St. MARY'S UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF SOCIAL WORK

EFFECTS OF OBSTETRIC FISTULA AMONG SURVIVORS:

THE CASE OF SURVIVORS AT HAMLIN FISTULA HOSPITAL ADDIS ABABA

BY

KIDIST ALEMAYEHU

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DECEMBER 2021

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ENDORSEMENT

This Thesis has been submitted to St. Mary's University, School of Graduate Studies for examination with my approval as a University advisor.

_____ _____

Mosisa Kejela (PhD. Cand.) Signature & Date

St. Mary's University, Addis Ababa

DECLARATION

This is to certify that the MA thesis written by Kidist Alemayehu Workineh titled “Effects Of Obstetric Fistula among Survivors: the case of survivors at Hamlin Fistula Hospital Addis Ababa” In partial fulfillment of the requirements for the Degree of Masters in Social Work complies with the regulations of the University and meets the accepted standard with respect to originality and quality.

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Kidist Alemayehu

St. Mary’s University, Addis Ababa Signature & Date

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Table of Contents

LIST OF TABLE

Tables **Page**

ACRONIYEMS

FGM- Female Genital Mutilation

UNFPA-United Nations Population Fund Activities

WHO- World Health Organization

EVF- Entro Vaginal Fistula

RVF- Recto Vaginal Fistula

UPF- Utero Peritoneal Fistula

VVF- Vesico Vaginal Fistula

FMoH- Federal Ministry of Health

OF – Obstetric Fistula

ABSTRACT

This research paper explores challenges of obstetric fistula with the aim of assessing the lived experiences, challenges and solutions of women survived from obstetric fistula at Hamelin Hospital. The study was undertaken utilizing an in-depth interview and eight participants were purposely selected and 5 participants were interviewed as data saturation reached on the 5th participant. Methodologically the research study is used Qualitative research method and case study. In-depth interview used as a main tool to capture qualitative data. Open-code categorization and content analysis is used for analyzing data. The key findings of the research indicate that first; the participant's sexuality and sexual experiences before marriage in that they denied having any intimate relationship or sexual interaction before marriage and stated that their parents or caretakers forced into marriage without their consent at early age. Second; Life, challenges and cope-up mechanism after developing fistula they faced many challenges medical and psychosocial. Their coping mechanisms was staying at home and isolating self. Third, perspectives about the future life and how do they shape it they were optimistic about their future after their repair. Fourth, predictions on fistula treatment and rehabilitation services participants were very satisfied by the treatment and very happy about the rehabilitation program. The interventions designed and implemented to understand effects of obstetric fistula and what impact it has in their psychosocial and economic situations, identifying areas of potential concern for supporting and the intervention activities. It helps to develop mechanisms that enable to explore and build up the strength of individuals and communities, which would ultimately help to prevent and manage obstetric fistula

CHAPTER ONE

1. Introduction

Under this chapter the researcher tried to address background of the study, statement of the problem, objective of the study, scope of the study, significance of the study, limitation of the study and other information included.

1.1.Background of the Study

This study aimed to understand the lived experiences of women obstetric fistula at Hamelin Hospital in Addis Ababa, Ethiopia. An obstetric fistula refers to an abnormal opening between a woman's genital tract and her urinary tract or rectum produced by obstetric causes, usually prolonged and obstructed labor. Fistula affects usually women from rural areas, who are poor, uneducated women and often with early first pregnancy. Obstetric fistula can be caused by prolonged labour which is mostly related to lack of access to health care facilities and socio-economic situation of the women. A study found that iatrogenic fistulas occur in women who faced emergency obstetric surgery, often to address a ruptured uterus. Majority of women with iatrogenic fistulas had a history of previous cesarean section, suggesting that women who undergo C-section are at heightened risk for iatrogenic fistula during a subsequent surgery (Mohamed, 2018).

Globally, more than 2 million women are living with obstetric fistula. In Sub Sahara Africa, obstetric fistula is estimated that 1.60 cases per 1000 women of reproductive age, and in South Asia the prevalence is estimated at 1.20 fistula cases per 1000 reproductive age women (Polan ML, 2015). Obstetric fistula is a serious and devastating complication of childbirth affecting millions of women in the world, especially the developing world. Unfortunately, women who endure such obstructed labors and resulting incontinence are often young, undernourished, and married early. The obstetric fistula is one of the most common and certainly most dreaded injuries. The impact of fistula in a country where maternal mortality rates are high is countless (Ayadi, 2018).

Obstetric fistula has an extensive physical, psychological, social, and economic cost for women affected. The women are left with persistent incontinence and the baby inevitably dies due to prolonged obstructed labor. As a result of fistula, women can't control the flow of urine or feces

or both. This may lead to abandonment by her partner, relatives, and /or detestation by the community. If treatment is not given to such victimized women, the life of the women and her family fall in danger. Several women are divorced or abandoned by their husbands, turned back by friends, and even by health professionals (Meurice M, 2017).

Obstetric fistula is not only devastating the physical health of women but emotionally and socially. Fistula is a massive psychological disturbance. It leads to severe socio-cultural stigmatization. In developing countries, obstetric fistula is always linked to prolonged labor and poorly performed abortion (Alison M El Ayadi, 2018). The Ethiopian health system suffers from the burden of other public health issues like malaria, HIV/AIDS, and tuberculosis breakdown. This may put many women at risk. Our Hospitals suffer from shortages of supply and manpower especially highly skilled professionals who can do the surgical repair for women with obstetric fistula (FMoH, 2010). There is also low institutional delivery in the country, in which women give birth in their home. The other challenge related to the fistula is the lack of information. Most women do not know as there is a treatment for fistula (Biruktawit Matiwos, 2020). They hide their circumstances and are ill within silence (FMoH, 2010).

Besides, the treatment of fistula is among the type of expensive treatment. The treatment center needs a laboratory, radiology, and blood bank before conducting the surgery to know patient history [(Biruktawit Matiwos, 2020). After surgery, it is needed post-operative wards, anesthetic services, psychological and social integration. The cost of salary, single used medical equipment, and other infrastructure, together endow with huge economic loads to treat fistula. In Ethiopia, there are limited numbers of hospitals that give treatment, rehabilitation, and reintegration services for obstetric fistula (Biruktawit Matiwos, 2020).

Women who experience obstetric fistula suffer constant incontinence of urine or feces or both, shame, anxiety, social segregation, and other health and social problems. It is estimated that more than 2 million young women live with untreated obstetric fistula in Asia and in sub-Saharan Africa (Kalembo F, 2012). Obstetric fistula victims often experience feelings of powerlessness, physical injury, emotional breakdown, depression, divorce, erosion of social capital, and loss of health years. It was reported that 50,000–100,000 new cases develop annually in which the majority of the cases (99%) occur in the developing world (Tarekegn, 2014).

In Ethiopia, it is estimated that there are about 39,000 women suffering from untreated fistula and 3700 women who develop fistula injuries each year, causing life-long disabilities and poor quality of life (Kalembo F, 2012). In Ethiopia Maternal health service utilization is very low. The 2011 Ethiopian Demographic and Health Survey (EDHS) reported that among 34% of the women attended ANC visits; only 11.7% used skilled delivery attendants. Therefore, poor compliance to seek for skilled delivery attendant in turn perpetuates risk for the occurrence of delivery complications including obstetric fistula (Tarekegn, 2014).

While obstetric fistula is inherently a physical injury, its consequences for mental wellbeing can be grave and this is why at Hamlin a holistic approach is taken to supporting patient recovery. Through our Rehabilitation and Reintegration Programme in Ethiopia we help women regain their self-worth; trust in their bodies and the confidence and empowerment to move forward in a new phase of their lives. For women suffering the effects of ob1stetric fistula in Ethiopia, having suffered a traumatic birth they are all too often misunderstood, stigmatized and excluded from their communities.

Due to superstitions surrounding the causes of fistula injuries, women may even be outcast by their husbands and families which can have devastating effects on their emotional wellbeing and ability to earn a living or live a normal life. For some women with no means of supporting themselves, they endure a poor quality of life, frequently suffering from depression. Research has found that almost 97% of women living with fistula experience depression, a truly alarming figure (HamlinFistulaUK, 2021).

Hamlin's surgical teams at hospitals across Ethiopia are performing vital work in repairing the injuries of fistula sufferers. Such surgeries not only repair the physical injuries but, according to recent evidence, mend emotional scars too. 2019 research by the University of South Africa's Addis Ababa campus found following successful fistula surgery at Hamlin's hospitals, the prevalence of depression among patients reduced hugely, to 27%. This suggests that medical complications of a fistula are only half the story. It is necessary to help women regain their sense of worth and rebuild their lives. This is why at Hamlin Fistula Ethiopia we had long recognized the physical and mental health implications of a fistula, and through our Rehabilitation

Programme we successfully helping women regain their confidence and livelihoods (HamlinFistulaUK, 2021).

The pandemic expected to cause significant delays in programmes to end female genital mutilation (FGM) - something that could lead to a spike in FGM cases, according to UNFPA, which is a contributing factor for obstetric fistula. As the virus advances in these countries, health services become overloaded, or provide a limited set of the services that women need. At the same time, many women and girls also skip important medical check-ups for fear of contracting the virus. With this possible future scenario of preventive measures in danger, now more than ever, it is important to call on the international community to use the International Day to End Obstetric Fistula to significantly raise awareness and intensify actions towards ending obstetric fistula, as well as urging post-surgery follow-up and tracking of fistula patients (UNFPA, 2020).

1.2.Statement of the Problem

Obstetric fistula is a condition that has medical and psychosocial outcomes that creates a demeaning injury that results in urine and/or fecal incontinence. The impact of stigma and discrimination are among the factors for that negatively affect the victims. It was reported that pregnant women in rural Ethiopia have little or no access to emergency obstetric services that contributes to obstructed labor for days and days. Most of these women lose their baby and suffer horrific bladder and/or rectum damage. As the result of the incontinence related problems, they are stigmatized by the society and labelled as filthy and cursed (Hamlin, 2004; Julia, 2004).

Studies indicated that obstetric fistula is preventable it can largely be avoided by delaying the age of first pregnancy; the cessation of harmful traditional practices; and timely access to obstetric care. Unfortunately, the current pandemic affects all these preventive measures in developing countries where obstetric fistula still exists - countries in which health care systems, even before the corona virus outbreak, failed to provide accessible, quality maternal health care (UNFPA, 2020). Unfortunately, women who experience this preventable condition suffer constant urinary incontinence which often leads to social isolation, skin infections, kidney disorders and even death if left untreated. Affected women are often abandoned by their husbands and families, and ostracized by their communities (WHO, 2015).

It was reported that the actual prevalence of obstetric fistula is not really known because nationwide community-based studies has not been conducted and not easy to manage. Besides, it highly affects women with poor access to obstetric care and who couldn't look for and afford the treatment whereas the existing data is dependent on women seeking medical care. Added to this, the situation is under reported because of the social stigma attached to it. Victims are also forced to leave their marriage, families and communities.

Once women develop fistula it has multiple implications in the lives of the victims. World Health organization (WHO) estimated that 21.9% of the disability-adjusted life years lost by the women, aged 15 through 44 years were attributable to reproductive ill health, and the 14.5 years per woman were lost to adverse maternity-related causes. Obstructed labor is the immediate effect of which fistula accounted for 22% of all morbid maternal conditions. Not only does the problem of fistula affect the productivity of a country, community, and household, it changes the life of the affected women forever. Women with fistulas can no longer successfully fulfill their societal role of wife and mother because women with obstetric fistula suffer from infections and sore due to the incontinence, as well as nerve damage due to the prolonged labor resulting in foot drop. Moreover, they are often abandoned by their husbands and family and stigmatized by society. Obstetric fistula is more than a woman's health problem. Its roots are embedded in economic, political, and social determinants that underlie poverty and vulnerability (WHO, 2006).

