Nsemo, 2014). Also, it might be as a result of comments

and reactions from people with a poor knowledge of the problem/condition (Bashah et al., 2018). Social stigma together with perceived causes of fistula have consequently lead to psychological morbidity among women (Bashah et al., 2018).

2.5 Factors associated with Obstetric Fistula

In a qualitative study in Ethiopia, a 40-year-old woman who has lived with obstetric fistula for about ten years recounts whiles crying that: *'...I wouldn't get this disease. Now I am living alone in a little hut'* (Animut et al., 2019). In the same study, another woman who has lived with the condition for more than three decades explained that she developed the condition at age nine when she started having sexual intercourse after marriage. Furthermore, similar results were reported in the Kebbi State, Nigeria, which showed a significant correlation (p-value <0.001) between the occurrence of vesicovaginal fistula and respondents' age. The majority of people with vesicovaginal fistula were between the ages of 15 and 26 years; however, individuals between the ages of 27 and 38 years were not as afflicted (Basheer & Pumpaibool, 2015). In Malawi, an explorative study was undertaken at the Fistula Care Center in Lilongwe, to understand the long-term quality of life and results among women who had obstetric fistula repair. The authors established a significant association between religious affiliation and obstetric fistula (Drew et al., 2016). Out of the 20 women with history of obstetric fistula in their study, more than half belonged to other religious affiliations other than Islam and Christianity. While Mselle & Kohi (2015) defined women with obstetric fistula as those with limited access to obstetric care, access to professional obstetric care is, without a doubt, referred to as a crucial instrument to combat maternal morbidity and mortality (Mselle & Kohi, 2015b).

Furthermore, parity of women has also been found by several researchers to be a significant contributor to the development of obstetric fistula. For example, a population-based sample was

used in a study in Pakistan to evaluate the prevalence of obstetric fistula, and the researchers observed that a larger percentage of the sample population who had the condition were primiparous women (Jokhio et al., 2014). According to a retrospective examination of hospital-based data undertaken in Dodoma by Lilungulu et al., the majority of the obstetric fistula cases were linked to protracted and difficult vaginal deliveries, with only two being linked to C-sections and hysterectomy (Lilungulu et al., 2018).

2.6 Theoretical review on obstetric fistula

2.6.1 The transactional model of stress and coping

This model elaborates on how individuals cope or deal with stressful events. When individuals are affected by stress, they examine the importance of a stressor as challenging, controllable, positive, or stressful, and making efforts to cope with it. Nonetheless, as far as this model is concerned, when individuals' perception of risk increases, it may lead to stress (Glanz et al., 2008). When individuals encounter stress, they do not only explore the stressful events' features, but also what they can do to address the situation. They manage their emotional reaction to the threat and examine their perceived capacity to address the event (Glanz et al., 2008).

The concept of this model is based on two dimensions: emotion-focused coping strategy and problem-focus coping strategy. The efforts of the emotion-focused coping strategy are directed at altering the way an individual feels or thinks about a stressful event. This dimension is more appropriate especially when the stressor cannot be changed. These may include the following; venting of feelings, seeking social support, denial, and avoidance (Mselle & Kohi, 2015a).

Similarly, women who are suffering from obstetric fistula encounter problems with some form of constraint such as information seeking, planning, active coping, problem-solving, and social

support utilization in situations they are affected by stress. The importance of stressors is being evaluated by them as challenging, controllable, positive, and stressful because they do not have a choice to make in stressful events.

2.6.2 The Stigma theory

Social stigmas can happen in several ways, including race, gender, culture, and disease. People who undergo stigmatization in society often feel devalued and different from others. Labeling someone that related him/her to a set of undesirable qualities that create a stereotype could be termed as a stigma (Akkoca, 2019). People in societies will continue to stigmatize an individual when they always see the stigmatizing characteristic in him and may stop when that attribute is no longer detectable. Several important generalizations are necessary to form groups, insinuating that regardless of how to fit a person is in a group, an individual is considered in the general group. Notwithstanding, the characteristics that people in the society identify vary due to place and time. What society sees as the norm may not be considered as a norm in another society (Goepfert et al., 2019).

Goffman's theory proposes that stigma is a characteristic, behaviour, and status devalued socially in a way that it makes a person be classified as undesirable mentally by others, a disregarded stereotype instead of an accepted or normal one. According to Goffman, stigma can be defined as an essential form of a gap between an actual social identity and a virtual social identity (Goffman, 2009).

Stigmatized people are often devalued, ostracized, shunned, and ignored. They go through all forms of discrimination at the workplace and in the realms of housing (Gladys, 2019). Perceived discrimination and prejudice are also related to adverse mental and physical health status (Doan Van et al., 2019). Research has shown that many young individuals who go through stigma related

to mental health challenges may experience negative behaviour from friends (Goepfert et al., 2019). Other literature have also stressed that individuals who consider themselves part of being stigmatized often face issues such as psychological distress, and some see themselves as contemptuous (Habtom, 2018; Lynch et al., 2021).

Even though stigmatization negatively impacts a person's academic performance, self-esteem, and other important outcomes, some stigmatized people perform exceptionally well, have higher self-esteem, and seem content or resilient in the face of their negative experiences (Goepfert et al., 2019). Additionally, there could also be something termed as a positive stigma: there is the possibility that one could be extraordinarily smart or rich. This is contended by Goffman when he explained about leaders who are permitted to act contrary to some norms owing to their significant contributions beyond society's expectations. This could lead to stigma in society (Goffman, 2009).

The present study implemented the theory of coping by Lazarus et al. (1980) and the theory of stigma by Goffman to elaborate experiences of fistula-affected women. Stigma was implemented in terms of the perception of the women regarding the manner and way of the experiences they have lived before (LAZARUS et al., 1980).

According to Goffman, stigma could be defined as "an attribute that is significantly discrediting" (Goffman, 1963). Consistent with the social domain, a person who is stigmatized has attributes that are not desirable or which deviate from social norms (Goffman, 1963). Stigma is a social process that is always changing, and the convergence of five interrelated components could bring about its occurrence. These components include separation, stereotyping, labeling, discrimination, loss of status, and political and social power (Przyborski & Wohlrab-Sahr, 2020).

Studies have shown that discrimination could be self-imposed/structural or individual. In anthropology, stigma is still not contextualized and remains empty if it does not entail any meaning from individuals' lived experiences. According to Yang and colleagues, the pragmatic reaction to "real dangers, perceived threat, and fear of the unknown" could be termed stigmatization, which could be felt or enacted (Yang et al., 2007). The unfair or unjust treatment directed to others toward the stigmatized individual is termed enacted stigma. These include acts and attitudes of discrimination. On the other hand, the stigmatized person's fear of discrimination and the internal feelings of shame are terms of stigma (Lynch et al., 2021).

The reaction to a stressful event is coping, which is consistently brought about by changes or activities solely determined to keep the individuals' emotional and mental well-being (Musyoki et al., 2020). Generally, there are two forms of coping strategies, namely, emotional-focused coping and problem-focused coping. Emotional-focused coping is tailored toward mitigating or managing the associated-emotional distress of the event. At the same time, problem-focused coping is focused on making efforts to change the source of the stress or solve the problem. Some stressors are able to elicit both coping forms, yet the predominant one among individuals who have the feeling that something should be done is the problem-focused coping strategy. By contrast, the predominant one among individuals with the sense that stressors could be endured is emotion-focused coping (Musyoki et al., 2020).

2.7 Conceptual framework of the study

In this study, the framework assumes that four specific applications of interest are associated with the lived experiences of women with fistula. The first focus is termed as "health care needs," which put more focus on explaining the lived experience of women with obstetric fistula, including the skilled healthcare services, access to healthcare facility, and availability of healthcare facilities.

The second focus is referred to as "treatment challenges," which puts more focus on what happened in the individual on the course of seeking treatment for the condition. The third focus is termed as the "socio-cultural factors," which depicts the cultural and social factors which contributes significantly to the development as well as the treatment of obstetric fistula. The fourth focus denotes "healthcare seeking pattern" which concerns the pattern of health care that is being sought by women with this condition.

The model includes the objectives of the present study, the lived experiences of women with obstetric fistula such as the health care needs of women living with obstetric fistula, and the treatment challenges faced by these women. Therefore, the first construct of the framework answers the first and second objectives. These two objectives entail the healthcare needs and treatment challenges faced by the women with obstetric fistula. Conceptually, these needs and challenges could be influenced by the sociocultural factors surrounded by the woman. For instance, the attitudes and beliefs a woman holds on to may affect her needs in terms of healthcare such as body odour, fitness, and urine or faces discharge. Moreover, sociocultural factors such as family's and community's support could also lead to treatment problems. The health challenges that may occur could have a specific effect in terms of causing disease to the wellbeing of the individual, including fitness, the odour of the body, and faces/urine. The variables presented on the socioeconomic variables are stigmatization, divorce, inability to work and isolation. Cultural parameters refer to the attitudes and beliefs of the individual.

Fistula affected women who have been ignored would be more likely to encounter these treatment challenges compared to women who have been cared for and aided by their families, friends, and community members. Some of the treatment challenges faced by these women who have been ignored could include financial problems, transportation difficulty, and malnutrition. The second

construct of the framework which is on sociocultural factors which influences both healthcare seeking pattern as well as health needs, and treatment challenges of the woman. This construct answers the second objective which seeks to explore the social and cultural factors which affect the lives and needs of obstetric fistula affected women. The final construct which is based on healthcare seeking pattern answers the last objective, which seeks to answer the pattern regarding seeking healthcare among women living with obstetric fistula.