Though data regarding the lived experiences and coping mechanisms of Ethiopian women with fistula is limited, Bashah, Worku, Mezgebe and Telake (2019) depicted the psychosocial and economic impacts of the victims and their families. The study showed that women had endured various social problems such as divorce, isolation and dependency. Beside they had difficulty of getting access to information and inability to afford products that can help manage their incontinence. They devised different strategies that might have both positive and negative health outcome to cope with the condition.

Studies conducted in other African countries also found out various challenges that fistula patients faced. For instance, indicated that 14% of new fistula patients were divorced and only 42% continued to live with their husbands; and if the condition persisted, 28% of the women were divorced and only 11% were allowed to stay. For instance, in Niger, 63% were fistula case

were divorced (Lendon, 2001). Often, until they are cured, married women with fistulas are sent back to their parents' home where they are not allowed to cook food, participate in social events, or to perform religious rituals (Ojanuga,1991). As well as a study of women with fistulas perceive the societal reaction toward them in Nigeria found that most (53%) consider themselves rejected (Kabir, Abubaker & Umar, 2004).

In fact, most of the quantitative studies conducted in Ethiopia are helpful to show the burden of the issue. However, quantitative do not provide in-depth understanding on obstetric fistula from victims' perspective, including 'how' they feel, understand and provide meaning for the phenomena they have experienced. As the result, the fundamental nature, feelings and meanings attached to social relationships and health issues of women with fistula has been left untouched. This problem is seen as a gap in the existing literature on obstetric fistula in Ethiopia. The primary emphasis of research on obstetric fistula, therefore, should be on how victims feel and understand their social relationships and health issues in their own context, and how it is influenced by one's own contextual factors. With this insight, this particular research will answer the following research questions.

There is a knowledge gap in understanding the lived experiences and feelings of the fistula survivors about their social and sexual experiences before developing fistula and how their life has changed as they pass through the process of getting married, sex debut, being pregnant and developing fistula. Qualitative studies on what the fistula survivors think about restoring their marriage, having children and a future life aspiration needs an in-depth exploration of survivors' experiences. Thus, this study is important in exploring and understanding what the survivors think about their life after completing their rehabilitation program and what can be done during and after discharge from the program.

There are very limited studies conducted using in-depth qualitative case study approaches on the fistula survivors, who received rehabilitation services, and their past and present experiences and their future perspectives about their life. Thus, this study will fill the gap in the understanding the of these survivors' experiences and design a compassionate and comprehensive social work interventions, paves the way for social work research and education and policy formulation or policy amendment.

1.3. Objectives

1.3.1. General Objective

The general objective of the study is to understand the past and present experiences of women with repaired obstetric fistula and how they picture their future.

1.3.2. Specific objectives

1. To understand how obstetric fistula survivors see their social and sexuality life before and after fistula.
2. To learn the challenges and cope up mechanisms of fistula survivors in the face medical, psychological and socio-cultural influences.
3. To understand what obstetric fistula survivors' perspectives of their future and what they do to shape it?
4. To know what the survivors think about the treatment and rehabilitation services they received.

1.4. Research Questions

According on the abovementioned objectives the following questions were developed and to be addressed as part of the research analysis;

1. How do women remark their social and sexuality life before fistula repair?
2. What were challenges influences and cope up mechanisms of fistula survivors?
3. What do the survivors think about the future hold for them?
4. What the survivors think about the treatment and rehabilitation services they received.

1.5. Significance of the Study

The study examined the effects of obstetric fistula and what impact it has in their psychosocial and economic situations, identifying areas of potential concern for supporting and the intervention activities. In the meantime, actions need to be taken to identify women who suffer from fistula without getting medical attentions. Obstetric fistula has received attention as a result continuous lobbying and sensitization done by the government and international and local organizations. The outcome of this study contributes to: prevention and care of maternal health

and pregnancy; inform directions to policies; review and/or designing programs; academics and research.

In general, this study significantly contributes to the social work practice, research, education, and social development policy. Specifically, it allows the replication of successful interventions and planning future services based on actual lived experiences; provide knowledge base for comparison of interventions related to obstetric fistula and maternal health women-friendly and effective prevention; provide feedback for knowledge and advancement of individual and group level social work practice; and contribute to empirical knowledge and social policy development to be based on the actual experience of the women who are obstetric fistula survivors.

1.6. Scope of the Study

This study attempts to explore the effects of obstetric fistula in the past and present eight fistula survivors and how these women picture their future life. The study focus on the women in post repaired obstetric fistula procedures who are referred and enrolled in the rehabilitation program at Hamlin Fistula Hospital.

1.7. Limitations of the Study

This study is limited to five obstetric fistula survivors who are referred and enrolled in rehabilitation program. Due to the small size of the study participants, this study is limited in terms of generalization of the findings. The level of education and the willingness of participants to share their actual life experiences may impact the depth and/or quality of data to be collected that in turn affects the result of this study and the study was in Addis Ababa Hamlin Fistula Hospital in this case the study cannot represent all obstetric fistula survivors in Ethiopian. Finally, time and financial limitations may play roles in terms of collecting each and every data and literature on the subject matter.

1.8. Operational Definitions of Terms

- **Early marriage:** Any marriage that is arranged below the age of 18.
- **Entero Vagina Fistula (EVF):** fistula that is between the intestine and the vagina.
- **Female Genital Mutilation:** a traditional practice in which part of or the entire external reproductive organ of the female is removed.

- **Fistula:** An abnormal communication between two hollow organs or between a hollow organ and the exterior.
- **Labor:** the process by which a woman delivers her baby in to the world.
- **Obstetric Fistula:** A fistula resulted from pregnancy and child birth problem, mainly obstructed prolonged labor.
- **Obstructed Labor:** A condition where by delivery is difficult and delayed hindering easy passage of the baby
- **Prolonged Labor:** an abnormal elongated labor lasting beyond 24 hours.
- **Recto-Vaginal Fistula (RVF):** fistula that is between rectum and vagina.
- **Utero peritoneal Fistula (UPF :** is fistula is in peritoneal cavity.
- **Vesico-Vaginal Fistula (VVF):** fistula that is between the vagina and bladder.
- **Social concept:** The primary root cause of obstetric fistula is pervasive poverty. Obstetric fistula arises from poor access to maternal health services, the traditional practice of early marriage and child bearing, malnutrition and female genital mutilation. It also occurs from lack of education and power imbalance within a household, which is associated with women's low social status.
- **Medical concept:** Obstetric fistula is a severe injury that can result from prolonged obstructed labor. Labor becomes obstructed when a woman cannot deliver her baby through her birth canal, because of a discrepancy between the size of the fetus and the space available in her pelvis. This often leads to stillbirths and can result fistulas in surviving women.

1.9. Organization of the Study

The thesis has composed of five chapters. Chapter one provide introduction of the study and specifically address the following: background of the study; statement of the problem; research questions; objectives of the study; scope of the study; significance of the study; simulation of the study; and Research Site Selection. Chapter two examines various local and international literatures around obstetric fistula and maternal health. Chapter three discuss the research method to be employed for this study purpose. The fourth chapter presents the main findings of the study. Finally, chapter five includes discussion of the major findings, implications of the study and conclusion. References and annexes such as the research tool follow the final chapter.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

2.1.Introduction

The literature review covers topics related to obstetric fistula. These include: history of obstetric fistula, sexual experiences, future life after fistula treatment, coping mechanisms, and reintegration of women after repair. The international and national instruments developed to promote maternal health, theoretical literature, and conceptual framework with its description is also discussed under this section.

2.2. History of Obstetric Fistula

Obstetric fistula is as old as mankind and has been a constant source of misery to the women affected. The oldest evidence of obstetric fistula was found in the remains of an Egyptian Queen's mummy sometimes in 2050 BC. This observation was made when Queen's mummy was sent to the Metropolitan Museum of Art, New York in 1909. In 1923, the mummy was returned to Cairo for extensive clinical examination. The examination found a defect in the bladder communicating directly with vagina. It was also found that the pelvic bone was abnormal in shape, approximating that of apes. Then, it has been assumed that severe pain and damage to the bladder and vagina was responsible for the death of the Queen (James, 1988).

The end of 16th century was a remarkable period because during this time several clear description of fistula started coming up. Following this, at the beginning of 19th century, major progress was made in the repair and treatment of fistula. In 1838, Dr. John Perere Meattauer wrote a letter to the Boston Medical and Surgical Journal confirming the relationship between obstructed labor and vesico-vaginal fistulas. On this letter he also reported that he had successfully closed a vesico-vaginal fistula with wire sutures (James, 1988).

In 1845, Dr. J.Marion Sims of America encountered his first case of obstetric fistula. Although he was not the first American to close a vesico-vaginal fistula, he significantly improved the surgical technique of fistula repair, and to this day many of his techniques remain the standard. In May 1855, Dr. Sims opened the first fistula hospital in New York City. Improvements in the

general health of women and maternity care led to this Women's Hospital becoming converted into a general hospital in 1895 as the prevalence of fistulae cases had fallen drastically. On the site of the hospital today, however, is the Waldorf Asotria Hotel, as there is now no need for a fistula hospital in America (James, 1988).

2.3. Sexual Experiences and Causes of Obstetric Fistula

A study conducted in NorthWest Ethiopia expressed about sexual experiences of obstetric fistula survivors are incontinence, coupled with inability to fulfill roles as a woman was a great challenge. Women become rejected and divorced due to the condition that left them with continuous leak and loss of newborn. Mostly where the urinary leak is heavy, having sexual activity is found embarrassing and painful to them thus they would abstain from sexual activity. As a result some became separated or get divorced and lost all what they had in their married life (Bashah et al. 2019).

A study conducted by WHO about causes of obstetric fistula are early marriage, harmful traditional practices, sexual abuse, lack of access to maternal health care, lack of skilled health care provider and inaccessibility of health care facilities, poverty are among the major causes of obstetric fistula (WHO, 2015).

Studies conducted in Ethiopia supports the above factors. Early marriage is one of the dominant factors that predispose women to obstetric fistula in Ethiopia. Though the law prohibits early age marriage, girls are forced into marriage at extremely early age. Socio-economic condition plays a huge role in this practice. Studies conducted in at the Hamlin Fistula Hospital show that the age of the girls along with the education status, socio-economic and cultural factors contribute the condition of babies and the girls' pregnancy outcome. The most common cause of obstetric fistula is female genital fistula in Ethiopia. Obstetric fistula occurs when women do not have access to timely, high quality care during childbirth. In settings where obstetric fistula is still a significant problem, health information systems are often incomplete, with gaps in routine reporting of births, maternal deaths and complications during childbirth, particularly for home births. (Alison, 2018)

A research conducted by WHO each year between 50 000 to 100 000 women worldwide are affected by obstetric fistula, an abnormal opening between a woman's genital tract and her urinary tract or rectum. The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. Women who experience obstetric fistula suffer constant incontinence, shame, social segregation and health problems. It is estimated that more than 2 million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa. (WHO, 2018)

Thus, health behavior is influenced by the interaction of personal, situational, socio-cultural and environmental factors including built environment. Understanding the influence of socio-cultural and environmental factors as related to health seeking behavior and outcome of intervention related to fistula is at the center of this study.