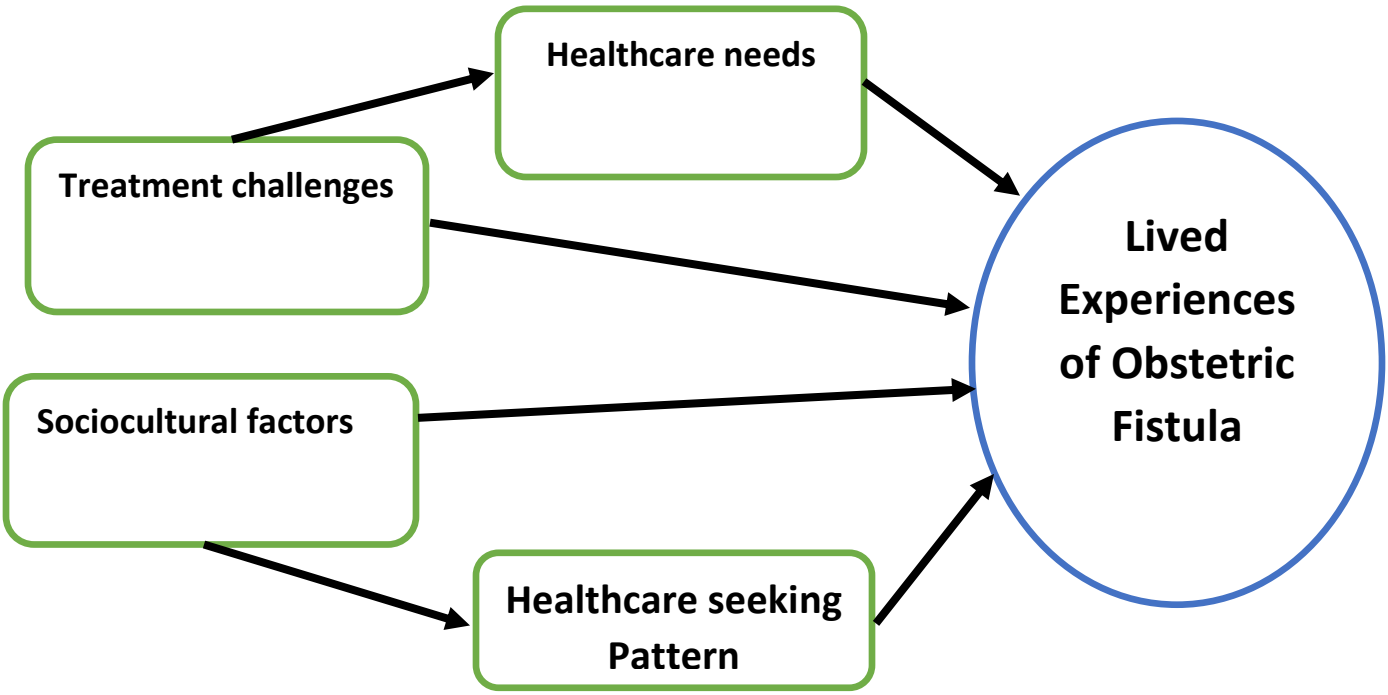

Figure 2.1: Conceptual framework of the factors affecting the lived experience of women with fistula

Conceptually, factors such as socioeconomic factors, treatment challenges, healthcare seeking pattern, and healthcare needs could ultimately affect the lived experiences of women with obstetric fistula. Theoretically, the transactional model of stress and coping, stigma theory, and the

ecological systems model explicitly shows the theories behind the lived experience of women with obstetric fistula and the challenges they go through.

2.8 Empirical evidence on health care needs of women living with obstetric fistula

2.8.1 Availability of skilled health care

Women suffering from obstetric fistula require special healthcare assistance during their condition and after the repair. The presence of skilled healthcare services for these group of individuals is critical in addressing these cares. A prior study has shown that, people with fistula condition tend to develop trust in hospitals providing skilled health services (Cromwell & Hilton, 2013). Also, when there is lack of skilled healthcare services, cases of fistula may be become rampant in the society. Other reports have shown that, the availability of services does not translate into utilization of services by the women (Pollaczek et al., 2022). Nevertheless, receipting proper care services from doctors, physicians, midwives, nurses, and other healthcare professionals have proven to contribute significantly to the fistula conditions of women (Mselle & Kohi, 2015).

2.8.2 Access to healthcare facilities and adequate healthcare services

In spite of the availability of healthcare facilities, it is crucially important for women to have the power to access these facilities and their services. Access to these important healthcare services could be determined by factors such as socioeconomic status of the women, perception of the women regarding these facilities and cultural or family beliefs (Dimbuene et al., 2018). Providing women with fistula the need for adequate healthcare is necessary to enhance the fistula cases in a country which could go a long way to empower them (Baker et al., 2017).

2.8.3 Regular antenatal care visits

Women with obstetric fistula need to be educated and advised to consistently use antenatal care services in order to improve and manage their condition. Women who attend ANC services are usually taking through series of education on emergency obstetric care, birth preparedness, and the significance of trained or skilled birth attendance (Sumankuuro et al., 2019).

2.9 Empirical evidence on treatment challenges of women with obstetric fistula

2.9.1 Difficulty in accessing proper treatment

Yeakey et al. (2011) explained the difficulty obstetric fistula women go through in accessing and seeking treatment for their condition. A study conducted by Alio et al. (2011) added the incidences of several failed attempts by women to get the proper care. Moreover, Yeakey et al. (2011) and the Women's Dignity Project (2006) cited the lengths women go through when they try to seek aid including accessing religious healers and traditional remedies, together with making several hospital visits. In addition, Mwini-Nyaledzigbor et al. (2013) highlighted concerns and challenges regarding financial constraints, spousal assistance, poor knowledge of repair service, poor access to professional care at health facilities, which all lead to women resorting to over-the-counter remedies or traditional remedies in order to get a cure (Mwini-Nyaledzigbor et al., 2013). According to a prior survey, Women's attempts to find a cure were not met with isolation; family and community members supported the women not only financially but also emotionally and providing assistance in terms of household chores (Yeakey et al., 2009). On the other hand, the fistula affected-women who lack support from their family and community were experiencing greater problems in accessing cure or treatment (Yeakey et al., 2009).

2.9.3 Financial burden on women and their families

Obstetric fistula places a heavy financial burden on victims and their families which results to their healthcare seeking challenges. Using quantitative and qualitative approaches in a cross-sectional study in southern Tanzania, it was found that women living with obstetric fistula had difficulties accessing healthcare for a variety of reasons, including lack of money or depletion of meager resources, lack of family support, and distance to healthcare facilities (Kazaura et al., 2011). Without access to a successful surgical correction, women with obstetric fistula are left with no alternative to face their own circumstances. In Ghana, a qualitative descriptive study which examined the experiences of women who experienced obstetric fistula during childbirth, found that obstacles to giving birth in a medical facility, and the difficulties of living with obstetric fistula, including socioeconomic, psychosocial, physical, and issues related to access to health care, are common (Mwini-Nyaledzigbor et al., 2013).

Economic difficulty resulting from being unable to work due to stigma or illness has also been cited by other literature (Landry et al., 2013a; Mwini-Nyaledzigbor et al., 2013) which has contributed to people relying too much on others for their livelihood (Khisa & Nyamongo, 2012). Additionally, maintaining women's hygiene was necessary for their participation in community activities, but doing so needed additional resources, which further put a pressure on family finances (Yeakey et al., 2009). Conversely, Nielsen et al. stated that some women, primarily farmers (92%), were able to continue earning a living while dealing with obstetric fistula, with only 22% choosing not to work (Nielsen et al., 2009). Other studies argue that, individuals with poor financial independence prior to the development of fistulas and those who were no longer living with their spouses experienced greater financial stress after developing the condition (El Ayadi et al., 2019; Pope et al., 2011). Intriguingly, it has been cited that socioeconomic comparisons between women in Bangladesh and the Democratic Republic of the Congo (DRC) revealed that DRC women had

greater financial freedom and autonomy, as they could still engage in financial activities despite the limitations of obstetric fistula (Mafo Degge et al., 2017). In their qualitative study 'to explore the lived experience of women with obstetric fistula at Bahir Dar Hamlin Fistula Center, Amhara Regional State, Ethiopia', it was revealed that, women were left to their own faith to fend for themselves after developing obstetric fistula (Animut et al., 2019). A woman hanging down to the floor whiles crying expressed the financial difficulties she faced living with this condition: *'...He (the husband) also told me to have someone who could work and produce income for supporting the household. I was unable to work as he expected…'* (Animut et al., 2019).

2.10 Empirical evidence on sociocultural experiences of obstetric fistula women

2.10.1 Beliefs about development and treatment of obstetric fistula

The beliefs and culture of women living with obstetric fistula plays a critical role in influencing the management type that is sought for their obstetric complications. Several studies have shown that culture plays a central role in shaping the perceptions and views of members of the society concerning obstetric fistula (Mohameda et al., 2016; Takang et al., 2022). Another study asserted that, culture shapes the lives of people more significantly especially among those who lack formal education (Donnelly et al., 2015). Also, culture has been shown to influence peoples' beliefs concerning perceptions about fistula, hospitals, and sociocultural practices that could increase risk of developing fistula (Mselle & Kohi, 2015a).

Most African societies belief that complications as a result of obstetric fistula are due to factors including witchcraft, heredity, and the will of God (Iyagba & Briggs, 2021; Mselle & Kohi, 2015a). Notably, these studies highlighted that most societies are established on basis of spirituality and tradition, resulting to a physiological challenge to be understood as caused by going against the society's custom. Some of these beliefs show that when the complications of fistula develop, the

blame is put on the women themselves (Kasamba et al., 2013). In addition, another study has asserted that, prior to women seeking medical care, they are entreated to apologize and confess their transgressions as well as doing a series of rituals which involves their husbands (Zheng & Anderson, 2009).

Some cultural beliefs according to studies perceive that the answer to obstetric fistula lies in religious and traditional practices (Banke-Thomas et al., 2013; Wegner et al., 2007). Such cultural beliefs perceive religious rituals and prayers as a way of managing these complications, yet do not aid the progression of labour directly (Wall, 2012b).