This study tried to give a brief understanding of effects of obstetric fistula among survivors in Hamlin Fistula Hospital in Addis Ababa and tried to understand their past and present experiences and how they picture their future. Bashah et al. (2019) conducted that the consequences of obstetric fistula are beyond its visible medical conditions in sub-Saharan Africa. This offers summarized evidences on consequences related to physical conditions; women's social and marital relationships, economic in capabilities; mental health and challenges to coping mechanisms. The result of the study indicates the thematic categories shared across most studies were related to the physical challenges of losing body control, women's social and family relationships, and the challenges of losing income. Obstetric fistula has far-reaching consequences on women's physical well-being, social and marital relationships, mental health and economic capacity. Fistula also challenged women coping abilities. Yenenesh (2014) conducted a qualitative study of the experience of obstetric fistula survivors in Addis Ababa, Ethiopia. The results of the study were to prevent and manage obstetric fistula successfully, there should be family-based interventions that improve access to and provision of emergency obstetric care. These initiatives should also ensure men's participation, women's empowerment, and the utilization of community-based institutions.

2.4. Future Life, Coping Mechanisms and Reintegration after Fistula Repair

A study conducted Southwest Ethiopia on quality of life of obstetrics fistula patients before and after surgical repair in the Jimma University Medical Center the overall quality of life of the patient with fistula was improved after successful surgical repair. Although all domains of quality of life had shown significant improvement after successful surgical repair, the psychological domain showed slight improvement (Tilahun , Hordofa, Aregawi, & Demisew , 2021).

A study conducted in Malawi, Africa on explores the strategies that women with obstetric fistula in Malawi use to manage it and its complications. Found women with fistula are to some extent 'modern day lepers' in the sense that they may not necessarily be excluded by their community as observed in this study, but they deem themselves as unclean and therefore exclude themselves. Considering that women in this study were using their faith in God to cope with their condition, if religious leaders are educated accordingly, they could be used to further help these women get guidance and help on how to deal with their condition. Also family and spouse support important in coping with such a devastating condition as fistula cannot be overemphasized. Family, spousal, and social support could be a source of strength and self-confidence (Josephine, et al., 2019).

A study conducted by Kyla growing recognition of the importance of linking obstetric fistula prevention and treatment strategies with rehabilitation and social reintegration programmes. Using in-depth interviews, this study aimed to examine the experiences of 51 Ethiopian women after fistula repair surgery to identify priority post-repair interventions that could maximize their quality of life. The results showed that the majority of women felt a dramatic sensation of relief and happiness following repair, yet some continued to experience mental anguish, stigma, and physical problems regardless of the outcome of the procedure (Kyla et al. 2014).

CHAPTER THREE

3. RESEARCH DESIGN AND METHODOLOGY

This chapter gives description of the research methodology. The study used Qualitative research method and case study. In-depth interview and direct observation used as a main tool to capture qualitative data. It also indicates procedures for data collection and analysis and ethical consideration.

3.1. Research Design

This study is aimed to capture the past and present experiences, and future aspirations of women survivors of obstetric fistula. Thus, a case study approach is implemented for this qualitative study. Research method literature indicated that this approach helps to discover, describe and capture the meaning and in the study of the lived and deep experience of individuals. It also focuses what all participants have in common as they experience a phenomenon (Padgett, 2008; Creswell, 2007). A case study method allows retaining the holistic and meaningful characteristics of real- life events as it is explained in (Yin, 2003). It is also argued that case studies offers analytic benefits since there is the possibility of direct replication, analytic conclusions independently arising from multiple-cases (Yin,2003). Thus, the interview tools, and analysis and reporting styles have been shaped by guiding assumptions of a case study.

3.2. Description of the Study Area

In qualitative research, for the purpose of deep understanding of the subject matter under study or research question, it is up to researcher to make a decision on the research participants, sites and even the material to use (Creswell, 2007). The study area of the research is in Addis Ababa. Addis Ababa is the capital city of Ethiopia and the seat of many international and continental organizations ever since its establishment in 1886. Addis Ababa is now growing and expanding rapidly in terms of its area and population size and availing various health and social services. One of the health care providers which is located in Addis Ababa, is Hamlin Hospital. Hamlin Hospital is the only hospital provides fistula repairs for free for patients who come from all the country. It was reported that, so far Hamlin Hospital provided free fistula repairs and rehabilitation services for over 60, 000 fistula cases. Hamlin Hospital also has around 500 health

care and administrative workers. Thus, study area is purposefully selected for there is only one organization dedicated in the treatment and rehabilitation of obstetric fistula cases in Ethiopia. It is located in Addis Ababa city. Hamlin Fistula Ethiopia runs a Fistula Hospital. This hospital is founded by Drs. Catherine and Reg Hamlin in 1974. This organization engaged in prevention, treatment and rehabilitation of women suffering from fistulas in Ethiopia. After women pass through the surgery, they are enrolled in rehabilitative services to assist them to reintegrate back into community life, build self-esteem and/or find meaningful employment. Therefore, this study takes place in Addis Ababa at Hamlin Fistula Hospital with an emphasis on women who are transferred for the rehabilitation service within the Hamlin Ethiopia system.

3.3. Research Approach of the Study

Based on the nature of this research the study the researcher decided to use qualitative research method. This qualitative method is framed in terms of using words rather than numbers and collect data using open-ended questions. In qualitative research method the researcher used a case study approach. Hence, the researcher used the qualitative study and a case study approach which is best suitable for the current study topic which is sensitive and emotional depth that requires empathy and understanding their experiences of participants.

3.4. Population of the Study

Population of the study was eight women survived from obstetric fistula at the Hamlin Fistula Hospital. A total of eight women's affected by obstetric fistula were selected purposefully out of the total women referred and/or enrolled at the Hamlin Fistula Hospital rehabilitation program.

3.5. Sampling and Sampling Method

The study used non-probability sampling technique as a sampling method. Purposive sampling method is employed to trace the first participant. This involved conscious selection of a participant by the researcher based on the inclusion criteria and purpose of the research from Hamlin Fistula Hospital in Addis Ababa. This has been done with the support of the Medical Director of Hamlin Fistula Hospital in Addis Ababa. She is assigned women's who survived from obstetric fistula and enrolled in rehabilitation program. The study sample size was subjected to change depending on the level of data saturation. To undertake this study eight

participants were purposely selected to complete the an in-depth interview. However, five participants were interviewed as data saturation reached at the 5th participant. Qualitative research method sources puts that data saturation is reached "when there is enough information to replicate the study when the ability to obtain additional new information has been attained, and when further coding is no longer feasible (Creswell, 2007, p.137). In-depth interview guides were used to collect the data from the participants. Participant's inclusion criteria were: willingness of the participants, age 18-29, and women who finished the fistula treatment and enrolled to rehabilitation program.

3.6. Methods of Data Collection

This qualitative research study relied on primary and secondary source of data. All the data collection tools that were prepared in English were translated to Amharic. The primary data covered an in-depth interview to capture challenges or stories of obstetric fistula survivors. Secondary data covered research reports, articles, journals and other relevant literature carefully reviewed for triangulation purpose. This means that, the primary data was collected from obstetric fistula survivors in Hamlin Fistula Hospital. Before data collection a pilot test was made with two women who fulfilled the inclusion criteria. This helped to make the guiding questions more compatible with the objective and the setting of the study.

3.6.1. In-depth Interview

In this study interview conducted face to face. In-depth interview guides were developed considering the research questions and literatures reviewed on fistula. The interview guides address the social sexual experiences before developing fistula; life, challenges and cope up mechanism after developing fistula; perspectives about the future life and what they do to shape it and about what the survivors think about fistula treatment and rehabilitation services in Hamlin Hospital, Addis Ababa.

This data collection method helped to explore the experience, perception, belief of the fistula survivors. I developed an open-ended interview guide with their follow up probing questions. Research method books indicated that open ended interviews the researcher prepared a topic guide or a certain amount of questions to be covered with each participant It is believed that the interview guide allows the researcher to maintain a certain level of control over the process while enabling the researcher to gather the most relevant data in relation to the phenomenon of interest

(Burns & Grove, 2007; Polit & Beck, 2008). Unlike closed ended questions, I chose an in-depth open-ended question because it allows participants to tell their experiences wholly including expressing their emotions feelings. Open ended questions allow participants to respond in their own words. Efforts have been made to include probing questions from the main stem items. These interview guiding items were developed in line with concepts assessed in literature section and research questions. These questions were attempted to assess the perception, barrier and utilization of antenatal care and institutional delivery service by young homeless mothers in Addis Ababa.

After developing the interview guides, I asked my research peers and my advisor to review them. Since this study is a qualitative study with the aim of using eight participants only two participants who met the selection criteria were used in the piloting the data collection tools. I then piloted the interview guides on the two fistula survivors who satisfied the selection and made clear some of the questions accordingly. A colleague, with experience in qualitative research methods reviewed all coding of data to confirm the categories and themes that were emerged from the data. In this study for the interview guiding items trustworthiness were assured by avoiding double barreled, long and complex questions. In addition, efforts were exerted to avoid leading and emotional questions. I consulted professional translators to translate the interview guiding items in to Amharic.

The interview was tape recorded to ensure the correct use of the tape recorder and to listen to the researcher's questions with probing and verbal reactions. These early interviews were transcribed and reviewed. In addition, some probing questions were added. During the exercise attention was given to body language and non-verbal responses as well as the manner of asking questions. This enhanced my level of confidence and identified some clarity issues with the questions. After the piloting some modifications were made and probing questions added to the interview guides.

3.6.2. Secondary Data Sources

To consolidate the primary collected data, documents like articles, scholarly books, and fistula service utilization of patients and survivors were reviewed. These were reviewed to show the views of different authors on the study problem and to connect the research with related

literatures. Thus, secondary sources were used to interpret and analyze the primary date collected from the survivors.

3.7.. Data Analysis and Interpretation

The data was collected in Amharic. The qualitative data were carefully transcribed to English and organized. To do this the tape-recorded interviews were written down and transcribed in to English on a note book by the researcher. At this stage, I made sure that what the participants said was entirely transcribed. As Burns and Grove (2003) say data analysis is a mechanism for reducing and organizing data to produce findings that require interpretation by the researcher (P. 479). Data analysis consists of preparing and organizing the data for analysis, reducing the data into themes through a process of coding and condensing the codes, and finally representing the data in figures, tables, or a discussion (Creswell, 2007, P. 164). Accordingly, the steps in the data analysis process of this study are the following.

The first step in data analysis is pre-coding the raw data. Here, I read and re-read the transcripts closely until understanding of the main points were achieved. According to Boyatzis (1998) pre-coding is done by circling, highlighting, bolding, underlining, or coloring rich or significant participant quotes or passages that strike the researcher. Accordingly, I underlined significant participant quotes that impressed me. Pen with different colors were used to underline these statements.

The second step was uploading the entire transcript to OpenCode qualitative data analysis software. Open Code was originally developed to follow the first steps of the Grounded Theory methodology but this version can as well be used for Qualitative Content Analysis. The program is compatible with PC-systems and runs on Windows version XP or later. By default, the program is installed in its own program sub-directory under the name OpenCode. The software automatically creates a new folder, labelled My OpenCode Projects, for storing data under My Documents. The program language is English but the data/text and coding can be in any language (Klas, 2015). I coded the entire transcript (i.e., that had 557 lines) line-by-line in OpenCode. 215 primary codes emerged from in the coding process and then codes that have close been merged. Then, the final codes were categorized into a set of categories that adequately encompass and summarize the data. A set of categories were organized in to four major themes or pattern that can describe and explain the subject area as related to each research question.

Finally, once the categories are developed and related with the sub-categories on the basis of similar characteristics analysis and interpretation of the data were carried out.

After the pre-coding, coding, categorizing and theme development processes, I exhaustively examined those themes that could be merged into a single super-ordinate theme. Moreover, after refining themes, interpretation followed to look for meanings. Interpretation deals with less obvious and more abstract dimensions of the data, the act of "reading into" and "extracting meaning from" (Padgett, 2008, p. 171). After all the processes the final report was prepared. I employed fictional names instead of code numbers while presenting participant's story to maintain their anonymity.

3.8. Trustworthiness of the Data

Different techniques were used to increase the trustworthiness of this study. To maintain the credibility of participant information, participants of the study were carefully selected based on the set criteria. To get accurate and detail information without any fear, participants were interviewed in private place that designated by the hospital where no one sees or hears them during the interview. Padgett (2008) explains that, researcher biases emerge when observations and interpretations are clouded by preconceptions and personal opinions of the researcher (p.184).

In every research, fairness, truthfulness, honesty, the researcher made sure that the personal information they provide will not be revealed to third person and there was liability in protecting the identity of participants by giving false name for participant's pseudonyms. A researcher bias was handled through "bracketing out". Stated that to fully describe how participants view and feel the phenomenon, and counter early categorization researchers must bracket out their own preconception and experiences.

To minimize biases, I tried everything avoid my experience with the phenomena under study. Equal opportunities were also given for data with different views. The participants might not also tell the real information about their experiences sexuality and fistula experiences as it might be sensitive and private issue. This would be a challenge to the truthfulness of the findings. To maximize the trustworthiness of the study and to avoid respondent biases I develop a good rapport with the participants and explain the purpose of the study genuinely.

3.9. Ethical Considerations

Obstetric fistula is a very sensitive issue for the participants. Research ethical standards were maintained throughout the research process. All the necessary paperwork was completed and permission was obtained from the hospital administration. After building a rapport with the participants, the purpose the study and confidentiality issues was discussed. Further, they made awareness to the importance of their responses in order to ensure reliability. They will also be made fully aware that they have the right to withdraw at any time they want without any explanation. Money was not given to participants to compensate their time. However, a bottled water and snack was provided as a refresher during the interview.

A consent form was presented to the participants and allows time read it through or the researcher read for them and signed. This is to ensure the participation in this study is completely on voluntary basis. Privacy of information was properly addressed as the real names of the participants were not appeared in the research report. The interview sessions were tape recorded based on the consent of each participant.

CHAPTER FOUR

4. DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1.INTRODUCTION

This chapter presents the findings obtained from the in-depth interviews with fistula survivors who were at Hamlin Hospital. This chapter looks at four thematic areas: how obstetric fistula survivors see their life before, during and after obstetric fistula repair; challenges and cope up mechanisms; survivors' perspectives of their future and what they did to shape it; and what they think about the treatment and rehabilitation services they received. Throughout this chapter, the names given to participants are pseudonyms.

4.1.1. Demographic Background of the respondent

Table 1. participant information sheet

Note: The participants name in this table are pseudonyms

No	Participant	Age	Age when Developed Fistula	Marital Status	Religion	Place of Origin	Education level or grade	Have a child and Number of Children
1	Etewush K	20	19	Divorced	Ortodox	Gojjam	Illiterate	-
2	Sichale C	20	15	Married	Ortodox	Wollega	Illiterate	Yes, 1
3	Geneme M	19	15	Divorced	Muslim	Arsi	Grade 2	-
4	Ayal Y	27	18	Divorced	Ortodox	Gojjam	Illiterate	-
5	Degnesh P	28	25	Married	Protestant	Gurage	Illiterate	Yes, 2

4.2.Social and Sexuality Experiences before Marriage

4.2.1. Social and Sexuality Experiences

The participants reported various ideas and experiences related to social relationship, intimate relationships, sexual matters and health issues. When asked about intimate relationship and sexual interaction, most of the participants denied having any intimate relationship or sexual interaction before marriage. They also stated that their parents or caretakers forced into marriage without their consent at early age. For example, Etewush described her experience as:

> I grew up in a rural area. My mother died when I was a child, and my grandmother raised me. I grew up in very difficult. My grandmother did not have any idea about education. I was married when I was a child. I had girlfriends, but I have never had a boyfriend. I had no idea [about intimate relationship or sexual matters]. I knew nothing about social and sexual issues. I had never felt sexually feeling Because, I was small. My grandmother forced me to marry when I was 14 years old. I got married without my consent. I would not consult anyone. Hey! I never knew anything like this. I have only girlfriends [best female friends], no boyfriends. No I didn't experience any sexual feelings at all.

Sichale also mentioned the challenges related to losing parents, information and cultural expectations that impacted her sexuality and preferences as follows:

> I grew up like any other country girls' by tending cattle, by cleaning dung and fetching water from distant river. My parents died when I was a child, and I grew up with my aunt. My aunt believes that a girl should not go to school. She didn't send me to school; she only wanted me to work for her. She never allowed me to have friends. I didn't have any boy or girl friends. She was so controlling. She forced me to marry when I was 10 years old and so I married. I didn't have any clue about any relationships, and I did everything according to our culture. I had no one to consult but my aunt. She explained

some things to me. She advised me not to come back home after marriage and whatever happened I should resist.

Only one participant, Degenesh, mentioned that she got married when she was matured at the age of 20 and this marriage was arranged by her family. She said:

> I was born and raised in the countryside. My parents are farmers. I was a good child when I was a child and help my parents in my capacity I keep cattle, sheep and goats. When I was a child, my parents raised me in a good manner. I didn't go to school because; the school was so far away from our village. In our area, if a girl starts to grow breast, she will marry someone by family choice. As I grew up according to our culture, I married the man by my family choice. But I was not married like any other girls in our village in early age, I got married at age 20. I had so many girlfriends.

All the participants started sex with their husbands on their wedding day after they got married. They never had any intimate or sexual relationship before marriage. Most of the participants expressed that they did not like their first husband they got married to at their young age and divorce happened. They also stated that there was a significant age difference with their husbands. For example, Sichale expressed: “I had sex on the day I got married. I was terrified.” Etewush also had the following to say:

> I have been married twice. I married my first husband when I was 14 years old. We divorced because we disagree, and I didn't like him. One year later I got married to my current husband, who is now with me. My husband was about 25 when we got married.

However, two of the participants mentioned that thought the marriage was arranged by their family, they liked their husband. For instance, Ayal expressed:

> We lived together for three years and I came to love him and I was happy. Yes. I married by my father's chose. After we got married, we loved and respected each other and living happily farming on our family gifted land. I got pregnant three years later when my womb refused. I prayed a lot to have a baby but the baby I was pregnant is dead. I got married when I was 13 years old. We don't have much age gap. When we get married, he will be 19 years old. Like many of my friends, I did not marry someone who was much older than I was. We were happy before this problem happened. We lived together in dignity and respect.

Geneme also stated:

> I started having sex with my husband when I was 15 years old. I was happy. I loved my husband. He looked handsome ... It was my parents chose. But after I married him, I loved him, and he loved me. I got married when I was 15 years old. When I got married, I was happy. I had a good life.

4.2.2. Age at First Marriage

Most of the participants reported that they were forced into marriage at their young age before turning 15 years of age. The marriages were arranged by the parents or their care takers without the consent of the victims. Most of the participants were not happy about their first marriage or divorced after getting fistula. For example, Etewesh described:

> I had no idea. I knew nothing about social and sexual issues. I have never felt sexually feeling Because, I was small. My grandmother forced me to marry when I was 14 years old. I got married without my consent. I would not consult anyone … I didn't feel anything because I was so young. I was not happy because my grandmother forced me to marry without my consent. I got married at the age of 14. But we got divorced.

Sichale expressed:

> She [aunt] forced me to marry when I was 10 years old and so I got married. I didn't have any clue about any relationships and I did everything according to our culture. I had no one to consult but my aunt. She explained some things to me. She advised me not to

> come back home after marriage and whatever happened I should resist … He lived with his family and I lived with my aunt. My aunt and his family had a fight and we divorced. Then, when I was 15, she forced me to marry my second husband. I had sex on our wedding day and I got pregnant.

Ayal also said:

> After my mother died, everything was messed up. My step mother would not let me go to school, but to work. Then my father made me marry when I was 13 years old. Yes, I had girlfriends. I became pregnant three years after I got married.

Only one participant, Degenesh, got married at the age of 20 but the marriage was arranged by her family and she was happy about her marriage. Degenesh stated:

> As I grew up according to our culture, I married the man by my family choice. But I was not married like any other girls in our village at early age, I got married at age 20. I had so many girlfriends … I started having sex when I was 20 years old. I was very happy. Thank God we are still in love together.

4.2.3. Education

The data presents that the survivors either did not go to school or dropped out of school after they got married. The reasons provided were cultural expectations, parents or caregivers' expectations, school distance or socioeconomic reasons. Geneme said:

> I was born and grown up in Arsi, Oromia region. My childhood dream was to become a wealthy businesswoman. My families are farmers. When I was child, I help my mother at home and my father at the farm. In our area, females are less educated than men. When a girl engaged, it is expected to stop education. So I dropped out of school at grade two when my parents made me married. After I got married, everything changed. I moved away from my village and went to my husband's place. At my husband's neighborhood I meet a new neighbors and friends.

Sichale also said:

> My parents died when I was a child, and I grew up with my aunt. My aunt believes that a girl should not go to school. She didn't send me to school; she only wanted me to work for her.

Ayal expressed, "My step mother would not let me go to school, but to work." For Degenesh the school distance and getting married was the reason for not going to school. She said,

> I didn't go to school because; the school was so far away from our village. In our area, if a girl starts to grow breast, she will marry someone by family choice. As I grew up according to our culture, I married the man by my family choice.

For Etewush, education was not a priority after passing through her fistula experiences. She said:

> I don't think I will go to school after this age. But like my friends I have a strong desire to work in the city and live in the city. So now that I am well, I think I will fulfill my desire in the future. My goal is to have children and move from the countryside to the city and live a better life.

4.2.4. Sources of Information.

The survivors reported relying on a limited source of information to understand social life, reproductive health, sexuality and relationship. Most of the participants were not consulted before getting married. For almost all of the participants their parents were not the source of information. Their source of information was what was traditionally said in their community. Few participants stated that their care takers like aunts were the source of information. Relatives were important information sources. However, the most frequent sources of information were said to have been peers and older friends, rather than parents or other family members. Parents

did not play an important role by giving victims some direction on issues of social life, sexuality and relationship. For instance, Etewush described:

> I had no idea. I knew nothing about social and sexual issues. I have never felt sexually feeling Because, I was small. My grandmother forced me to marry when I was 14 years old. I got married without my consent. I did not consult anyone.

Sichale reported:

> I didn't have any clue about any relationships and I did everything according to our culture. I had no one to consult but my aunt. She explained some things to me. She advised me not to come back home after marriage and whatever happened I should resist.

For Ayal and Degenesh their parents and friend were the main sources of information. Ayal said:

> We lived in a very close-knit community, but I had no idea about sex related things. I had a friend to talk to about many things and she has learned till eighth grade so I trust her with everything. She is a really good friend. My father also gives me a great advice; after all I am his only daughter.

Degenesh described:

> I live in harmony with everyone. I have a good relationship with my neighbors. We talk about health, social issues and anything else. They let me know what they know and let them know what I know. My neighbors are my most important source of information. My parents, my husband, my girlfriends, and my neighbors are all very nice to me.