2.10.2 The perceptions of societies about Hospitals treating obstetric fistula

Studies have reported that most societies have negative perceptions about the hospital and healthcare facilities in general. A study reported that, people's responses to obstetric fistula as well as labour is being shaped by their fear of hospitals and healthcare facilities (Nalubwama et al., 2020). Notable, a prior study reported that, participants in the study were perceiving hospital as a place where individuals go to die (Wegner et al., 2007). Moreover, people's perception regarding the quality of care that are provided by these health institutions also plays a significant role in where and when to seek healthcare. These two studies detailed specifically that fear of healthcare facilities shaped responses to both labour and the condition itself. Some of these reports asserted that the care that is provided by these institutions are substandard trying to justify their negative perception about them (Wegner et al., 2007).

2.10.3 Cultural practices

Previous studies have argued that, the cultural practices surrounding marriage also contribute significantly in perpetuating fistula among women. Some parents in an attempt to ensure that their

daughters are financially secured married their daughters in exchange for bride price which has been reported to play a central role in the perpetuation of obstetric fistula (Lowes & Nunn, 2018). In other cultures, the bride price reduces with age which serve as an incentive for some people to allow their daughters marry at tender age (Corno et al., 2020). Resultantly, there is pressure on young girls who are newly married to give birth quickly, in order to prove that they are fertile, and to secure their respect and status (Nour, 2006).

Some studies have reported child marriage has a direct influence on the rates of fistula, which are prevalent in settings where women are married at tender age (Andargie & Debu, 2017; Woldegebriel et al., 2023). Some researchers contended that people participating in early marriage practices are not completely cognizant of the evil health consequences on the young girl (Montazeri et al., 2016). Some studies have also reported that child marriage as a means of violating human rights (Callister, 2013; Kanmiki et al., 2014).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents information on how the study was conducted. It covers the study setting, study approach and design, study population and sampling, methods and instrument for data collection, data collection techniques, credibility and dependability, data processing and analysis, and ethical considerations.

3.2 Study setting

The study was conducted in the Tamale Metropolis, the capital of the Northern Region of Ghana. The Metropolis is located in the western part of the region and is about 180 metres above sea level (GSS, 2021). It shares boundaries with Sagnarigu Municipality to the North and West, Mion District to the east, Central Gonja District to the south-West, and North-East Gonja District to the south (GSS, 2021). The dominant tribe/ethnic group are the Dagombas and the dominant religion is the Islamic Religion (GSS, 2021). The Bugum, Damba, and Eid festivals are the main traditional and religious celebrations where women play key roles (GSS, 2021). Regarding the population dynamics of the Metropolis, there are about 374,744 living in the Metropolis, with 185,051 men making up that number (or 49.4%), and 189,693 females making up the remaining 50.6% (GSS, 2021). The average fertility rate in the district is 4.4 with urban centers 3.9 and rural centers 4.9 (GSS, 2021). The male-female share of household deaths in the region is 58.3:41.7 (GSS, 2021).

The Metropolis has several health facilities dotted across the length and breadth of its administrative sections with one teaching hospital, one regional hospital, and one Municipal hospital located in the heart of the Metropolis. Other important facilities in the Metropolis are the

Seventh Day Adventist (SDA) hospital, Reproductive and Child Health (RCH) unit, Vittin, Nyohini, and Bilpela Health Centers. The Metropolis is also dominated by private health facilities, chemical shops, and laboratories. In addition, there are several health training institutions in the Metropolis but the dominant ones are the University for Development Studies (UDS) and the Tamale Nursing and Midwifery Training College (TNMTC).

The proportion of pregnancy-related deaths of women aged 15-49 years occurring 12 months preceding the census night in the region is 24.6% (GSS, 2021). The proportion of maternal-related deaths of women 15-49 years occurring 12 months preceding the census night is 21.1% (GSS, 2021). The overall number of household deaths in the region is 9,297 with females accounting for 3,881 (GSS, 2021). In addition, the total number of deaths among women of reproductive age is 1,301 (GSS, 2021).

3.3 Study approach and design

Considering the questions sought to be answered by this study, a qualitative research approach was adopted to explore the lived experiences of women with obstetric fistula in the Tamale Metropolis. This study approach, according to the literature, is the ideal method used by researchers to study human and social problems, such as fistula, facing the entire society or a group of people within the society (Thorogood & Green, 2018). A qualitative research approach encapsulates several study designs including grounded theory, case study, action research, phenomenology, ethnography, and narrative research (TÜMEN AKYILDIZ, 2021). The descriptive phenomenology design is commonly used in nursing and clinical research to examine and describe people's experiences related to a particular disease outcome or condition (Shorey & Ng, 2022). The design examines human experience in daily life constraints while putting aside the researchers' prior notions or assumptions about the phenomenon (Neubauer et al., 2019). In other words,

phenomenology research investigates actual events to learn more about how people interpret or explain experiences they have based on a certain exposure. In fact, the premise behind phenomenological research design is that individuals employ a common structure or essence to interpret participants' emotions, perceptions, and beliefs on a particular phenomenon (in this case obstetric fistula) (Neubauer et al., 2019). Considering the prospects of this design together with the study aims, the present study adopted the phenomenology design to explore the lived experiences of women with obstetric fistula.

3.4 Study population and sampling

3.4.1 Target population

The population targeted in this study were two groups: reproductive-aged women (15 to 49 years old) who have had obstetric fistula in their lifetime and healthcare professionals such as midwives, gynecologists, nurses, and obstetricians who are working with patients diagnosed with obstetric fistula. The rationale for choosing this population is that the targeted women are old enough to give an account of the experiences they went through or are going through after being diagnosed with obstetric fistula. Also, since healthcare professionals are noted to be among the first-line contacts for patients on issues of health care, they were in a better position to provide details on the experiences their clients report to them following the diagnosis of obstetric fistula.

3.4.2 Inclusion and exclusion criteria

All reproductive-aged women (15 to 49 years old) who have ever been diagnosed with obstetric fistula and have lived in the Tamale Metropolis for at least 6 months before the time of data collection were included in the study. In addition, care was taken to exempt women who have completely recovered from the condition more than two years prior to the day of data collection. This was to ensure that participants included in this study were able to give accounts of their

experiences living with fistula and to reduce incidence of recall bias. Also, healthcare professionals who are working or have worked with clients diagnosed with obstetric fistula in the past 3 months were recruited as key informants in this study. Health workers (such as orderlies and OPD nurses/midwives) who interact with obstetric fistula clients but do not participate in providing direct healthcare services to the clients were not included in this study because such people may not be able to give in-depth accounts of the experiences the women go through.

3.4.3 Sample size and sampling procedure

Creswell recommends that qualitative studies should be conducted until a point of saturation is reached (Creswell & Inquiry, 1998). According to literature, saturation in qualitative research is achieved when new emerging themes are not forthcoming and when the researcher does not get any new thoughts or ideas after repetitively interviewing study participants (Houghton et al., 2013). The 'point of saturation' is said to be between 5 and 25 participants (Creswell & Inquiry, 1998). In this study, 11 obstetric fistula women and three healthcare professionals constituted the total sample size for this study.

The present study adopted non-probability sampling techniques (purposive and snowballing) to gather information from eligible participants across some chosen health facilities in the Metropolis. The purposive sampling technique is necessary because it allows the researcher to gather as much information as possible from participants who have experienced the outcome of interest (obstetric fistula) (Obilor, 2023). The Tamale Regional and Teaching Hospitals are the two major facilities that provide robust services for obstetric fistula clients in the Metropolis hence, participants for this study were recruited from these facilities. In these facilities, units providing obstetric fistula services were identified and professionals who have higher working experience with obstetric fistula clients were identified and interviewed as key-informants. In the obstetric fistula clinics,

data (contact and address) about women with obstetric fistula were taken and contacted. To avoid the possibility of missing out on eligible women who may not visit the facilities for treatment, the snowballing technique was used as a backup technique.

3.5 Methods and Instruments/tools for data collection

3.5.1 In-depth interviews

In-depth interviews were held with obstetric fistula survivors using an in-depth interview guide as a tool. This method is ideal for collecting sensitive information from people who have gone through some life experiences. The focus of these interviews were on the experiences obstetric fistula survivors go through and comparing the felt and enacted stigma these women face. Information on the perspective of social, cultural, and economic challenges these women go through were also gathered. Note pads and audio tape recorders were other tools used during the interviews.

The in-depth interview guide was structured into three sections. The first section covered respondents' socio-demographic information such as their age, parity, and number of years they have lived with the condition. The second section sought information on the experiences they went or are going through following the diagnosis of obstetric fistula. The last section covered information on how they cope with the stressors associated with these experiences.

3.5.2 Key-informant interviews

Interviews with key informants were held with different categories of professionals (such as nurses, midwives, doctors, obstetricians, gynecologists, etc.) who interact with obstetric fistula women in providing healthcare for them. The interviews focused on how these professionals manage women with obstetric fistula and the challenges they encounter in integrating them into

the community. The key-informant interview guide led the way in questioning the respondents and their responses were recorded on notepads and using audio tape recorders.

The key-informant interview guide was also structured into three sections. The first part covered socio-demographic information of participants such as their professions (e.g. Nurse, midwife, doctor, obstetrician etc) and the number of years they have worked with women with obstetric fistula. The second part covered the challenges they face in rendering care to these women as well as the experiences the women report to them. Finally, section three sought the opinions of the professionals on how to tackle the menace.

3.6 Data collection techniques

Both the in-depth and key-informant interviews were administered face-to-face. Two research assistants were trained by the researcher who aided in the data collection and translation processes. All those recruited as research assistants were fluent in both Dagbani and English since these were the dominant spoken languages in the study setting and this also aided in easy translation of the interview guides.

The in-depth interviews were conducted in Dagbani and English in a quiet, and convenient location for the respondent. This was to allow them to be as open as possible. In addition, the key-informant interviews were held at the facilities where the professionals work. This was administered in English Language. All the interviews were recorded (using tape recorders and notepads) and each lasted for 20 to 40 minutes.