4.3. Life, Challenges and Cope up Mechanism after Developing Fistula

4.3.1. Challenges

The findings of this study depicted that the participants faced many challenges because of their fistula situation. The challenges mentioned by most of the participants were both medical and psychosocial. The medical challenges were: unable to control their faces and urine, wound and pain around genital areas and smell, “twisted leg”, and lost their babies during birth. The psychosocial challenges that most of the participants experienced were: “scared and sad”, “told me to kill myself”, “stigmatized, hated, and cursed”, “fear of looking other peoples”, “divorce”, “gossip”, “isolation”, “isolated from social activities”, feeling of “can’t remarry” etc. One of the participants, however, mentioned that she did not face any challenges from the people around her but she was the one who isolated herself. For instance, Geneme stated the medical and psychosocial challenges as follows,

> When, I stayed with my family for two months, the neighbors gossiping that I smell bad. Generally, my whole mind was affected badly. Because of, the neighbors gossip I didn’t want to come out off house. That’s why my leg remains twisted. Everyone isolated me, and stayed isolated. When my health condition gets worse and when I couldn’t find anyone to take care of me, I returned to Yirgalem hospital. Because of, my twisted legs I couldn’t walk without support. So, I can’t remarry and I don’t have opportunity to have children.

She added,

> I had so many challenges. For example, like any other girl I can’t give birth to baby and this disease makes me to separate from my husband. I separated from the people around me. Because of this disease I don’t have interest to return to my village. When my family and my husband isolate me I returned to Yirgalem Hospital and they wrote me refer to Addis Ababa. So, I only got support from doctors.

Etewush expressed her challenges and the help she received from her husband,

> My urine and feces just go down uncontrollably. I also feel the loss of my child. I tried a lot to control by myself but when my urine and feces just go down uncontrollably and when it becomes beyond my control I went to the hospital, where the doctor told me that was Fistula and he told me that it will recover. While I was sick at home, my husband helped me washing my clothes, cooking foods, and caring for me.

Ayal stated her challenges,

> Extreme sadness, loss of my son, remaining bedridden and fear of looking other peoples. My neighbors isolated me, except my father and my friend. When my neighbors come to my house to visit me, they will cover their noses. When they cover their noses, I feel so bad. After this illness, I was hospitalized for nine years without doing anything.

Sichale had the following they say about the extreme challenges she faced,

> I faced so many challenges! My whole life was ruined. My husband challenged me, my aunt told me to kill myself and everyone around me was disgusted. I was stigmatized, hated, and cursed. I suffered for 2 years and at last I decided to go to Ambo hospital.

Degenesh had a different experience than most of the participants. She stated she did not face challenges from people around her,

> God Bless my neighbors, friends, relatives, my wife and children they didn't show me any bad face. I am the one who isolate myself and tormented, but they didn't isolate me. Before I got surgery and treatment I had suffered terribly. I was also wanted to commit suicide. I feel sad because like other mothers I was not able to take care of my children by being by the side of my husband.

Almost all of my participants didn't have any idea about fistula and lost their baby during when giving birth. They learned about fistula after giving birth at hospital. Most of the participants were taken to hospital after being in labor for days at home. Most of my participants get divorced

immediately after they develop fistula. Only few participants are still maintained their marriage and receiving support from their husband. For Example, Sichale told:

> I didn't have any idea about this disease, I just felt hopeless. But the doctors told me that there was treatment in Addis Ababa and told me I will be cured there. There was a lot of urine and faeces … They said that it was a curse … My husband immediately divorced me …I faced so many challenges! My whole life was ruined.

Etewush had the following to say:

> When I came home after the operation ["C-section"], I could not control my urine and feces. I just went back to hospital and the doctor told me that it is fistula. I told my husband that I will recover soon and they refer me to Addis Ababa. I feel well after the doctor told me that I would recover. But at first I felt sorry for myself, I was angry because I also lost my baby and I felt I will living in isolation forever. During all that time, my husband was very supportive … I was so scared of social interactions that I isolated myself for fear of getting involved in social activities. I was so ashamed by myself if someone said I could smell. Before I used to help with our farm, but now my husband works alone.

Ayal reported her experience on developing obstetric fistula as:

> They ruined me when they trying to get my dead son out of my womb. When I returned to the doctor, they told me it was a fistula. Adet hospital doctors wrote me refers to Bahir Dar Hospital. And then Bahir Dar Hospital doctors wrote me refers to Addis Ababa … After that, I decided not to associate with anyone. My husband become hating me and slowly ran away. I think he thought I would not be healed and be the same again … loss of my baby, remaining bedridden, and fear of looking other peoples.

Geneme also experience:

> When I went to give birth and had an operation on my uterus, they touched my bladder and I started to urinate … and my legs started to twist … Because of, my twisted legs I

couldn’t walk without support. So, I can’t remarry and I don’t have opportunity to have children.

4.3.2. Cope-up Mechanism

Most of the participants had some form of coping mechanisms after developing fistula. Participants mentioned that staying home and isolating self, help from husbands and spirituality helped them to cope with their challenges. Ayal also said,

> Before I went to the hospital, I had no desire and hope to live. I tried to cope by myself by staying at home. But I didn’t get any relief so, decided to go to the hospital. Maybe the decision I made to go to hospital makes me better for my life of this days.

Degenesh and Etewesh used their husband, family and spirituality as a coping mechanism to deal with their situation. For example, Degenesh expressed,

> I didn’t cope-up challenges only by myself but, with the help of my husband, children, relatives, friends, and neighbours. I wished to die because; I didn’t think it was possible to be saved. But they encouraged me and now I am recovering.

Etewesh told,

> I was established with the help of St. Mary and my husband. But I was very scared and sad. At the same time, I tried to cope on my own, but when it got worse and I realized I could not control by myself and go to hospital. They wrote to me referral to Addis Ababa when I went to the hospital. If I hadn't gone to the doctor, I would have had a lot of trouble and everyone in my area would hear and will reject me.

Some of the participants, however, did not have any cope mechanism after developing fistula. For example, Sichale said, “I did not know any coping method. My aunt was angry with me so I did get out of the house.”

4.4. Perspectives about the Future Life and what they do to shape it

When asked the participants about their perspective of their future and what we were doing to shape it, most of the participants optimistic about their future after their fistula repair. Most of the participants felt that they will cope-up with any challenges when reintegrated with their family or community. Most of the participants mentioned challenges of fistula and the treatment process made them strong and will get back to happiness and normal life again like starting business and farming. However, few participants stated that they return to their family or community after completing their rehabilitation time. For Example, Etewush expressed:

> Oh my God!! I was so happy I slept with no sewage. Before I come here and got treatment, I had difficulty getting out and reconnecting with others. But now I am very happy. I have become like any other healthy person. I told my husband and uncle about my salvation. Thank God I will be reunited with my family tomorrow. I bought a ticket with my uncle and spent the night in my uncle's home and the next day I will enter to my village in the afternoon … I feel that I have nothing to fear. I think I am very healthy and the people around me will be very happy."

Etewush further said:

My husband is happy that I have regained my health because we have been in a state of extreme anxiety for the past year. I think the community will welcome me. My husband and I have a very good relationship. We are still very happy. Nothing has changed.

Sichale described:

The doctors told me that I would be out soon. So, I think there is nothing wrong with joining the community. I want to start a small chicken [poultry] business if I get starting money because I have had experience in the past. I have a plan to change and work on my overall health. The new thing in my life is being completely cured.

Ayal told:

I am very happy to be back at my father's house. Even in the past my neighbours who hated me and covers their noses when they came to visit me would be amazed by the

> work God. I hope they will be happy. I don't have financial problem; my father is ploughing my land. So, I have money. The only problem was my health. But now I am in good health and happy.
>
> Degnesh described:
>
> I will be very happy to return to my community. I don't think I will face any challenges. I think everyone around me will welcome me. Now I only feel joy in my heart and I can't wait to see children.

However, Geneme had a different view about reintegrating with her family or community will be challenging for her. She expressed: "I don't have any interest to visit my relatives. What am I going to do with a family that hasn't asked me for 20 years? I still can't walk much, so I think I'll be worse if I come back."

When asked about their feeling about life before and after medical treatment and for who do they share their situation after the repair/fistula treatment all of the participants are very happy by the fistula treatment which changed their life with hope and happiness. Most of them feel that they got second chance in life and got rebirth. For instance, Degnesh expressed:

> Oh!! I was always thinking about what will happen if this fistula hospital is not existed. Because, before I didn't know about the existence of hospital for fistula and I didn't think I will be cured, that's why I was wishing to committed suicide. The treatment saved me for my children and my family. My salvation is so amazing!! I never thought my abdominal swelling will go and I will be saved. I told my salvation for everyone. But Firstly I told to my husband and he told to our relatives. Everyone rejoices in my salvation.

The participants expressed their feelings when asked about their future. They stated that it is possible for them to own a house in the city, start business and begin a new life with their intimates. Most of them were hoping for bright future and happy life since fistula and its challenges taught them a good lesson about life and what matters most. For example, Etewush described:

I don’t think I will go to school after this age. But like my friends I have a strong desire to work in the city and live in the city. So now that I am well, I think I will fulfil my desire in the future. My goal is to have children and move from the countryside to the city and live a better life. After this treatment, I feel that I should be very close to the hospital to take care of my health and during pregnancy. The treatment was excellent. It brought me back from a disgusting life to wonderful health.

Sichale also said:
In the past, I just wanted to have as many children as any other rural woman. But now I want to focus on myself, do my business in the city, marry and then have children.

Ayal expressed:

Before, I wish to have a baby and to live good life with my families. But now I am divorced from my husband. But now I got many life experiences of many great women. Now I have self-confidence. In the future I have a dream to get married and to have a baby. Even If I am not married, I feel I will continue living my life by doing my favourite work. I am very happy by the treatment they gave me.

Geneme expressed her wish: “If I got financial support here, I would like to sew embroidery and lace for the hospital.”

Degnesh:

I had so many plans. Now after the treatment I feel better but, I should have enough rest well and I will go to business and trade. I want to send my children to a better school. I am eager to return home because I want to achieve those goals.

4.5. Prospects on Fistula Treatment and Rehabilitation Services

Concerning Hamlin Fistula Hospital, most of the participants stated that they learned about this hospital after they were referred from reginal hospital for better care and intervention due to their fistula situation. For Example, Etewush expressed: “I knew nothing about the hospital. The

doctor referred me from the hospital where I was treated at first. But I didn't think it was possible to be healed." Ayal also described:

> I don't have any idea before the referral from Bahir Dar Hospital to here. I have access to accommodation, food and medical care. After a few months I got surgery. I was treated perfectly.

All of the participants mentioned that they are happy about the services they received. They stated that they received medical, psychosocial, self-care/sanitation trainings, food and bed services. Participants also mentioned that they received various skill trainings like embroiling that they will use it when discharged from the program. All of the participants said that they are very thankful and feel very happy the services they received from the hospital. They also expressed that the staff was very professional and supportive. Sichale had the following to say:

> I am very happy and thankful. This hospital has helped me a lot. Without this hospital, my life would have been so chaotic and meaningless. God bless the owner of this hospital. She has changed the lives of many women. I did not receive any training … Before I came to this hospital, I was in a lot of trouble, crying day and night and hoping I would die. I was sad; I lost my child and my husband at the same time. I was isolated from my relatives and neighbors. But now, thank God I have forgotten all my sorrows. I have a new beginning and I feel like I can live anywhere without being ashamed. I think the community will welcome me with joy and praise God because it was a miracle that I was cured.

Geneme also expressed:

> Alhamdulillah! Now I sleep in a clean bed, eat good food, sleep in a clean environment, they will wash my body and made my hair. Before I was bedridden but now I am able to move because of the treatment. I don't have relatives to ask or visit me. The doctors are happy with my daily change.