3.7 Credibility and dependability

Credibility and dependability of the data were ensured from the beginning to the end of the study using different methods. Firstly, a pilot study was conducted before the actual data collection date.

The interview questions were pretested on at least two study participants who met the criteria for inclusion, and their responses were taped. This was important because it allowed the researcher to check if there was the need to change, modify or eliminate certain components of the guides and to ensure that the tape recorders produced a good quality sound. Secondly, the researcher ensured the credibility of the data by purposively recruiting participants who met the inclusion criteria and can give in-depth and reliable information on the experiences of women living with obstetric fistula. Also, after each interview, the researcher restated the key responses to the respondent for validation in order to ensure that the researcher really captures the correct responses. Finally, the recorded data was translated and transcribed on the day each of them was taken to avoid mixing the data sets. The researcher also requested that the data sets be translated and transcribed independently by the other two research assistants so that comparisons could be made. The researcher discussed with the other research assistants as well as the supervisor and decided how to handle discrepancies in the data transcription and coding.

3.8 Data processing and analysis

With the use of both inductive and deductive reasoning, the data gathered in this study was analyzed manually using thematic content analysis following the recommendations given by Byrne (2022) and Creswell & Inquiry (1998). This strategy of qualitative data analysis comprises identifying patterns or themes that are significant or compelling, then employing those themes to address the research questions (Byrne, 2022). The six step methods of examining qualitative data proposed by Braun and Crack was applied (Byrne, 2022).

First, the interviews done in other languages (commonly the Dagbani language) were translated and transcribed into English language by the researcher. The researcher listened to each sentence in the audio-recording for the transcription, paused the recording, wrote it down, and then resumed.

The researcher continuously listened to the audiotapes and verbatim transcribed the responses until the last recorded interview was covered. The words, phrases, and sentences used by the Informants that were relevant to the study topic were coded or categorized by the researcher and two trained assistants. Afterwards, the transcripts were compared in order to identify any patterns of overlap or divergence. The original codes were divided or merged, and renaming was done as necessary, to create the final codes. Codes that were related or comparable were grouped together to create subthemes. Similarly, related subthemes were combined to create the main themes. The researcher continued to analyze the data until it was satisfied that the themes fully capture and reflect the participants' narratives.

3.9 Ethical considerations

Ethical clearance for the study was obtained from the University for Development Studies Institutional Review Board (UDS/RB/205/24). Permission was sought from the health facilities whose workers were participating in the study. Also, consent was sought from each respondent before the interview commences after the purpose, benefits, and possible dangers of the study were explained to them. Each respondent was given the free will to make their decision without any form of coercion. Confidentiality of respondents' identities and their responses was ensured by assigning codes to their responses rather than using their names or titles.

CHAPTER FOUR

RESULTS

4.1 Characteristics of Respondents

Eleven women with obstetric fistula were interviewed. The basic socio-demographic characteristics of the respondents are presented in Table 4.1. As shown in the table, although the youngest woman interviewed in this study was 21 years and the oldest being 41 years, the majority of the women were between the ages of 30 and 40 years. Of the eleven women who were interviewed, one was single (never married), two were divorced, and eight were still married. All survivors who were single or divorced were living with their parents while women who were married were still staying with their husbands. That notwithstanding, 2/8 of the married women had experienced periods of separation with their husbands before. The literacy level of participants was generally low as only three had formal education up to at least Senior High School level. Two of the 11 women were pursuing vocational training in tailoring shops. In addition, four of the respondents were engaged in direct revenue-generating activities while seven were literally unemployed and five of them said they lost their jobs due to the obstetric fistula. Six of the unemployed women depend on their husbands while one depends on her parents. Regarding the obstetric history of respondents, all except one have ever been pregnant. Long-term obstructed labor was experienced by three of the women. Of the survivors interviewed, 6/11 had completely healed, three were awaiting further surgical correction whiles 2/11 were at the post-operative stage. All the survivors, except three, had undergone more than one corrective surgery, and had lived with the condition for periods ranging from one to six years prior to the first corrective surgery.

Table 4.1: Socio-demographic characteristics of obstetric fistula women

No.	Participant	Age (years)	Occupation	Marital status	Educational level	Parity
1	P1	41	Unemployed	Married	None	G4p4 (3 alive)
2	P2	39	Farmer	Divorced	None	G2P2 (all alive)
3	P3	32	Unemployed	Married	JHS	G3P3 (2 alive)
4	P4	37	Teacher	Married	Tertiary	G6P4 (all alive)
5	P5	36	Unemployed	Married	Primary	G4P4 (all alive)
6	P6	21	Student	Single	SHS	G0P0
7	P7	29	Trader	Married	Primary	G3P2 (all alive)
8	P8	25	Apprentice	Married	JHS	G1P1 (alive)
9	P9	32	Unemployed	Married	SHS	G3p3 (2 alive)
10	P10	36	Trader	Married	None	G4p3 (3 alive)
11	P11	24	Apprentice	Divorced	JHS	G1p1 (dead)

Three healthcare professionals were also interviewed including two midwives and one medical officer. Each of the midwives had at least 9 years of work experience whiles the medical officer had four years of experience. Table 4.2 summarizes the characteristics of the key-informants:

Table 4.2: Summary of medical professionals (key-informants)

No.	Profession	Rank	Years of experience
1	Midwife 1	Principal Midwifery Officer (PMO)	14 years
2	Midwife 2	Senior Midwifery Officer (SMO)	9 years
3	Medical doctor	Medical Officer (MO)	4 years

4.2 Overview of the results on the lived experiences of women with obstetric fistula

During interactions with respondents, the line of questioning was guided by the specific objectives of this study and so the feedbacks given by participants reflected the key aims of this study. Therefore, each of the specific objectives of this study represents a main theme and from deductive reasoning, sub-themes emerged under each main theme. The main themes and their respective sub-themes are presented in Table 4.3:

Table 4.3: Main themes and sub-themes of the study

Main themes	Sub-themes
Health care needs of women with obstetric fistula	• Improved ANC services • Availability of skilled healthcare practitioners • Access to health facilities and adequate services
Treatment challenges faced by women with obstetric fistula	• Financial barriers • Repeated/unsuccessful repairs • Negative Attitude of health professionals • Coping with postoperative instructions
Treatment-seeking pattern of women with obstetric fistula	• Where women seek treatment first after developing fistula • Where women go last for treatment • Support in seeking treatment
Socioeconomic consequences faced by women living with obstetric fistula	• Problems with social integration • Stigma and psychological trauma • Reduced self-esteem • Economic burden

The first major theme of this study was healthcare needs of women who have obstetric fistula. A particular emphasis was placed on the accessibility to improved/quality antenatal care (ANC), availability of professional healthcare providers, as well as availability of and access to health facilities and sufficient services. Regarding the challenges respondents face in the course of their treatment, four sub-themes emerged: financial barriers, repeated/unsuccessful repairs, negative attitude of health professionals, and coping with postoperative instructions. Moreover, in the treatment-seeking pattern of women with obstetric fistula, three important sub-themes emerged: where women seek treatment first after developing fistula, where women seek treatment last after developing fistula, and the support women get in seeking treatment. Finally, the socio-economic consequences faced by obstetric fistula women in this study were problems with social integration, stigma and psychological trauma, reduced self-esteem, and poverty. It is important to emphasize that some of the difficulties were short-lived especially following corrective surgery while new ones emerged in some cases even after the surgery.

4.3 Healthcare needs of women with obstetric fistula

4.3.1 Improved ANC Services

Improved ANC services have a role to play in reducing the magnitude of obstetric fistula in communities. Participants voiced dissatisfaction with the comprehensiveness and quality of treatment they received throughout pregnancy. Many of the respondents emphasized the need to improve healthcare providers' knowledge and instruction on the prevention and treatment of obstetric fistulas. Twenty-five-year-old respondent, who has been battling with obstetric fistula following her first childbirth bemoaned;

> *'No one ever discussed the risks of obstetric fistula with me during my antenatal checkups. Maybe I could have prevented this agony if they had told me sooner.' (P8)*

In a similar vein, 36-year-old mother of three stressed,

> *'It's like the midwives have just limited ANC to the checking of blood pressure and weight but in my opinion, it should not be the exclusive emphasis of antenatal care. If they were observant enough, they should have prevented this condition at the early days of my pregnancy. Hmmmm, madam, it is very painful. I think more knowledge and adequate supervision is required to prevent birth traumas like fistulas.' (P10)*

4.3.2 Availability of skilled healthcare practitioners

Participants frequently mentioned having trouble finding qualified medical professionals to treat obstetric fistulas. Many, especially those in rural/remote locations, complained that there were few qualified healthcare personnel available. A participant who is 32 years old talked about her difficulties, saying that;

'Although we have a health facility in our community, none of them was able to treat me when I acquired fistula after childbirth. I had to travel for hours to go to the closest hospital (TTH) in the hopes of finding a doctor who could help.' (P9)

Another mother of two who is 27 years old, also emphasized the lack of specialists when she stated that;

'Even when I made it to the hospital, there was only one doctor who could perform the surgery and unfortunately, they said that the doctor had travelled. I had to put up with my illness for months because the waiting list was so lengthy.' (P7)

Similarly, health professionals lamented about the inadequacy of specialists to handle obstetric fistula cases. The fact that only few doctors can perform obstetric fistula repair aggravates the plight of women with this condition. One senior midwife narrated that;

'There are few specialists who can perform the surgery especially in this our setting and they are not always available as they attend to other cases. So sometimes we can book and cancel cases for more than three just because the surgeon is not available to do the operation. There is the need to get more specialists so that women can get the needed attention at the appropriate time without any delays.' (Midwife 2)

4.3.3 Access to health facilities and adequate services

Another major healthcare need was access to health facilities that provide the needed services. Getting to medical facilities has become a major obstacle for people with obstetric fistulas. Significant hurdles included lack of infrastructure, transportation expenses, and geographic distance. A mother of two described the difficulties she had to face before accessing services for her condition;

'I really faced a lot of challenges before I was able to access quality services for my condition. The hospital was so packed that even once I got there, I had to wait days to get care. The roads to the hospital are often impassable, especially during the rainy season.' (P2)

Also, another respondent narrated her experience as follows;

'Hmmm madam, getting to the hospital does not even guarantee you of getting immediate medical services. Sometimes, you can spend your last pesewa and chat a 'yellow-yellow' to the hospital, wait there for hours only to be told that the doctor is not around or their machines are not working.' (P5)

Interaction with the healthcare professionals also revealed that only few hospitals have the required capacity to manage obstetric fistula even though those facilities are under-resourced. Thus, patients will have to travel for longer distances in order to receive the needed services. According to one medical officer;

'There is the need to establish more obstetric fistula centers in the region and across the entire nation at large. The number of obstetric fistula cases nowadays is increasing dramatically and something really needs to be done. Even the few facilities currently doing the surgeries do not have enough medical supplies which further compounds the situation of the patient as they may have to buy the items out of their pockets.' (Medical Officer)

Another midwife added;

'I think that if more fistula centers are established and well resourced, women will be able to get the needed attention.' (Midwife 1)

4.4 Treatment challenges faced by women with obstetric fistula

4.4.1 Financial barriers

The research participants regularly brought attention to the substantial financial cost of treating obstetric fistulas. Due to financial issues, some women had to delay seeking treatment for themselves despite knowing they were diagnosed of obstetric fistula. Numerous women talked about how expensive it was to get medical care, including diagnostic testing, and surgery. This problem was reported by many respondents especially those residing in remote areas in the metropolis with no dependable sources of income. To meet these costs, women and their families had to sell their properties, and household goods. According to a 32-year-old gravida 3 mother:

> *'My inability to pay was the factor that prevented me from seeking treatment earlier despite knowing my condition. At the initial stages of my plight, my husband and his father had to sell some of their belongings for us to come to the hospital. We were told that we need to pay some money for them to operate on me but we didn't have that money to cater for the medical and surgical bills. So the only option we had was to seek traditional treatment which is somehow cheap.' (P3)*

Another respondent added that:

> *'I was unable to pay for the surgery, so I tried traditional treatments, hoping they would help. However, my condition rather got worse over time. Hmmmmm… madam. I wish my access to healthcare wasn't limited by my ability to pay.' (P6)*

In another narration, it emerged that some women decided to deliver at home due to their inability to afford the items prescribed for them during child birth. Some of the respondents believed their inability to deliver at the health facility may have contributed to them developing the condition. For instance, a 25-year-old woman who gave birth at home narrated her story as follows:

'When I was pregnant, I attended ANC about four times. When my expected date of delivery was getting closer, the midwives gave me a paper containing a list of items I need to bring when I am coming for delivery. The items were too many that I and my husband couldn't afford them so my mother-in-law suggested that I deliver at home so as to do away with the embarrassment of going to the health facility without those items. It was after the delivery I started seeing leakage of urine and feces. I think this wouldn't have occurred if we were able to afford the items they asked me to buy' (P8)

Healthcare professionals were also aware of the financial difficulties obstetric fistula women face during the course of their treatment. One senior midwife with over 14 years of work experience shares her experience as follows;

'Yes, we face a lot of challenges in managing obstetric fistula cases. The cost of obstetric fistula surgeries are not covered by the NHIS and this is indeed a very big challenge to most of the women. Some of them can be suffering from the condition but will be hesitant to come to the hospital because they have no money to pay for the bills. Just a few of obstetric fistula women are able to report and bear the full cost of the treatment' (Midwife 2)

Another professional (a medical officer), also shares the following story;

'We face a lot of challenges regarding the treatment regimen. We can diagnose a woman of obstetric fistula and book her for surgery on a stated date only for her not to show up due to financial challenges. Some of the women will stay in the house for months trying to gather money for the surgery and by the time they report back, the condition may extend to affect nearby tissues and organs which will be another cost. Others will have to wait until the free surgeries time before they will report.' (Medical Officer)

Notwithstanding the devastating experiences given by the respondents, some of the women expressed how they were supported by their partners and loved ones during their treatment. The majority of those who were able to finance their treatment mentioned that their husbands were their main financiers. One gravida 3 woman reported that;

'As for my husband, he has been so supportive throughout this fight. If not for his support, I would have suffered a lot. He is always good to me. He finances all my surgeries, medication and medical bills.' (P9)

4.4.2 Repeated/unsuccessful repairs

Another treatment challenge that women with obstetric fistula reported was repeated unsuccessful surgeries they have gone through which they said attracted negative perceptions towards them. It is the community/family expectations that after the surgery, one should get healed. However, unsuccessful repairs leave survivors continue to suffer as before surgery; they attract thoughts of being cursed. They are also alienated and isolated. One woman explained;

'After going through this condition, I have gone through 3 surgeries which were all unsuccessful. I just went through the fourth one few weeks ago and I am hoping that fistula doesn't resurface again.' (P11)

Another woman who just went through her third surgery in a tertiary hospital also reported as follows;

'I had this condition after going through CS in my 4th delivery at the Zogbeli Hospital. After about two weeks of being on urethral catheter, there was no improvement so I was finally referred to the Tamale Teaching Hospital (TTH). In TTH, I went through two surgeries which all were unsuccessful. Hmmmm, Madam, it's not easy but what can we do. I just went through my third surgery a few days ago and I am praying that it goes successfully.' (P1)

4.4.3 Negative attitude of health professionals

Some participants said that during their treatment for obstetric fistula, they encountered stigma and unfavorable attitudes from healthcare professionals, especially nurses or midwives. These unpleasant experiences discouraged women from obtaining additional medical care, added to their feelings of loneliness, and made them reluctant to disclose their illnesses. The mental anguish that

women with obstetric fistula endured was made worse by the medical professionals' lack of compassion and understanding. A 24-year-old respondent claimed;

> *'The nurse chastised me for not pushing hard enough during labour when I initially went to the clinic with my fistula. I was ashamed and embarrassed.' (P11)*

Another woman bemoaned and her expression was full of sorrow;

> *'I told the nurse about my health, thinking she would offer me help and advice. Rather, she wrote me off, telling me that I ought to have looked after myself more when I was pregnant. Her lack of empathy made me feel helpless and abandoned.' (P7)*

Another unhappy a single mother narrated her experience. She said;

> *'The nurse's attitude made me hesitant to seek further medical help. I feared criticism and mockery once more. I needed a while to work up the guts to return to the clinic.' (P2)*

4.4.4 Coping with postoperative instructions

From the collated responses of participants, it emerged that after surgery, women are given a number of instructions by their care givers. Some of these instructions were restrictions from certain lifestyles while others were recommendations. One of the healthcare providers stated that;

> *'Anytime we manage women with obstetric fistula, we give them a number of instructions. We usually advise them to drink plenty of water, eat a balanced diet and carry out pelvic floor muscle exercises so as to enable better physical healing. They are also advised to abstain from sexual intercourse for six months and withhold getting pregnant for at least two years.' (Medical Officer)*

However, this study found mixed experiences regarding how participants responded to these instructions. The informants think that the diet and exercise is not as challenging to the survivors as compared to the abstinence and delaying the next childbirth. For many survivors they have to live with the social pressures of living the life of a married woman. Respondents narrated the

external pressure they had to face from family and community members in their quest to abide by the instructions given at the health facilities. Accordingly, a 36-year-old mother of four children reported that;

> *'Oi Madam, it was not easy at all especially when I was gaining full recovery from the condition. Although my husband was ready to abide by the instructions given at the hospital (abstinence from sex and delay child birth), some of his family members did not understand why we had to delay child birth. So they were giving us unnecessary pressure.' (P5)*

Another respondent, a 29-year-old woman who had given birth before narrated her experience as follows;

> *'You see, it made me feel like I was not fulfilling my obligation as a married woman. This is because, the dignity of a woman (in my society) lies on her ability to give birth and perform certain household chores such as carrying water. But here I was, unable to perform all these duties. Will you believe, madam? I and my husband stayed for over two years without giving birth. People were now pointing fingers at me that the condition has made me barren and some were even advising my husband to marry a second wife and add. But I thank God, now we have a baby girl.' (P7)*

Reportedly, some survivors couldn't withstand the external pressure and had to defy these instructions and end up engaging in sexual intercourse much earlier than the recommended time with detrimental effects. One 32-year-old woman who just went through a second surgical repair narrated her situation as follows;

> *'Yes, the doctors advised us to abstain from sex for about six months but after about two months, I thought I was fully healed; there was no pain again, no leakage and everything seemed Okay. So I and my husband started having an affair again. After a few weeks, I started seeing some spots of leakage on my thighs periodically and it was getting worse by day. We reported to the hospital and the doctors said the condition had relapsed and that they needed to book me for another surgery. Hmm, I regretted my action, madam.' (P3)*

4.5 Treatment-seeking pattern of women with obstetric fistula

4.5.1 Where women seek treatment first after developing fistula

When seeking treatment for obstetric fistula, a number of the participants had tried traditional methods such as spiritual therapies and traditional herbs. Word-of-mouth plays a major role in traditional practice, and many women who had obstetric fistulas sought treatment from a traditional healer, and most of them were influenced by their spouse, community, and relatives. A respondent gave the account as follows;

> *'When the condition started, my husband took me to a herbalist in the village. We went there for several weeks but we were not getting any improvement. We were moving from one traditional healer to another until someone advised us to come to the hospital.' (P7)*

Another unemployed woman narrated that;

> *'When I initially saw the leakage, I alerted my husband and he consulted my mother-in-law who sent for one TBA in a nearby house. At that stage, it was just some spots of urine droplets and so we never thought it was something serious. But as days went ahead, it was getting serious.' (P5)*

Notwithstanding visiting traditional healers, several women, especially those who got diagnosed immediately after childbirth in the hospital and those who stay in the urban centers sought immediate attention from the hospital. According to one multiparous woman;

> *'I gave birth to my index child some few months ago and it was through that I developed this condition. I sustained some tears in my private parts during the delivery and the midwives sutured it for me. The midwives said I sustained the tears because the baby was too big. Few days after I was discharged home, I was experiencing some leakage of urine which I was not able to control. My bed sheet was always getting soaked after every short period so my husband rushed me back to the hospital on that same day and notified the midwives.'(P3)*

4.5.2 Where women go last for treatment

Women with obstetric fistulas went through several care-seeking processes (going to traditional places, staying at home with traditional birth attendants' care) before ultimately arriving at fistula treatment facilities following a long-term trial period with conventional care.