4.5.1. Rehabilitation Services

The findings of this study depicted that most of the participants has been receiving rehabilitation services after receiving the fistula repair. When asked about the rehabilitation program, what training provided to them and what knowledge/ skill they got all the participants feel very happy about the rehabilitation program. Most of the participants received, psychosocial treatment and skill trainings such as: writing and reading skill, self-care and sanitation skill, embroidery skill, shoe lace making skill etc. Participants stated that this rehabilitation services have equipped them to be productive and successfully return to their family or community. All participants are very much satisfied by the service provided in this rehabilitation services. For instance, Etewush described:

> As I told you before, they took good care of me. There are so many women like me in this recovery programme. I would like to thank all the doctors. I was no longer afraid to join the community. What I learned here was about personal hygiene. I did not learn any other subject. Their treatment is perfect and excellent. It's a place where my life is adjusted. I am happy. God bless the foreigner woman who built this hospital.

Ayal expressed:

> Starting from the day I came to this hospital they took care of me very good and I got lots of friends like me. I don’t have word to express I am very happy. If I am saved, who will stop me from joining the community? I hope they will welcome me happily. This hospital did everything to save me. So, there is nothing to stop me from returning to my country. I learned to embroider. I am also learning to read and write. I'm used to writing and reading a phone number.

Geneme also described:

> This hospital is a place of my rebirth and the place I lived for 20 years since I was a child. Still, I didn’t try to join my community. But here they give us some education. The doctors are happy to see our recover and they need to release us to join our community, but I still can't walk without my support aid. When I sat down, I do embroidery and lace that I learned here.

Degnesh said:

I am very happy in this rehabilitation service. I got good friends here and this is a place where I feel like I’m actually better when I compare myself to others. It helps me a lot and I am very well. I got trained in embroidery and was able to embroider. I am also learning to read and write.

CHAPTER FIVE

5. SUMMERY OF FINDINGS AND CONCLUSION

5.1. Introduction

This chapter discusses the qualitative data obtained from fistula survivors who were attending post-fistula repair rehabilitation program at Hamlin Hospital, Addis Ababa. This chapter discusses four thematic areas: social and sexual experiences before marriage; challenges and cope up mechanisms; survivors' perspectives of their future; and what they think about the treatment and rehabilitation services they received. Social work implication of the study and conclusion are also presented.

5.2. Social and Sexual Experiences before Marriage

The participants' data reveal that most of the participants denied having any intimate relationship or sexual interaction before marriage. Participants never had any intimate or sexual relationship before marriage. It was found out that participants debut sex with their first husbands on their wedding day after they got married. It was also found out that the participants' parents or caretakers forced them into marriage without their consent at early age before turning 15 years of age. According the participants, most of them they did not like their first husband they got married to at their young age. Thus, age, girls' consent and social and sexual experiences emerged in the data as a contributing factor.

Findings in studies conducted in Ethiopia are consistent with the above findings. For instance, Andargie and Debu (2017) conducted a study on the determinants of obstetric fistula in Ethiopia based on the Ethiopian Demographic and Health Survey data (EDHS, 2005), from 14,070 women who were interviewed face to face on their reproductive health issues, found out that Ethiopian "social culture encourages marriage at a young age, often shortly after the girls' first menstrual period between the ages of 9 to 15." (p. 671). A study conducted in Gondar public health hospital, Ethiopia, showed that 50% of women were aged between 15-20 years and their marriage had been arranged by their parents at age as young as 5 years with mean marriage of 11.5 years (Muleta, 2007). Andargie and Debu (2017) also found out that a significant percent of women's (i.e., 32.1%) first marriage were when they were below 15 years age and the first

pregnancy happens right after marriage and before the pelvis of a woman is not fully developed which could result in obstructed labor and develop fistula as a result.

The participants' data showed that the survivors either did not go to school or dropped out of primary school after they got married which was presented as one of the factors for their lack of awareness related social, sexual, rights and fistula complication. Some of the reasons for no or little education the data presented are: cultural expectations, parents or caregivers' expectations, school distance or socioeconomic reasons. Most of the participants were not aware of the obstetric fistula before it actually happened to them. The result of this study showed that educational status is one of the determinant factors for obstetric fistula. Studies showed that women who had primary education, secondary and higher education were less likely to suffer obstetric fistula than illiterate women. Andargie and Debu (2017) found out that distinctively fistula patients in Ethiopia were young girls from rural areas and married at young age with little or no education. Education is related to the awareness of obstetric fistula and related factors that affects women's quality of life. For instance, found out that women who cannot read and write are 85% less likely to have good awareness of fistula and reproductive and sexual health issues than women who are above the secondary level of education. The educational level of women, and awareness of obstetrics complications were the factors associated with awareness of reproductive age women on obstetrics fistula. (Rundasa, Ayana & Worke 2021).

The participants' data illustrated that the fistula survivors relied on limited sources of information to understand social life, reproductive health, sexuality and relationship. Participants were not consulted about their preference before getting married and their decision-making was very limited. The data also showed that participants' using of their parents as a source of information about social life, sexuality and relationship was very minimal. Close relatives, peers and older friends were mentioned as an important source of information sources. Parents who play an important role by giving direction about social life, reproductive health, sexuality and relationship would help to avert or cope up with life and health challenges like fistula and increase quality of life (Matios, et al., 2021).

5.3. Life, Challenges and Cope up Mechanism after Developing Fistula

5.3.1. Challenges and Coping Mechanisms

The participant's data depicted the challenges they faced because of their fistula situation. The challenges mentioned were medical, psychosocial and economic. The medical challenges were: unable to control their faces and urine, wound and pain around genital areas and smell, "twisted leg", and lost their babies during birth. The psychosocial challenges that most of the participants experienced were: "scared and sad", "told me to kill myself", "stigmatized, hated, and cursed", "fear of looking other peoples", "divorce", "gossip", "isolation", "isolated from social activities", feeling of "can't remarry" etc. One of the participants, however, mentioned that she did not face any challenges from the people around her but she was the one who isolated herself. A qualitative study conducted on "The loss of dignity: social experience and coping of women with obstetric fistula, in Northwest Ethiopia" found similar findings, "The women faced challenges in role performance, marital and social relationships and economic capability… self-isolation and hiding from being observed, wearing extra clothes as cover, increasing water intake and reducing hot drinks and fluids other than water were the ways they have devised to cope with the incontinence." Bashah, Worku, Yitayal & Azale, 2019, p.6)

The study conducted by Yenenesh (2014) also indicated that participants experienced the anger, sadness, and shame associated with loss of a child, as well as the loss of ability to work and acceptance and support by their husbands, family members, relatives, classmates, community members, and other passengers when using public transport. Participants also reported experiencing bad moods, feeling morally weak, waiting for the end, and asking "Why only me?" Participants' responses regarding the anger and sadness they experienced shows that they continuously felt emotional disturbance (Yenenesh, 2014).

Concerning cope up mechanisms, the date revealed that the participants used various cope up mechanisms after developing fistula. Participants mentioned that staying home and isolating self, help from husbands and spirituality helped them to cope with their challenges. This finding is also consistent with some of the studies conducted in Ethiopia. These studies showed that participants coping mechanisms made efforts to regulate their emotion through suicidal thoughts, avoiding family and community members, suffering in isolation, hiding their story or status,

accepting the changes associated with obstetric fistula, and positive subjective interpretation. Also, they tried to manage the disease through seeking family support, selling their properties, and orienting to reality (Matiwos et al., 2021; Yenenesh, 2014). For survivors with the about challenges, Matios et al. (2021) recommended that treating depression and anxiety, and devising a way to increase social support and community awareness are necessary to increase women's quality of life.

5.4. Perspectives about the Future Life

The participants report that were optimistic about their future after their fistula repair and receiving rehabilitation services. They felt that they will cope-up with any challenges when reintegrated with their family or community. It was found out that the participant's challenge of fistula and the treatment process made them strong and will get back to happiness and normal life again like starting business and farming. However, the date also revealed that they return to their family or community after completing their rehabilitation time. Similarly, Yenenesh (2014) indicated that struggling to keep going is also related to integrating the changes caused by obstetric fistula by developing participants' perspectives on life. In this way, participants developed a vision of hard work, the desire to change their status, and sympathetic feelings toward others. They also became less dependent and more self-centered. Participants saw obstetric fistula as a reason to lose their personal identities (Gebresilase, 2014; Yenenesh, 2014).

5.5. Prospects on Fistula Treatment and Rehabilitation Services

Concerning Hamlin Fistula Hospital, most of the participants stated that they learned about this hospital after they were referred from regional hospital for better care and intervention due to their fistula situation.

The data showed that participants were happy about the services they received and has positive outlook about it. They stated that they received medical, psychosocial, self-care/sanitation trainings, food and bed services. Participants also mentioned that they received various skill trainings like embroiling that they will use it when discharged from the program. Participants report that they are very thankful and feel very happy the services they received from the hospital. The participant data showed that the care providers were very compassionate, professional and supportive. This study depicted that most of the participants has been receiving

rehabilitation services after receiving the fistula repair. When asked about the rehabilitation program, what training provided to them and what knowledge/ skill they got all the participants feel very happy about the rehabilitation program. Participants report that they received psychosocial treatment and skill trainings such as: writing and reading skill, self-care and sanitation skill, embroidery skill, shoe lace making skill etc. Participants report that they were very much satisfied with the rehabilitation services. It was mentioned those participants were equipped them to be productive and successfully return to their family or community.

Studies in Ethiopia showed that advised that most of the fistula repair survivors and health care provider were happy with the health services they received and with their management, support, and understand their challenges. The patients were happy with the services as it actually positively impacted their quality of life. The services ignited hope and maximized social support. Thus, "comprehensive and compassionate fistula care", creativity and cultural sensitivity needs to be capitalized to address the unique challenges of fistula patients and brings the positive outcomes (Jacbson, Marye, Phoutride & Nardos, 2020; Gebresilase, 2014; Yenenesh, 2014**).**

5.6. Social Work Implications

Social work is a profession that intervenes where people interact with their environment to promote and prevent health; and protect social wellbeing by availing opportunities, resources, services, and advocating and creating policies protect human rights and the quality of life (CSWE, 2018). Thus, based on the finding, the health care social worker would help in women's social, sexual, reproductive health promotion and prevention of unneeded health outcomes like fistula. Curative and preventive aims, to seek out, identify, and strengthen the maximum potential in individual, groups and communities that can be a source of strength to the victims. Social worker services is key on providing therapy, psych education, building the survivors' strength and help them work through a positive and productive coping strategy. Social workers can play a key role to assist in identifying and connecting survivors to community resources and strengthening their coping mechanism.

Education, advocacy and improving the lives of the needy or victims is at the center of the social work practice. Thus, social workers should advocate for social protection and educate girls and public about fistula using social and religious institutions as a platform as strategy to promote

social protection fistula survivor. This would help in enhancing the coping mechanism of the victim, their family and strengthen source of resilience of individuals.

Given the sense “silence” about early marriage and sense “shame” shame about fistula, and associated problems in Ethiopia, social work researchers, policy makers and educators need to set the agenda about early marriage, girl’s education, girl’s empowerment and the implication of culture and socio-economic status in predisposing the girls to fistula at their early age. For instance, it will be imperative social work research to explore the patterns and impacts of the socio-cultural and ethnic background, economic conditions, geographic areas, and religious and spirituality. The social work education curriculum also needs to incorporate knowledge and skills that prepares social work students creatively, by being context specific and culturally sensitive, address the unique challenges of fistula patients and promote positive and productive coping mechanisms.