> *'As I stated earlier, we only went to TTH as our last resort because we realized that the traditional methods were not working for us. Initially, we went to one small facility in our area but they said they could not manage it and referred us here. That was how come we reported to the Tamale Teaching Hospital.' (P9)*

In another narration, it emerged that respondents and their families underrated the condition and never saw the need to report to the hospital until realizing that things were going worse. Below is an account given by a 36-year-old gravida four unemployed mother;

> *'We thought the condition could just be managed at home without necessarily coming to the hospital. It was after weeks of trials that we realized things were getting complicated by day. It started with only urine leaking later feces also started leaking out. That was when we had to report to the hospital.' (P5)*

These attestations were confirmed by reports from the healthcare professionals who were interviewed in this study. The providers believed that lack of understanding of the condition could have played a crucial role in women's inability to seek medical care at the early stage. The professionals further elaborated that most clients, especially those at the remote places, usually report to the facility at the advanced stage of the condition where treatment becomes more complicated.

> *'...there is one mistake some of the women make especially those in rural or deprived settings. They will not come to the hospital at the early stage instated, they will be going from one traditional healer to the other until they realize that they are not getting any better, then they report to the hospital.' (Medical Officer)*

4.5.3 Support in seeking treatment

During their care-seeking journeys, the participants reported receiving a multitude of supports from their family, community and healthcare providers. A 41-year-old married mother with four children narrated the support she got from her husband and the family when she was seeking care for her condition;

> *'The family was so supportive during the course of my treatment. I always pray for my husband. He is a true definition of man. He was so supportive throughout the challenging times. The family members were supporting me in finding cure to the sickness, and they were also helping me in accomplishing my household chores.' (P1)*

In addition, a similar account was given by another respondent;

> *'Well, I can't complain. My people (husband and family members) have done their best. They were those taking me on a motor bike from one facility to the other in search of treatment. Any time we were asked to come for a review, it is my husband's brothers who used to send me there.' (P5)*

A number of the respondents expressed the support they received from some of the health professionals in the hospitals. For instance, a 29-year-old trader narrates that;

> *'Although we reported to the hospital late, the midwives received us very well and gave us a lot of education concerning the condition. In fact, they were very friendly and supportive.' (P7)*

One of the midwives narrates how they care for obstetric fistula women especially those who usually miss out their scheduled review dates;

> *'There are some of the women we usually book for the surgery but they never show-up. So we sometimes try to make a follow-up to some of them by reaching out to them on phone. In some instances, we make calls to discharged patients to ensure that they are safe at home and adhering to the treatment regimen.' (Midwife 1)*

4.6 Socioeconomic consequences faced by women living with obstetric fistula

4.6.1 Problems with social Integration

Women in this study lamented on the difficulties they face in trying to socialize with their peers and sometimes loved ones. The majority of participants stated that they are unable to take part in community and religious events. Some women narrated how the condition has prevented them from participating in congregational prayers;

> *'Madam, because of the condition, I have stopped attending all social events. I don't even go to the mosque anymore; I always pray in the room. You know, we Muslims consider urine and feces as dirt and so when they touch your clothes you cannot use them to pray until you wash them. That has stopped me from going to the mosque to pray because if I go there, the urine will leak and spoil the mats in the mosque.' (P2)*

> *'I am unable to join people in congregational prayers in the mosque due to the leakage. If I go into the mosque, the urine will spoil the floor. So I just offer all my prayers in the room alone.' (P7)*

> *'As for the society, they don't want to see me because of the leakage of urine so I am always indoors. I don't attend any social event. Even I have stopped going to church after contracting this condition.' (P9)*

4.6.2 Stigma and psychological trauma

Women with obstetric fistula face a wide range of stigma. Even after corrective surgery, stigma persisted and took many different forms, ranging from subtle discrimination and isolation to overt discrimination. The women faced stigma from both their families and the community, which kept them apart and prevented them from fully engaging in social or domestic tasks. Regarding their prior state, they received disparaging remarks, were ridiculed, and were called spoiled and unaccepted. One respondent narrated her experience as follows;

'Sometimes, I myself find it difficult to bear the smell from the urine and faeces, how much more those around me? I used to attend social events at the initial stage but people did not want to sit by me. With this bad odor coming from me, who will agree to come and sit with me and inhale it? Of course, no one. That is even the painful part of the whole issue. Whenever I am in a gathering, some people behave to show that they are uncomfortable with my presence by holding their nose or spitting anyhow and making utterances such as 'mm mm, something is smelling''. (p3)

Another respondent lamented that;

'You know women and stigma. Women have taken stigmatization as their daily bread where ever they find themselves. This condition has taught me the real side of humanity. Hmmmmm (whiles nodding the head in pain with tears in the eyes), madam, it is very painful. I am being treated like a piece of rug by people I considered to be my close friends and associates. People I have helped in life are now turning their backs on me.' (P4)

A 36-year-old trader also added her story;

'Hmmmm, madam, this condition is not something on should wish for her colleague. I don't even want to witness my enemy suffer from this disease of shame.' (P10)

4.6.3 Reduced self-esteem

The condition (obstetric fistula) has made some of the women feel worthless. Following surgery, the survivors feel scared and doubtful of themselves. They lack self-assurance and don't think of themselves as regular people. Even though they may not have experienced any isolation from any member of the family or community, a survivor may still lack self-confidence. So even go the extent of wishing for death for themselves because they felt no essence of their lives anymore. This is evident in several narrations given by the women;

'I think death will be a better solution to this terrible and difficult situation I am going through. Abba… just look at me, I can never be like the other women nor be able to fulfill my role as a woman.' (P3)

A young lady laments that;

> *'I have the fear that I may not get a husband to marry. Just look at me; who will want to marry a woman like me? Even if I have been repaired successfully, there is more than meets the eye. Could I be less [of a woman]? I just wonder if my body will be alright.' (P6)*

Despite the devastating situation women with obstetric fistula go through, some of them still tried to maintain a pleasant and positive self-esteem as one woman narrated;

> *'Regarding my body image, I have always tried to maintain a good personal hygiene. I clean myself and wash my cloth and rugs frequently. Sometimes when I get money, I buy perfume and adult diaper and use.' (P4)*

4.6.4 Economic burden

The financial and economic burden among obstetric fistula women was also noted as one of the consequences respondents face. Those who had survived an obstetric fistula were unable to continue with their businesses or other revenue-generating endeavors and so they lost many of their customers. Many of them spent their business capital in treating themselves and were worried of how they could get back to the business after they are fully recovered. The following narrations explain more;

> *'I have been jobless since when I had this condition. I used to sell food in this area but because of what I am going through, I have stopped the business. Life hasn't been easy on me. Some people even propose to me to go on the roads to beg but I don't think I can do that.' (P5)*

Another respondent added that;

> *'As I told you earlier, I have been battling with this condition for over 3 months and because of that I haven't been able to go to my store. So my business has collapsed. I have loosed all the capital and as I am sitting here, I can't even boast of a penny from the store again. We have spent everything in paying medical bills.' (P1)*

Nonetheless, some of the women were still able to engage in their usual day-to-day economic activities albeit suffering from the condition as one respondent narrated as follows:

> *'Before getting this condition, I used to cultivate some vegetables and maize and I am still able to go to the farm. That is where I get small money to support myself. I feel OK going to the farm because when I am there, I do not worry about anybody or anything.' (P2)*

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter of the thesis extensively discusses the study findings based on the study objectives. The results of the analysis, together with their interpretations and explanations, are also discussed in this section. Previous findings in the literature are also reported in this section, and the association they have with the current results are highlighted.

5.2 Healthcare needs of women with obstetric fistula

The present study assessed the healthcare needs of women living with obstetric fistula. According to the findings of this study, accessibility to effective ANC services was identified as a prime healthcare need for women with obstetric fistula. ANC is usually the first contact between expectant mothers and their healthcare providers thus, instituting proper check-ups at this stage will have a greater effect on reducing pregnancy related complications including obstetric fistula (Afulani, 2016). A number of studies have established a strong relationship between quality of ANC services and the development of obstetric fistula. In Ethiopia, for instance, Andargie and Debu (2017) found that women who had better ANC services during pregnancy had lower chances of getting obstetric fistula. That is, obstetric fistula was common among women who received poor attention during their gestational period (Andargie & Debu, 2017). Similar results were replicated in other places like Mozambique (Boene et al., 2020), Rwanda (Egziabher et al., 2015), and Nigeria (Bello et al., 2020). Arguably, women who are given proper prenatal care are conscious of possible pregnancy and childbirth-related complications and are more likely to take measures to prevent them.

Moreover, another healthcare need of the women was the availability of skilled healthcare professionals. Participants in this study frequently mentioned the need to have qualified medical professionals to treat obstetric fistulas. Even women who detected and reported to the hospital early were not able to receive timely care due to the scarcity of professionals. This finding agrees with what was reported in other literature (Baker et al., 2017; Meurice et al., 2016). According to a similar study in Malawi, most complicated and failed obstetric surgeries were linked to delayed reception of services in the hospital as a result of the inadequacy of trained staff (Gondwe & Maharaj, 2019). Moreover, Lufumpa et al. (2018) established in their study that low staff strength in hospitals reduces the care women receive during labor leading to the development of obstetric fistula (Lufumpa et al., 2018). In Ghana, the rate of obstetric fistula cases is becoming overwhelming and there is therefore the need to proactively train more specialists to prevent and manage victims of this condition. Despite training more healthcare professionals, there is also the need to ensure availability and easy accessibility of health facilities and infrastructure.