This study entails implication for policy. Social, health and social policies should focus on gender mainstreaming to ensure that a gender perspective and women participation is integrated in all service provision social, health and development programs. Policy makers needs to considerate a system that create opportunities for women to participate in the economic and agricultural development, have decent employment and income since most of fistula survivors are economically dependent on their husbands or partners. Thus, social worker needs to identify and advocate for policy development and policy amendment.

5.7. Conclusion

This study identifies that obstetric fistula is a complex problem that has medical, psychological, social and economic impacts. Since it is multi-factored problem, girls in rural areas needs to be empowered and educated about their social, sexuality, reproductive health and their rights. Awareness creation at individual, family, and community level; and enactment of social responsorial about women health and life about fistula helps to curb most of the determining that makes it difficult to identify and treat obstetric fistula. Doing so helps to protect and improve the health and productivity of the women and the economic productivity of society.

Fistula survivors who received both fistula repair and rehabilitation services are happy about the services, optimistic about their future and positively impacted their quality of life. Pairing medical or fistula repair medical services with rehabilitation programs that comprehensively address various needs of the survivors ignites hope and maximized social support. Compassion, creativity and cultural sensitivity helps to address the unique challenges of fistula patients and brings the positive outcomes.

This study provides a deeper understanding of what it means to be a survivor of obstetric fistula. It also reveals how obstetric fistula survivors see their life before, during and after obstetric fistula repair; challenges and cope up mechanisms; survivors' perspectives of their future and what they did to shape it; and what they think about the treatment and rehabilitation services they received.

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Annex 1: Data Collection Tools

In-depth Interview Guide

For Obstetric Fistula Survivors

This in-depth interview guide is prepared to understand the experiences of women with repaired obstetric fistula survivors and how they picture their future. This interview will be conducted with informants who are in rehabilitation program at Hamlin Fistula Hospital. Please see the consent form.

1. Tell me your stories related to your childhood, interests, friendship, family and education. How did things change as you grow-up?
2. How did you learn about social relationships, intimate relationships, sexual matters, health issues etc.? Whom or what do you rely on for information? Whom or what are the most important sources to you? How important to you is each source in informing you about social relationships and sex? Why*?*
3. How would you describe your first intimate relationship (such as being looked at or approached by someone in a sexual way)?
4. Have you ever married? Tell me how you get married—can you tell me a story about your experience of marriage/s and sexual life/s?
5. Let me ask you about your experience of child birth. How do you describe it?
6. Tell me about your experiences related to advocating for and protect yourself as woman before and after developing fistula?
7. *Please tell about* how you learned that you developed obstetric fistula?
8. What did happen in your life after developing obstetric fistula? What meaning does it have in your life?
9. What were the challenges that you faced after developing fistula? Who did you reached out to get support? Why?
10. How did you cope up with challenges you faced because of fistula? What coping skills did you use?

11. Tell me about how learned about Hamlin Fistula Hospital. What services have you received so far? How do you feel about the services provided to you during your stay in the medical facility?
12. What changes did the fistula treatment bring in your life?
13. Tell me about the rehabilitation program. Please describe to me how this program equipped so that you will successfully reintegrate in your community.
14. How do you feel about the being reintegrated into community after fistula repair? What challenges are you facing? How did you cope up with these challenges? What is now new in your life?
15. Now you have received obstetric fistula treatment and you are receiving rehabilitation services. Look back your situation before and after you receiving fistula repair treatment. What does your relationship look like with your husband/partner, children, extended families, friends, community members?
16. Tell me the things that you are looking forward to doing in the future, that was not possible in the past?

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Table 1: Participant Information Sheet

No	Participant	Age	Age when Developed Fistula	Marital Status	Religion	Place of Origin	Education level or grade	Have a child	Whom they used to live with
1									
2									
3									
4									
5									
6									
7									
8									

በጥልቀት የሚካሄድ የቃለ ማኪይቅ መሚያ

<u>በወሊድ ጊዜ ከሚከሰት ፌስቱላ በሕይወት የተረፉ</u>

ይህ በጥልቀት የሚካሄድ የቃለ ማኪይቅ መሚያ የተዘጋጀውበወሊድ ጊዜ ከሚከሰት ፌስቱላ በሕይወት የተረፉ ሴቶች ተሞክሮዎችን እና የወደፊት ሕይወታቸውን እንዴት እንደሚሻለከቱ ለሚዳትነው ፡ ይህ ቃለ ምልልስ በሀምሊን ፌስቱላ ሆስፒታል በተሃድሶ ፕሮግራምውስጥ ካሉ ሚጃ ሰጭዎች ጋር ይካሄዳል ፡ ፡

1. እስኪ ስለ ልጅነትሽ ፣ ስለ ፍላጎቶችሽ ፣ ስለቤተሰብዎችሽ እና ስለ ትምህርት ህይወትሽ አንዳንድ ነገር ንገረኝ ፡ ፡ ጓደኞች ነበሩሽ? ስታድጊ ነገሮች እንዴት ተለውጡ? ከላይ ካሉት ከእነዚህ ጋር የሚዛመዱ ታሪኮችሽን ንገሪኝ ፡ ፡
2. ስለ ማህበራዊ ግንኙነቶች ፣ ስለጠበቀ ግንኙነቶች ፣ ስለ ወሲባዊ ጉዳዮች ፣ ስለ ጡፍ ጉዳዮች እና ወዘተ ምን ግንዛቤ አለሽ? ሚጃ ለማገኘት በማን ወይም በምን ትተማመኛሽ? ላንቺ በጣምአስፈላጊ እና ታማኝ የሚጃ ምንጮች እነማን ናቸው? ስለ ማህበራዊ ግንኙነቶች እና ስለ ወሲብላንቺ ለማሳወቅ እነዚህ ምንጮች ምን ያህል ጠቃሚናቸው? ለምን?

ምርመራ-የወላጆችሽ ፣ የቤተሰቦችሽ ፣ የጓደኞችሽ / የእኩዮችሽ፣ የሚዲያውእና የማህበረሰቡ አባላት ሚና ምንድነው

3. የመጀመሪያ ግንኙነትሽን እንዴት ታስታውሺዋለሽ? (ለምሳሌ በወሲባዊ በሆነ መንገድ አንድ ሰውሲጣላከትሽ ወይምሲቀርብሽ)?

ምርመራ፡ - በስንት ዓመትሽ ወሲባዊ ግንኙነ ት ጀመርሽ? ግንኙነ ታቹ ጊዜያዊ ፣ ቋሚ፣ ወዘተ ... ለምን ያህል ጊዜ ቆየ ? ከመጀመሪያ ግንኙነ ት በኋላ የቅርብግንኙነ ትሽ ምን ይመስልነበር?

4. አግብተሽ ታውቂያለሽ ወይ? እንዴት እንዳገባሽ ንገረኝ? ስለ ጋብቻ እና ስለ ወሲባዊ ሕይወትሽ አንዳንድ ታሪኮችን ልትነግሪኝ ትችያለሽ?

ምርመራ፡ - ለማገባት ወይምወሲባዊ ግንኙነ ት ለመጀጸምእንዴት ወሰንሽ ፈልገሽ (ወይስ ተገደሽ ነው)? በስንት አመትሽ አገባሽ ወይም ወሲባዊ ግንኙነ ት ፈፀምሽ? በኋላ ምን ሆነ ? መቼ እና

እንዴት? ባለቤትሽ / ፍቅረኛሽ ስንት ዓመቱ ነበር? በትዳር ሕይወትሽ ውስጥ ምን ጥሩ እና ሞኮፎ ጊዜያት ነበሩ? የ ጋብቻ ሕይወትሽ ወደኋላ ስትመለከቺውምን ይሰማሻል?

5. .በወሊድ ጊዜ የነበረሽን ተሞክሮ እንዴት ትገልጪዋለሽ?

ምርመራ፡ - ሞደበኛ የእርግዝና ምርመራ እና ክትትል እየተከታተልሽ ነበር? በባህላዊ ወይም በዘመናዊ ህክምና ለመውለድ ምን እና እንዴት ተዘጋጀሽ? የመጀመሪያ ልጅሽን በስንት ዓመትሽ ነው የወለድሽው? ምጥ ሲጀምርሽ ወደ የትኛውየ ጤና ተቋም ተወስደሽ? ከእርግዝና እና ከወሊድ ጋር በተያያዙ እንክብካቤዎች ወይም አገልግሎቶች ሂደት ውስጥ አብዛኛውን ውሳኔ የሚወስነው ማ ው?

6. .በወሊድ ጊዜ በሚከሰት ፊስቱላ ከማኪቃትሽ በፊትም ሆነ በኋላ እራስሽን እንደ ሴት ከመሟ ት እና ከማከበቅ ጋር የተያያዙ ልምዶችሽን አካፍይኝ?

ምርመራ፡ - በእርግዝናሽ ወቅት ስለ ጤና ፣ ትምህርት ፣ ሕጋዊ ወ.ዘ.ተ.የ ባለሞያ ምክር አገልግሎት ተቀብለሻል? የ ቅድመወሊድ እና ድህረ ወሊድ አገልግሎትስ አግኝተሻል? የ አከባቢ የህግ / ሴት ጉዳዮች አገልግሎቶች ፣ የ ባልሽ ፣ ቤተሰቦችሽ ፣ ጓደኞችሽ እና ዘመዶችሽ አስተዋፅዖ ምን ይመስላል?

7. .በወሊድ ጊዜ በሚከሰት ፊስቱላ ማኪቃትሽን በምን አወቅሽ?

ምርመራ፡ - እርስሽ ላይ ያየሻቸውአዲስ ልምዶች እና ለውጦች ነበሩ? እነዚያ ለውጦች ምን ነበሩ? በመጀመሪያ ለማን ነገርሽ? ለምን? አንድ ሰውእንኳ ስለዚህ ነገር ነግሮሻል? በዚያን ጊዜ ያንቺ ስሜት ምን ነበረ? ምን አደረግሽ? የ ባልሽ/ የ ጓደኛሽ ስሜት እንዴት ነበር? አንቺ ወይምየ ትዳር አጋርሽ/ጓደኛሽ ለምን እንደዚህ ተሰማቹ?

8 . በወሊድ ጊዜ በሚከሰት ፊስቱላ ከተጠቃሽ በህዋላ በህይወትሽ ላይ ምን አጋጠሞሽ? በሕይወትሽ ላይ ምን ተፅዕኖ ፈጠረ?

ምርመራ፡ - ከባለቤትሽ ፣ ከቤተሰብዎችሽ አባላት ወይምከጎረቤቶችሽ ጋር የግንኙነ ት ለውጥ ነበር? አዎ ከሆነ ሜልሱ እነዚህ ለውጦች ምን ነበሩ? ምን የተለየ ነገር አጋጠሞሽ? እንዴት ተቆጣጠርሻቸው? የ ስነ ልቦና ፣ ኢኮኖሚያዊ እና መንፈሳዊ ተፅእኖዎች አጋጥሟቹ ይሆን? እንደ እናት/እንደ ሴት ኃላፊነ ትን እነ ዳትወጣያጋጠሟቹ ተግዳሮቶች ፡ ፡

9. በወሊድ ጊዜ በሚከሰት ፊስቱላ ከተጠቃሽ በህዋላ ምን ተግዳሮቶች አጋጠሞሽ? ድጋፍ ለማገኘት ማን ጋር ሄድሽ? ለምን?

ምርመራ:- እንዴት ድጋፍ አገኘሽ? በእነዚያ ጊዜያት ረዳሽ ማን ነው ወይም ያልረዳሽስ ማን ነው ? ለምን? ምን ዓይነት እርዳታ አገሽ? [የህክምና ፣ የስነ-ልቦና ፣ ስሜታዊ ፣ ኢኮኖሚያዊ ፣ መንፈሳዊ ወዘተ. የተሰጣት ድጋፍ በቂ እንደሆነ ተሰምቷታል ወይም እንደጠበቀችውነው? አዎ / አይደለም ከሆነ ለምን? ከእነዚያ ተግዳሮቶች ምን ተሞሽ? ከእነዚህ ተግዳሮቶች ምን የሕይወት ትርጉምተሞሽ?

10. በፊስቱላ ምክንያት የተጋረጡብሽን ተግዳሮቶች እንዴት በፅናት ተቋቁማሻቸው? ምን ዓይነት የመቋቋምዘዴዎችን ተጠቀምሽ?

ምርመራ;- ከእሷ ጥንካሬ እና የመቋቋምዘዴዎች ምን ተማራችሁ? ምን ትርጉምሰጠዎት?

11. ስለ ሀምሊን ፊስቱላ ሆስፒታል እንዴት አወቅሽ ፡፡ እስካሁን ምን ምን አገልግሎቶችን አገኘሽ? በተቋሙባለሽ ቆይታ እየተሰጠሽ ባለው የሕክምና አገልግሎት ምን አስተያየት አለሽ?

ምርመራ;- በሚሰጡት አገልግሎቶቹ ረክተሻል? አዎ / አይደለም ከሆነ ለምን? ምን መሻሻል አለበት? እንዴት? የህክምና እና የአስተዳደር ሰራተኞች እንዴት ነው የተንከባከቡሽ?

12. የፊስቱላ ህክምና ውበህይወትሽ ውስጥ ምን ለውጦች አመጣ?

ምርመራ;- በሕይወትሽ ውስጥ ምን ተለጠ? ህክምና ከሚድረግሽ በፊት እና ህክምና ካደረግሽ በኋላ ያለውን ህይወትሽን እንዴት ታይዋለሽ? ላንቺ ምን ትርጉምአለው? ካገገሞች በኋላ ያለችበትን ሁኔታ ለማን ተናግራለች? አዎ / አይደለም ከሆነ ለምን? ከህክምና በኋላ ያለሽበትን ሁኔታ ሲሰሙየ እነሱምላሽ ምን ነበር?

13. ስለ ማገሚያ ተቋሙየ ሚሰማሽን ነገር ንገረኝ? ከሚህበረሰቡ ጋር ዳግምእንድትቀላቀይ ይህ የማገምያ ተቋምእንዴት ሊረዳሽ ይችላል ፡፡

ምርመራ;- ምን አይነት ስልጠና ወይም አገልግሎቶች ተሰጠሽ? ምን ዓይነት እውቀት/ ችሎታ አገኘሽ? ለምን ያህል ጊዜ? መሻሻል የሚያስፈልገውነገር አለ?

14. በወሊድ ጊዜ በሚከሰት ፊስቱላ ሕክምና ካገኘሽ በኃላ ዳግምወደ ማህበረሰቡ ስለመቀላቀል ምን ታሰቢያለሽ? ምን ዓይነት ተግዳሮቶች ያጋጠሞሽል ብለሽ ታስቢያለሽ? እነዚህን ተግዳሮቶች እንዴት ለመቋቋምአስበሻል? በሕይወትሽ ውስጥአሁን ምን አዲስ ነገር አለ?

15. አሁን በወሊድ ጊዜ በሚከሰት ፊስቱላ ህክምናን ተቀብለሽ የሚሌሰ መቋቋም አገልግሎት እየተቀበልሽ ነው፡ ፡ የፊስቱላ ቀዶ-ጥገና ሕክምናን ከመቀበልሽ በፊት እና በኋላ ሁኔታሽን ወደኋላ ስትመሊከቺው፤ ከባልሽ / ጓደኛሽ ፣ ከልጅሽ ፣ ከቤተሰቦችሽ ፣ ከጓደኞችሽ ፣ ከማህበረሰቡጋር ያለሽ ግንኙነት ምን ይሚከላል ብለሽ ታስቢያለሽ?

ምር ሚራ;- ከዚህ በፊት የነበረው ግንኙነቷ ምን ይሚከላል? አሁንስ? ምን ተለውጧል? ያልተለወጠውስ ምንድነ ው?

16. ከዚህ በፊት አሳካቸዋለውብለሽ ያላሰብሻቸውን ነገሮች፤ ወደፊት እንዴት አሳካቸዋለሁ ብለሽ ታሰቢያለሽ?

ምር ሚራ;- ለምን በጉጉት ተጠባበቂያለሽ? የወደፊት ግቦችሽ ምንድናቸው? የወደፊት ሕይወትሽ እንዴት ታየዋለሽ? ከፊስቱላ ሕክምና በኋላ ምን የተለየ ነገር አለ? ስለ ህክምናው ምን ተሰማሽ? ለምን እንደዚያ ሊሰማሽ ቻለ?

St. Mary's University

የ ሶሻል ወርክ ት/ቤት

ሰንጠረዥ 1 ምላሽ ሰጪዎች የ ግል ሚጃ

ቁጥር	ምላሽ ሰጪው	ዕድሜ	በስንት ዓመትሽ ነ ው በፊስቱላ የ ተጠቃሽው	ሃ ይማኖት	ቀበሌና በከተማው	የ ትምደረጃ	የ ልጅ እና ት ስለ ሚሆን/ ወለጅነ ት
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2							
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Annex 2: Consent Form

St. Mary's University

School of Social Work

Consent Form

You are invited to participate in this interview because you experienced obstetric fistula and received treatment at Hamlin Fistula Hospital in Addis Ababa. This study can be used to develop better prevention and intervention services for women in reproductive age. By sharing your experiences, you will be assisting in building local knowledge that can be used to develop programs to promote and prevent obstetric fistula in Addis Ababa and in Ethiopia, in general. The interview will take 1½ to 2 hours. Please let me know if you need to take a short break during the interview.

You will be asked about your sexual relationships, marriage, childbirth and obstetric fistula experiences. Please note that you have the right to refrain from responding to any questions, halt the interview, or withdraw from the interview process if you feel uneasiness, at any time, and for any reason. During the interview, snack or refreshments will be provided. By participating in this study, there could be potential risks of vulnerability or discomfort for the topic is sensitive. Therefore, if any question makes you feel uncomfortable, for any reason, you can refuse to answer any question or stop the interview at any time. The information you have given will be confidential. Your name will not be referred in any written reports of this study.

Please be advised that participation in this study is completely voluntary. You will receive a copy this consent form. Please feel free to ask any questions that you may have about the study. By signing this consent form, you are acknowledging that you have voluntarily participated in this study.

If you have any questions about this research, please contact Kidist Alemayehu, MSW Candidate, at 251-911-119796; or Dr. Mosisa Kejela, thesis advisor and School of Social Work head, St. Mary's University, at 251-933-7782.

_____	_____	_____
Participant's Name	Signature	Date
_____	_____	_____
Witness' Name	Signature	Date

የ ፍቃደኝ ነ ት ማጠየ ቅያ ቅጽ

በወሊድ ጊዜ የ ሚከሰት ፊስቱላ አ ጋጥሞም ት በአዲስ አበባ በሀምሊን ፊስቱላ ሆስፒታል ህክምና እያገ ኘሽ ስለሆነ በዚህ ቃለ ምልልስ ላይ እንድትሳተፊ ተጋብዘሻል ፡ ፡ ይህ ጥና ት እድሜያቸው ልጅ ለሞክለድ የ ደረሰ ሴቶች የ ተሻለ እንክብካቤ እና ህክምና አገ ልግሎቶችን እንዲያገ ኙ ሊረዳ ይችላል ፡ ፡ ልምድሽን በማ ካፈል በአዲስ አበባ እና በአጠቃላይ በኢትዮጵያ በወሊድ ጊዜ የ ሚከሰት ፊስቱላን ለ ሚያ ውቁት ለማ ስተዋወቅ እና በወሊድ ጊዜ የ ሚከሰት ፊስቱላን ለ ማከላከል የ ተለያዩ ግንዛቤዎችን ለ ማዳበር የ ሚያገ ለግሉ አ ካባቢያዊ ዕ ውቀቶችን በ ማ ንባት እገዛ ታደርጊያለሽ፡ ፡ ቃለ-ማጠይቁ ከ 1½ እስከ 2 ሰዓት ይወስዳል ፡ ፡ አ ጭር እረፍት ሞክሰድ ከፈለግሽ እባክሽን አ ሳውቂኝ ፡ ፡

በዚህ ቃለ-ማጠየ ቅ ስለ ፆ ታዊ ግንኙነ ቶች ፣ ስለ ጋብቻ፣ ስለ ወሊድ እና በወሊድ ጊዜ ስለ ሚከሰት ፊስቱላ አ ንዳንድ ነ ገ ሮች የ ምጠየ ቅሽ ይሆናል ፡ ፡ በቃለ-ማጠይቅ ወቅት መሞላስ የ ማትፈልጊውን ማ ነኛውን ም ጥያቄዎች ሜልስ አለማነጠት ፣ ቃለ-ማጠይቁን ለ ማቆም፣ ወይም ጥሩ ስሜ ካልተሰማሽ በ ማ ነኛውም ጊዜ የ ቃለ ማጠይቁን ሂደት የ ሜቋረጥ መብት እንዳለሽ መ ግለፅ እፈልጋለው ፡ በቃለ-ማጠይቁ ወቅት ብስኩት ወይም ውሃ ይቀርባል ፡ ፡ በዚህ ጥና ት ውስጥ በ ማ ሳተፍሽ ለችግር ልትጋለጪወይም ምቾት የ ሚ ሱ ነ ገ ሮች ሊያጋ ጥሞሽ ይችላሉ ፡ ፡ ስለሆነ ም ፣ የ ምትሰጪውሚጃ በ ሚነጥር የ ሚያ ዝ እንደሆነ አረጋግጥልሻለው ፡ በዚህ ጥና ት በየ ትኛውም የ ጽሁፍ ሪፖርቶች ውስጥ ስ ምሽ አ ይጠቀስ ም ፡

በዚህ ጥና ት ላይ ማ ሳተፍሽ ሞሉ በ ሞሉ በ ፈቃደኝ ነ ት ላይ የ ተመሠረ ተ ሚሆን አለበት። የ እዚህን የ ስ ምማ ት ቅጽ ቅጂ እሰጥሻለው። ስለ ጥና ቱ ያለሽን ማ ነኛውን ም ጥያቄ ለማጠየ ቅ እባክሽን አ ትፍሪ ፡ ፡ ይህንን የ ስ ምማ ት ቅጽ ከፈረ ምሽ በዚህ ጥና ት ላይ በ ፈቃደኝ ነ ት እንደተሳ ተፍሽ እውቅና እየ ሰጠሽ ነ ውማለ ት ነ ው ፡

ስለዚህ ጥና ት ማ ነኛውም ጥያቄ ካለሽ እባክሽን ቅድስት አለማ ሁ ፣ የ (MSW እጩተ ሚራቂ) በ 251-911-11-9796 ልትጠየ ቂኝ ትችያለሽ ፡ ፡ ወይም ዶ/ር ሞኒሳ ቀጀላ፣ የ ፅ ሑፍ አ ማካሪ / የ ማ ነ በራዊ ሥራ ትምህር ት ቤት ኃ ላፊ ፣ ቅድስት ሜ ር ያ ምዩ ኒ ቨር ሲቲ ፣ በ 251-933-70-7782፡ ፡

_____ _____ _____

Participant's Name	Signature	Date
_____	_____	_____
Witness' Name	Signature	Date