5.3 Treatment challenges faced by women with obstetric Fistula

In this study, most of the respondents stated how expensive it was to get medical care, including diagnostic testing, and surgery. These were the factors that made some of them delay in seeking treatment for their condition. Previous studies have also reported similar challenges in other places. In Somalia, for instance, obstetric fistula women had to stay in the house with their condition for months because they could not meet the financial demands of accessing care in the hospital (Mohamed et al., 2018). Recently, a similar result was unearthed by Dako-Gyeke et al. (2022) in the Kpandai District when they investigated the sufferings of women living with obstetric fistula. Respondents in this study also had challenges reporting to the facility and were also unable to meet hospital-scheduled appointments due to high cost of transport fares. This finding is in line with

previous literature (Bashah et al., 2018; Dako-Gyeke et al., 2022). Consequently, the financial difficulties left the women with no other option than to seek care from traditional healers and only report to the health facility when they had enough money on them. Invariably, most of them move from one spiritualist to the other and finally report to the hospital at a complicated stage of their plight.

Repeated and unsuccessful surgeries was another treatment challenge reported by obstetric fistula women in the current study. Respondents were so concerned about the pain, cost, and reduced body image they had to suffer due to failed surgical operations. The current finding agrees with prior studies in Guinea (Delamou et al., 2017), Angola (Bernard et al., 2019), and Uganda (Nalubwama et al., 2020). It is so concerning to note that, the magnitude of unsuccessful surgeries that women with obstetric fistula face is not just limited in geography but is highly saturated, especially in the sub-Saharan African continent (Hareru et al., 2024). This suggests the need for stakeholder engagement in finding a remedy to this menace.

Furthermore, the poor attitude of healthcare professionals toward patients was a major concern to many respondents in this survey. These unpleasant experiences discouraged women from obtaining additional medical care, added to their feelings of loneliness, and made them reluctant to disclose their illnesses. This research finding goes contrary to previous cross-sectional surveys in Ethiopia where over half of healthcare workers demonstrated a positive attitude towards obstetric fistula women (Legesse, 2016; Olukemi Bello & Lawal, 2018). Scholarly literature has shown that the attitude of healthcare professionals not only affects the healing process of patients but also predicts the health-seeking behavior among the populace (Musinguzi et al., 2018). It is therefore imperative to institute measures that will encourage healthcare professionals to show good attitude towards their patients.

5.4 Treatment-seeking pattern of women with obstetric fistula

Disease prognosis and management is strongly linked to the time, place, and manner patients seek healthcare. Thus, to increase the chances of recovering from a particular disease condition and to reduce the risk or magnitude of any possible complication, it is recommended that individuals seek medical attention from experts as early as possible (Samal, 2016). Regarding obstetric fistula, surgical intervention is shown to be the gold standard for its management (Egziabher et al., 2015). Although some of the women interviewed in this study reported to the hospital at the initial stage of their condition, the results indicate that the health-seeking experiences of the women were characterized by long delays in care-seeking which is consistent with previous research (Asiedua et al., 2023). A lot of factors influenced their choice of seeking healthcare services.

In the current research, the attribution of obstetric fistula to spiritual factors influenced many women to seek care from traditional healers. A similar result was found in a previous study where most women with obstetric fistula failed to appreciate the biomedical justifications for their illness (Wall, 2012a) thereby seeking the services of spiritualists. This finding is not also different from what was reported in other places like Nigeria (Okoye et al., 2014) and Ethiopia (Hurissa et al., 2023). Even among the few women who attributed their condition to biomedical factors, they still attached some sense of spirituality to their illness. This suggests that women may still be discouraged from seeking surgical care even if the right care is delivered to their doorstep unless proper education is given.

Moreover, financial independence and a lack of psychosocial support were frequently cited in the women's narratives as barriers to seeking care. Many of the women stated their inability to pay for medical bills as the force deriving them to seek the care of traditional healers rather than seeking medical attention. Similar results have been found in other studies conducted in Ghana, where

some obstetric fistula patients were either prevented from timely receiving treatment or required consent from their husbands or mothers-in-law (Asiedua et al., 2023; Mantey et al., 2020). Studies elsewhere in Guinea (Delamou et al., 2016), Ethiopia (Hurissa et al., 2023) and Nigeria (Okoye et al., 2014) also reported a similar observation among obstetric fistula women.

Numerous obstetric fistula women in this study were also observed to visit multiple healing services. Since faith healers are widely accessible in most Ghanaian communities and because their services are thought to be less expensive comparative to orthodox medicine, the majority of the women in this study were more comfortable to seek care from them first. Others also employed both faith healing and orthodox medicine concurrently. Similar to this finding is a study in Guinea where majority of women with fistulas were reported to seek healthcare from traditional healers before going to the hospital especially when the former had failed (Delamou et al., 2016). The movement between traditional healers coupled with the delays in seeking care at the health facilities further aggravates the plight of the women. According to a Ugandan study, unsuccessful repairs of obstetric fistula was common among women who delayed in seeking care as well as women who were moving from one healer to another (Nalubwama et al., 2020). It is not surprising that the USA and Europe are recording lower rates of obstetric fistula over a period now. The reason for this is that women in those developed settings adopt appropriate treatment seeking behavior by regularly visiting the health facility and the universal health coverage also reduced the burden of accessing healthcare (Ahmed & Tunçalp, 2015). Thus, in order to lower the rates of obstetric fistula, developing and underdeveloped countries must implement strategies to improve access to healthcare and educate women on the need to adopt appropriate health seeking behavior.

5.5 Socioeconomic consequences faced by women living with obstetric fistula

In the present study, obstetric fistula women face a lot of challenges both in their families and the communities they live. These challenges, some of which persist even after corrective surgery, were problems with social integration, stigma and psychological trauma, reduced self-esteem, and economic challenges. Similar observations were resonated in other studies (Mwini-Nyaledzigbor et al., 2013; Sori et al., 2021). Among all these, social stigma was the greatest challenge faced by the women which led to serious psychological trauma, including despair and suicidal ideation which is in line with a previous study in Ethiopia (Animut et al., 2019). Similarly, a qualitative study in the Upper West Region of Ghana found that women living with fistula were stigmatized to the extent that they lost hope in life and wished death for themselves (Mwini-Nyaledzigbor et al., 2013). In most cases, when someone realizes there is nothing they can do about a situation, they typically have a shift in attitude (Dako-Gyeke et al., 2022). Given the realm of this study, some of the respondents were optimistic about the future, while others were depressed. Some of the women in this study were motivated by optimism, depending on hope and faith in God to help them deal with the circumstances.

Moreover, women with obstetric fistula in the current study faced a demanding situation regarding social integration with their peers and community members. The majority of the women in this study stated how their condition prevented them from participating in community and religious events. The present findings are congruent with previous studies in Tanzania (Mselle & Kohi, 2015b), Malawi (Changole et al., 2017), and Ghana (Asiedua et al., 2023). In these studies, the researchers highlighted how obstetric fistula women were prevented from attending social and religious gatherings, and how they were marginalized and ostracized by their loved ones and

family members. Research indicates that the majority of African women with obstetric fistulas faced comparable challenges in their social lives and related consequences.

In addition, the financial challenges faced by the women in this study were exacerbated by the fact that they had to pay a high price for medical care, medications to treat their pains, and detergents to keep themselves clean. The participants were forced to live with the condition because most of them were already from impoverished homes and the National Health Insurance was also deficient in financing their healthcare. Even some of the few women who were gainfully employed lost their jobs through the condition and thus meeting their treatment bills became a challenge to them. The current result is in agreement with what Dako-Gyeke and co found in their qualitative study (Dako-Gyeke et al., 2022). It is interesting to note that the economic consequences that result from obstetric fistula are not only driven by the physical symptoms of the disease but are often intertwined with the complex psychosocial consequences of the condition. For instance, physical symptoms like incontinence or social factors like the stigma associated with the condition may be the cause of the incapacity to work.

Cleanliness is very important for women living with obstetric fistula because the smell of urine and leaking are discrediting and stigmatizing for them as they are sources of shame, low self-esteem, anxiety, embarrassment and humiliation (Musyoki et al., 2020). Prior studies have shown that obstetric fistula women require sanitary materials and solutions to maintain their personal hygiene as it was revealed in this study. Meanwhile, the economic catastrophes associated with this condition force many women to resort to bad and unhygienic ways of taking care of themselves. For instance, in Northwestern Ethiopia women with obstetric fistula were using old pieces of cloth as pads, and powder as perfume to manage fistula-related odor (Bashah et al., 2019). Similarly, obstetric fistula women who could not afford to purchase sanitary items had to ware

many clothes at a time to cope with the wetness and odors associated with their condition (Hurissa et al., 2022). Given the disproportionate burden posed by obstetric fistula and its economic consequences, all interventions and strategies to address fistula will require careful consideration on how they will impact women who are poorer and living in rural areas, as findings from this survey shows the denigrating experiences women go through.

CHAPTER SIX

SUMMARY, CONCLUSION, AND RECOMMENDATION

6.1 Introduction

The main findings of this study are highlighted in this chapter and based on these findings, conclusions are reached and recommendations are given for practice and policy guidance. Insights are also provided for future research on the lived experiences of women with obstetric fistula.

6.2 Summary of the key findings

The main objective of the study was to explore the lived experiences of women with obstetric fistula after a complicated childbirth in the Northern Region, Ghana. Specifically, the study identified the health care needs of women living with obstetric fistula, explored the treatment challenges faced by women living with obstetric fistula after childbirth, the treatment-seeking pattern of women living with obstetric fistula after childbirth, and explored the socioeconomic consequence of living with obstetric fistula after childbirth in the Northern Region.

In this study, the healthcare needs identified by women living with obstetric fistula included improved ANC services, availability of skilled healthcare practitioners, and access to health facilities and adequate services. The participants voiced dissatisfaction with the comprehensiveness and quality of treatment they received throughout pregnancy about ANC services. Many of the respondents put emphasis the need to improve healthcare providers' knowledge and instruction on the prevention and treatment of obstetric fistulas. Also, participants frequently mentioned having trouble finding qualified medical professionals to treat obstetric fistulas. Moreover, another major healthcare need was the access to health facilities that provide the needed services. Getting to medical facilities has become a major obstacle for people with

obstetric fistulas. Significant hurdles included lack of infrastructure, transportation expenses, and geographic distance.

The treatment challenges faced by women with obstetric fistula were financial barriers, repeated/unsuccessful repairs, negative attitude of health professionals, and coping with postoperative instructions. The participants in this study regularly brought attention to the substantial financial cost of treating obstetric fistulas. Due to financial issues, some women had to delay seeking treatment for themselves despite knowing they were diagnosed of obstetric fistula. Additionally, another treatment challenge that women with obstetric fistula reported was repeated unsuccessful surgeries they have gone through which they said attracted negative perceptions towards them. Furthermore, some participants said that during their treatment for obstetric fistula, they encountered stigma and unfavorable attitudes from healthcare professionals, especially nurses or midwives.

In terms of the treatment-seeking pattern of women with obstetric fistula, places where women seek treatment first after developing fistula, places where women go last for treatment, and support in seeking treatment. According to the findings, a number of the participants had tried traditional methods such as spiritual therapies and traditional herbs. Women with obstetric fistulas went through several care-seeking processes (going to traditional places, staying at home with traditional birth attendants' care) before ultimately arriving at fistula treatment facilities following a long-term trial period with conventional care. However, the participants reported receiving a multitude of support from their family, community, and healthcare

Finally, the consequences faced by women living with obstetric fistula are problems with social integration, stigma and psychological trauma, reduced self-esteem, and poverty. The majority of participants stated that they are unable to take part in community and religious events. Even after

corrective surgery, stigma persisted and took many different forms, ranging from subtle discrimination and isolation to overt discrimination. They lack self-assurance and don't think of themselves as regular people. Those who had survived an obstetric fistula were unable to continue with their businesses or other revenue-generating endeavors and so they lost many of their customers.

6.3 Conclusion

The results of this study show that the healthcare needs of women living with obstetric fistula included improved ANC services, availability of skilled healthcare practitioners, access to health facilities, and adequate services. Also, the treatment challenges faced by women with obstetric fistula were financial barriers, repeated/unsuccessful repairs, negative attitudes of health professionals, and coping with postoperative instructions. Treatment-seeking patterns experienced by the participants include places where women seek treatment first after developing a fistula, places where women finally go for treatment, and support in seeking treatment. Finally, the participants experienced a variety of challenges that had an impact on their well-being, including physiological problems, psychological issues, divorce and abandonment, financial limitations, and difficulty accessing health care. Undoubtedly, uncontrollably leaking urine or feces was the primary cause of the difficulties faced by the women in this study, and the misconceptions surrounding the illness made matters worse. As a result, it's critical to give obstetric fistula treatment top priority and to allocate resources to enhance both the general well-being of women and the quality and accessibility of this care. Furthermore, a large number of the women were socially isolated, which kept them cooped up in their homes with little to no chance of earning a living or interacting with others outside of them. This implies that women living with obstetric fistula warrants financial support and psychosocial counseling.

6.4 Recommendations

The following recommendations are made taking into consideration the study results:

1. The Ministry of Health should ensure adequate training and availability of healthcare providers and specialists so as to equip personnel with the requisite skills required to manage obstetric fistula cases.
2. The Ghana Health Service should instill mass sensitization programs to educate people, especially women, about the risk factors associated with obstetric fistula.
3. The government should ensure that treatment of obstetric fistula is fully or partly covered by the NHIS given the financial difficulties such victims face living with the condition.
4. The government of Ghana should liaise with other stakeholders like the religious leaders to lead a crusade against negative socio-cultural perceptions held against obstetric fistula and its victims
5. Healthcare workers in various health delivery institutions should establish trust with their clients by ensuring good interpersonal relationship with them.
6. Traditional and religious leaders should adopt measures that will ensure swift integration of women living with obstetric fistula into the general public and take measures to reduce stigma associated with the condition.

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APPENDICES

IN-DEPTH INTERVIEW GUIDE

My name is Agamba Shaline, a student of the University for Development Studies. I am conducting a study on the lived experiences of women with obstetric fistula in this Metropolis, Tamale. You are assured that all responses provided would be strictly confidential and used only for academic purposes. Please, your participation in the study is voluntary; however, your decision to participate will be very much appreciated. The discussion will take about 30 minutes of your time. Thank you for agreeing to participate in the study.

Time of interview [Begins]..... [Ended].....

Date.....

Section A: Basic information about participant

1. Participant code……
2. Age of participant in years……..
3. Occupation of the participant……..
4. Gravida…….. Parity……..
5. Common place of deliveries: Hospital…… Home…….
6. What is your marital status? …… (If married, describe your experience surrounding marriage? Probe for age at marriage, whether or not she is still living with the partner)
7. If divorced, were you divorced before or after sustaining the condition?

Section B: Treatment seeking pattern of women with obstetric fistula

1. Tell me about your condition (obstetric fistula). Probe for how it started, any possible cause, the nature of the leakage (urine or faeces).
2. When you noted it, what did you do? Probe: who did you inform? Was it your husband, mother-in-law etc..?
3. Where did you send it first for treatment? Probe: did you go to the hospital or you sent it to a traditional healer or religious leaders? Probe: if any of these, why did you take that decision?
4. Did you get a successful treatment after visiting that place? Probe: if NO, where did you go next and what was your experience there?

Section C: Health care needs of women living with obstetric fistula

Describe your health care needs while living with obstetric fistula? Probe for;

1. Availability of skilled health care
2. Access to health facility and adequate health services: did the services meet your expectations.
3. Improved ANC services

Section D: To explore the treatment challenges faced by women living with obstetric fistula

During the course of your treatment, did you face challenge or difficulties related your condition? Probe: can you describe the challenges you faced during the course of your treatment? Probe for;

1. Financial burden: affording medical supplies, medications and cost of surgeries
2. Success of surgical repair: did you ever had unsuccessful surgical repair? What might have caused that?

3. Attitude of health professionals: how were you handled by the nurses, midwives and doctors?
4. Treatment guidelines: were able to adhere to the treatment recommendations? If NO, why?

Section E: Sociocultural consequence of women living with obstetric fistula

Describe your experience living with obstetric fistula? Probe for;

1. Economic experience (ability to do income earning activities)
2. Social experience (stigma/acceptance, self-esteem, relationship during social gatherings such as funerals, weddings)
3. Physical consequences: Probe for physical injuries, incontinence, urinary tract infections
4. Psychological and emotional consequences: Probe for despair, depression, hopelessness, fear of the future, loss of dignity,
5. Cultural experience: Probe for traditional beliefs, practices, and perceptions about fistula
6. Religious experience (ability to play roles during religious worships)
7. Leadership and performance of roles

End of interview

Thank you for your time

KEY INFORMANT INTERVIEW GUIDE

My name is Agamba Shaline, a student of the University for Development Studies. I am conducting a study on the lived experiences of women living with obstetric fistula in this Metropolis, Tamale. You are assured that all responses provided would be strictly confidential and used only for academic purposes. Please, your participation in the study is voluntary; however, your decision to participate will be very much appreciated. The discussion will take about 30 minutes of your time. Thank you for agreeing to participate in the study.

Time of interview [Begins].....

[Ended].....

Date.....

Section A: Respondent's socio-demographic characteristics

1. Profession…….
2. Rank…….
3. Number of years working with obstetric fistula clients……..

Section B: Health care needs of women living with obstetric fistula

1. Describe your health care needs of women suffering from obstetric fistula? Probe for;
    a. Skilled health care availability
    b. Access to health facility and adequate health services
    c. Improved ANC services

Section C: Treatment seeking pattern for women living with obstetric fistula

1. Describe the treatment-seeking pattern for women living with obstetric fistula? Probe for;

a. Orthodox treatment
b. Traditional/religious treatment
c. Herbal treatment

2. What is the magnitude of obstetric fistula in this facility?
3. What interaction do you have with obstetric fistula survivors and how often do you interact?
4. Which treatments modalities are available for obstetric fistula cases? Probe: which are available in this facility?
5. Who bears the cost for treating obstetric fistula? Probe: is it fully or partly covered by the NHIS?
6. Do women seek treatment in isolation? (Do friends and family provide support in terms of emotional support, financial assistance, or helping with house chores?)

Section D: Treatment challenges faced by women living with obstetric fistula

1. Describe the treatment challenges of your obstetric fistula? Probe for;
   a. Financial burden
   b. Difficulty in accessing improved healthcare
   c. Negative attitude of the mid-wife or nurse
2. What is the success rates of obstetric fistula repairs? Probe: how often does surgical repairs fail?
3. How does unsuccessful surgeries affect the woman? Probe for:
   a. Financially
   b. Physiologically
   c. Psychologically

Section E: Sociocultural consequence of women living with obstetric fistula

1. Describe your experience living with women suffering from obstetric fistula? Probe for the challenges obstetric fistula women experience in terms of;
    a. Economic experience (ability to do income earning activities)
    b. Social experience (stigma/acceptance, relationship during social gatherings such as funerals, weddings)
    c. Physical consequences: probe for physical injuries, incontinence, urinary tract infections
    d. Psychological and emotional consequences: probe for despair, depression, hopelessness, fear of the future, loss of dignity,
    e. Cultural experience: probe for traditional beliefs, practices, and perceptions about fistula.

End of interview

Thank you for your time